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Jaimee York
University of the Cumberlands, jyorkllc@gmail.com

Adrienne Baggs
University of the Cumberlands, adrienne.baggs@ucumberlands.edu

Laura Schmuldt
University of the Cumberlands, laura.schmuldt@ucumberlands.edu

Nancy Sherman
Bradley University, nes@fsmail.bradley.edu

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Author Note Jaimee M. York Orcid ID 0000-0001-7492-5952 Adrienne Baggs Orcid 0000-0003-3607-6683 Laura Schmuldt Orcid 0000-0001-8629-3673 No conflicts of interest to disclose Correspondence regarding this article should be addressed to Jaimee M. York 1390 County Road 1000 N, Lacon, IL 61540 Email: jyorkllc@gmail.com

Trauma Curriculum Integration in Counselor Education: A Delphi Study

Jaimee M. York University of the Cumberlands | Adrienne Baggs Department of Counseling, University of the Cumberlands at Williamsburg, Kentucky | Laura Schmuldt Department of Counseling, University of the Cumberlands at Williamsburg, Kentucky | Nancy E. Sherman, Professor Emerita, Department of Education, Counseling, and Leadership, Bradley University at Peoria, Illinois

Author Note
Jaimee M. York
Orcid ID 0000-0001-7492-5952
Adrienne Baggs
Orcid 0000-0003-3607-6683
Laura Schmuldt
Orcid 0000-0001-8629-3673

No conflicts of interest to disclose

Correspondence regarding this article should be addressed to Jaimee M. York
1390 County Road 1000 N,
Lacon, IL 61540
Email: jyorkllc@gmail.com

Abstract

Research has established the need for trauma education and training for safe and effective entry-level practice. However, studies have shown insufficient and inconsistent training in graduate counseling programs. Those studies reflected the opinions and experiences of practitioners and graduate students. To add to the extant literature, we used the Delphi method to gather information from counselor educators who have experience in trauma counseling and education. The Delphi technique is a group communication strategy designed to obtain expert consensus through a series of survey questionnaires, modified and adapted to reflect group opinion. We asked participants for their insight into the most effective way to integrate trauma education into the graduate counseling curriculum. After three survey rounds, 12 trauma and counselor education experts reached consensus on the following: (a) faculty education and training to increase competence and efficacy in teaching trauma-focused material and utilization of trauma-informed teaching practices that enhance learning; (b) counselor educator dispositions that reflect a responsive, trauma-informed, and resilience-oriented framework to facilitate change; (c) development of course content that incorporates trauma-informed principles, trauma-specific knowledge and skills, cultural diversity, and assessment; (d) accreditation standards that support trauma education. The expert panel offered recommendations that the counseling profession can utilize to move forward in making trauma education a priority.

KEYWORDS
trauma, counselor education, counseling, Delphi study, trauma curriculum

INTRODUCTION

It has been well established that trauma is pervasive and may adversely impact individuals, families, communities, and populations (CDC-Kaiser Permanente, 2016; Cook & Newman, 2014; Courtois & Gold, 2009; Kilpatrick et al., 2013; New Freedom Commission on Mental Health, 2003;

SAMHSA, 2014a). In recent years, the far-reaching effects of trauma exposure became increasingly evident as the world's population was forced to navigate a pandemic and various social injustices. Although many individuals report a single traumatic event, "others, especially those seeking services for mental or substance use disorders, have been exposed to multiple or chronic traumatic events" (SAMHSA, 2014b, p. 1). Due to the impact and prevalence of trauma, all counselors will work with clients directly or indirectly affected by trauma.

The American Counseling Association (ACA) issued a resolution on trauma-focused mental health care that briefly highlighted the significant impact of trauma and the need for trauma competent counselors to provide safe and effective services (2018). The ACA recommended that counselors acquire trauma competencies outlined by the American Psychological Association (APA). *Trauma competencies* are the skills, knowledge, and attitudes necessary for prevention, treatment, and recovery (APA, 2015).

A panel of 60 experts from the fields of psychology, social work, and psychiatry developed the APA's *Guidelines on Trauma Competencies for Education and Training* (2015) that outline the minimal expectations for entry-level professional practice. The competencies consist of nine cross-cutting competencies and five core competency domains. The cross-cutting competencies outline knowledge, skills, and attitudes representative of all competencies: demonstrating the ability to understand the impact of trauma, modifying each aspect of assessment and treatment to honor diversity and account for developmental lifespan factors, maintaining self-awareness and self-care, enhancing safety and respecting autonomy, incorporating survivor's strengths and resilience, evaluating and applying research-supported treatment, and collaborating with others to improve outcomes (APA, 2015). The five core domains are scientific knowledge, psychological assessment, psychological intervention, professionalism, and relational and systems.

In addition to the ACA's recommendation, counselors have an ethical duty (ACA, 2014) and legal obligation (Wheeler & Bertram, 2015) to develop professional competencies to reduce harm and promote client welfare. However, studies have shown that many counselors, counselor educators, and clinical supervisors lack sufficient training and education necessary to develop trauma competencies (Cook et al., 2011; Cook & Newman, 2014). Adams and Riggs (2008) found that a significant percentage of therapist trainees reported minimal-to-no trauma training before their work with trauma survivors. This finding is consistent with Parker and Henfield's (2012) qualitative study of school counselors' experiences with vicarious trauma and their expressed need for additional graduate school training. Cook et al. (2011) also found that a significant percentage of practicing therapists expressed a need for additional trauma-specific education and training, as the majority work with trauma survivors.

More recently, Cook et al. (2017) conducted a national survey of doctoral psychology programs to identify trauma training options and barriers. Their results indicated that most programs assessed were not trauma-focused, and only 31.8% offered trauma courses. Although there are no similar surveys to assess graduate counseling programs, this lack of preparation in providing trauma-informed services was reflected throughout the literature (Chatters & Liu, 2020; Cook et al., 2019; Kenney & Abreu, 2015; Simiola et al., 2018).

Inadequate training can harm both clients and counselors. For example, research has shown that training inadequacies may influence the following: service utilization and attrition rates (Schottenbauer et al., 2008), diagnosis, treatment planning, level of client distress and impairment (Cook et al., 2019), counselor's attention to multicultural considerations (Mattar, 2011), counselor self-efficacy (Sartor, 2016), and counselor mental health (Phillips, 2020).

Since trauma education in graduate programs has not been consistently provided, counseling professionals wishing to develop trauma-specific knowledge and skills must seek continuing education opportunities, review scholarly literature, consult with trauma-informed peers, or obtain trauma supervision (Bray, 2015).

Numerous researchers have illustrated a need for trauma-focused graduate coursework to provide students an opportunity to develop core competencies and mitigate the potentially harmful effects of inadequate training (Baker, 2012; Cook et al., 2019; Courtois & Gold, 2009; Webber & Mascari, 2009). Counselor educators are well-positioned to provide this crucial training as they are responsible for facilitating counseling student professional development. As gatekeepers of the profession, counselor educators have an ethical obligation to protect clients and counselors (ACA, 2014; ACES, 2011). Since most counselors will work with clients impacted by trauma, this responsibility would reasonably include the development of trauma competencies. The obligation to counseling students and their future clients is based on professional (i.e., counselor educators' role and responsibilities to clients, counselors, and the profession), ethical (e.g., competence, avoiding harm), social justice (e.g., increasing equal access to safe and effective healthcare, understanding the role of culture), and accreditation standards (i.e., inclusion of trauma, crisis, and disaster).

Although the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2015) requires accredited counseling programs to instruct students on the impact of trauma, crisis, and disaster response, graduate programs are provided autonomy in instituting these standards. Current research in counseling and allied professions indicates a lack of consensus on effectively integrating trauma curriculum (Chatters & Liu, 2020; Cook et al., 2019; Greene et al., 2016; VanAusdale & Swank, 2020). At the time of this study, research on trauma education and pedagogy was scarce (Barrio Minton et al., 2014; Cook et al., 2017; Simiola et al., 2018), especially within the counseling field (Webber et al., 2017). Most research focused on crisis intervention and disaster response instead of trauma-specific education (Barrio Minton & Pease Carter, 2011; Guo et al., 2016; Peters et al., 2017; Wachter Morris & Barrio Minton, 2012). Additionally, those studies focused on counseling students' and practitioners' reports of graduate-level trauma training instead of evaluating the programs directly. Chatters and Liu (2020) indicated a need for further inquiry into how graduate programs incorporate trauma curriculum to assist others in moving forward with this critical task.

This study was conducted to allow counselor educators to provide insight and guidance on trauma curriculum integration. The primary research question guiding this study was: What does a group of counselor educators with expertise in trauma counseling agree is the most effective way to integrate trauma education into the graduate counseling curriculum? Although participants were also asked to provide insight into barriers to trauma integration and resources needed to reduce those barriers, the primary research question is the focus of this article. The results from this study may be used to inform practice, program development, and assessment in both master's- and doctoral-level graduate counseling programs. The experts' insight might spark meaningful conversations about how to best serve and advocate for students, clients, and the profession through consistent utilization of trauma-informed and trauma-competent practices.

METHOD

This study used the Delphi methodology due to its exploratory nature and the need for more empirical research focused on counselor educators and graduate counseling programs. Delphi research is conducted to gather currently unknown or unavailable information and is often used for

curriculum development (Linstone & Turoff, 2002; Sitlington & Coetzer, 2015). The Delphi technique is a group communication strategy designed to obtain expert consensus through a series of survey questionnaires, modified and adapted to reflect group opinion (Hsu & Sandford, 2007). The Delphi method typically includes two to three rounds (Keeney et al., 2011). Round 1 of a traditional Delphi uses open-ended questions to generate ideas guiding the study (Keeney et al., 2011). In Delphi research, participants' responses in each round are utilized to construct the next round's questionnaire. The four defining characteristics of Delphi are anonymity, controlled feedback, statistical group response, and iteration (Hsu & Sandford, 2007). These characteristics offer several advantages related to other group research methods. Anonymity may lead to more open and honest responses and reduce subject bias (Keeney et al., 2011). The process allows participants to review data and feedback at their convenience (Avella, 2016). In each subsequent round, participants check their responses in relation to the group, which lends credibility to the data (Keeney et al., 2001).

PARTICIPANTS

Participants in Delphi studies are chosen for their knowledge and experience in an area of interest. Their expertise is often determined by years of experience, specific qualifications, and publications (Keeney et al., 2011). The inclusion criteria and sample size are based on the available timeframe, purpose, and research design (Keeney et al., 2011). The inclusion criteria for this study were in line with the Delphi study of Adams et al. (2015) which focused on counselor education and curricular modifications. In addition, optional criteria reflected the need for trauma-specific training for competent practice (Cook & Newman, 2014; Gentry et al., 2017).

Participants were therefore required to (a) possess a doctoral degree in counselor education and supervision, or equivalent; (b) possess experience teaching master's-level counseling courses; (c) have counselor educator experience in a CACREP-accredited program; (d) hold membership in the ACA or other counseling-related professional membership; and (e) have modified counseling courses to include trauma, implemented a modified syllabus that included trauma, or other experience as a counselor educator in which trauma content was added to the curriculum. The following optional criteria further delineated expert status: (a) possess certification and training in trauma, (b) completed research or published articles related to trauma.

After obtaining IRB approval (Approval #11-0321), the primary researcher utilized two methods to identify potential participants. A review of CACREP's website listing of master's-level counseling programs and associated links to faculty bios and curricula vitae helped identify counselor educators with trauma-related experience, publications, and research interests. An additional search identified authors who have published trauma-related articles in counseling journals over the past 10 years. Authors who worked in CACREP programs were invited to participate. Invitations and informed consent documents were sent to 68 counselor educators. The goal was to recruit up to 20 expert panelists with a minimum requirement of 12. This sample size was consistent with other Delphi studies found throughout the literature in the field of counselor education and supervision (Adams et al., 2015; West, 2010). In this study, 12 of the initial 16 individuals who agreed to participate completed Round 1, 10 experts completed Round 2, and nine completed Round 3.

The collected demographic information ensured that participants met the inclusion criteria and allowed readers to determine the transferability of results. Instead of pre-selected categories, participants were provided space to write in their race and ethnicity, gender, and languages spoken. One participant identified as Asian, two identified as Caucasian, one identified as Caucasian

American from German and Scottish ancestry, and eight identified as White. Although the categories of White and Caucasian are often combined in research, both categories were included to reflect participant self-identification and to reduce potential bias from how the researcher defines these terms.

In response to the question regarding gender identification, three individuals identified as cisgender female, seven identified as female, and two identified as male. All participants reported speaking English, one participant speaks Spanish, two participants speak French, one speaks Romanian, and one participant speaks Mandarin/Chinese. Of the 12 participants, four were between the ages of 31–40, four were between 41–50, two were 51–60, one was between 71–80, and one participant chose not to answer.

All participants reported teaching at CACREP-accredited graduate programs, and all integrated trauma into the curriculum. Responses ranged from 1 to over 21 years of experience. Ten experts provided clinical supervision to students while employed as counselor educators, and their years of experience providing clinical supervision ranged from 1 to 36 years. Those who provided clinical supervision supervised students who worked with clients affected by trauma. Their years of experience practicing as a professional counselor, full or part-time, ranged from 2 to 48 years. Years of experience counseling clients impacted by trauma ranged from 0 to 42, with nearly half of participants (41.67%) reporting 13–15 years of experience.

In addition to general certifications, 10 participants (83.33%) maintained trauma certification. All participants reported completing trauma-specific training or attending conferences, webinars, workshops, or other counseling-related functions in which the presenters discussed trauma counseling or trauma education. Participants reported a wide range of membership in professional organizations, including marriage and family therapy, school counseling, and resilience and trauma counseling. Ten participants (83.33%) were members of the ACA, seven participants had membership in the Association for Counselor Education and Supervision (ACES) (58.33%), and five belonged to the international honor society of professional counseling, Chi Sigma Iota (41.67%).

Ten participants (83.33%) completed research or published trauma-related articles. The number of research studies or publications ranged from 1–12 for an approximate combined total of over 48. All participants have presented on trauma-focused topics. The number of presentations and trauma training reported ranged from 4 to 167 for an approximated combined total of over 308 presentations or trainings.

PROCEDURE

Although no universal guidelines dictate the number of rounds required in a Delphi study, at least two rounds are required to gain consensus (Keeney et al., 2011). Researchers must also consider the potential for high dropout rates due to the time required for facilitators and respondents, the time between rounds, and the number of rounds (Hsu & Sandford, 2007; Keeney et al., 2011). For this study, three rounds were sufficient based on the nature of the study, time frame, and anticipated challenges with attrition and response rates. Data collection took place over two months, April and May of 2021. Participants were contacted via email and provided informed consent documents, contact information, and separate survey links. A two-week deadline was set for each survey round.

Before the study began, a response rate of 70% was deemed acceptable to maintain rigor (Keeney et al., 2011). To reduce attrition and enhance response rates, participants who completed the study had the chance to win one of five $50 e-gift cards. Of the 16 recruited experts, 12 completed the first round, 10 (83.33%) completed Round 2, and nine (75%) completed Round 3.

Questionnaires were distributed using Qualtrics, an online survey tool that allows researchers to remove identifiers to protect confidentiality. Each participant was assigned a numeric ID, and research files were password-protected. Only the primary researcher had access to participants' identities to track response rates and determine who qualified for the gift card incentive.

Pilot Study

We conducted a pilot test as part of the questionnaire construction process and modified the documents based on recommendations consistent with the study's research questions, purpose, and design. Three counselor educators with experience in trauma counseling provided written feedback regarding the layout, comprehensibility, completion time, and clarity of the informed consent document, invitation, and Round 1 survey.

The counselor educators were chosen based on their professional experience with trauma and counselor education. Two of the participants had previous experience with Delphi studies and could offer additional insight into the methodology. All participants spoke English only, were between the ages of 31 and 50, identified as White or Caucasian, and identified as female. All three participants possessed a doctoral degree in Counselor Education and Supervision, 1–3 years of teaching experience as a counselor educator, and worked at CACREP-accredited institutions. All participants had modified a syllabus to include trauma or otherwise integrated trauma into the curriculum. The years of experience as a counseling supervisor ranged from 7–15 years, and experience as a professional counselor ranged from 10–18 years. All three participants reported working with clients impacted by trauma for most of their professional experience.

Round 1

In addition to the demographic section, the final version of the Round 1 questionnaire consisted of three open-ended questions. The first question relating to effective trauma curriculum integration included numerous factors for the panel to consider in their response. The factors were consistent with those identified in the literature review (Chatters & Liu, 2020; Cook et al., 2019; Courtois & Gold, 2009; Kenny & Abreu, 2015; Strand et al., 2014; VanAusdale & Swank, 2020). The question read: (a) "What do you believe is the most effective way to integrate trauma education into the master's-level graduate counseling curriculum? Note: You may consider the following factors in your response. However, you are not required to include these factors: competencies and resources utilized in structuring courses; details of course content; which courses should contain trauma education and training components; should trauma be a stand-alone course, specialization, or integrated throughout; at what point in a counseling program should students start to learn about trauma; assessments to evaluate learning; methods of instruction; trauma training for counselor educators; cultural considerations; teaching strategies to reduce the impact of trauma content on students."

Although the responses to the second and third open-ended questions are not the focus of this article, participants were asked the following: (b) "What barriers exist to integrating trauma education in the graduate counseling curriculum? For example, barriers may include cost, lack of time, training, administrative support, personal history, concerns for students' health, or other factors that may interfere with trauma curriculum integration. (c) What resources and support are needed to reduce or eliminate those barriers?"

Round 2

The primary researcher and a peer reviewer completed a content analysis to combine, categorize, and conceptualize Round 1 responses. This analysis was an inductive process in which categories and themes emerged from the data while using a modified version of Burnard's 14-stage content analysis process (1991). The modified process consisted of an initial transcript review and

notation of general themes; notation and grouping of meaning units (i.e., sentence or phrase conveying an idea) into category headings; second transcript review alongside the list of categories; transcript coding and organizing under category headings; an independent peer review to generate categories; participants were asked to check data in each round and provided space to add categories, comment, or ask questions; and use of the literature to compare results. This process generated 144 items and representative statements used to construct the Round 2 questionnaire. Of those items, 77 corresponded to the first research question regarding effective trauma curriculum integration.

For Round 2, the experts rated and evaluated each item on a 7-point Likert scale (1= strongly disagree, 7= strongly agree) representing their level of agreement. The survey included space for comments, edits, and additional information. The primary researcher analyzed responses to determine if the panel reached consensus. An item was required to meet the following three conditions for consensus: interquartile range (IQR) equal to or less than 1, a median score of 6 or greater, and 70% of responses must fall within two categories on the scale.

Sixty-two of 77 statements related to trauma curriculum integration met the criteria for consensus. For example, the experts agreed that trauma is a cross-cutting theme and relevant to every course; the study of trauma needs to be integrated throughout the curriculum and should also have its own dedicated course; instructors should integrate established trauma competencies as baseline guides for developing trauma learning objectives for students. The remaining 15 items that did not reach consensus were incorporated into the Round 3 survey for expert panel reconsideration. Participant feedback led to the inclusion of an additional four items focused on individualizing client treatment plans, learning about integrative trauma techniques and interventions, the evolution of treatment from retelling the story to recovery without the trauma narrative, and the need to teach phase-specific treatments and strategies.

Round 3

The structure of Round 3 provided panelists an opportunity to reconsider their initial response in the context of the group response (Hsu & Sandford, 2007). All feedback from Round 2 was included in Round 3 to assist in this process. In addition, participants were provided three documents: (a) a statistical summary of the Round 2 responses that reached consensus, including the median, IQR, and frequency tables; (b) a statistical summary of the remaining statements that did not reach consensus; and (c) an individualized list of each participant's Round 2 responses.

Participants reconsidered their initial rating in this final round based on the new information provided (i.e., IQR, median, input from expert panelists). The same 7-point Likert scale was utilized. After each item, participants could add comments, edits, or provide a rationale for their decision to keep or change their initial rating.

Trustworthiness

The qualitative standard of *trustworthiness* was utilized to determine the *credibility* and *transferability* of results (Keeney et al., 2011). Trustworthiness was accomplished through member checking, peer debriefing, data collection, and analysis (Morrow, 2005). The experts were allowed to review, revise, and comment on the data and data analysis, thereby adding their perspective to data interpretation. The iterative rounds and feedback served as a form of member checking.

Triangulation was used to reduce researcher bias by using multiple sources, methods, and theories to support findings and interpretations (Young, 2017). Using numerous sources of information and providing multiple opportunities for participant feedback added to the richness of the data (Morrow, 2005). The research literature was viewed as part of the context of the study as it provided additional insight and clarity about the research topic (Haverkamp & Young, 2007).

Comparing results to the literature allowed us to triangulate expert opinion with the existing literature.

FINDINGS AND DISCUSSION

After three rounds, the expert panelists reached consensus on 73 (85.9%) of 85 representative statements regarding effective trauma curriculum integration. Six categories emerged from the data: trauma integration vs. stand-alone course, CACREP standards, student learning and course content, attitudes of counselor educators, faculty training and education, and teaching practices. Table 1 provides a statistical summary of eight representative statements not included in the following text.

Table 1

Effective Trauma Curriculum Integration, Representative Statements Not Included in Text

Representative Statements	IQR	Median	%
Trauma education should be the equivalent to at least a 1-hour graduate credit.	1	7	70
All students need basic trauma counseling education because roughly 90% of clients have experienced at least one traumatic event.	0	7	100
Many courses in counselor education programs (e.g., Lifespan, Theories, school counseling courses) cannot be taught without integrating trauma within them.	1	6.5	90
How assessments and course structure are addressed is up to the faculty member, but it needs to be addressed.	1	6	80
A stand-alone trauma course is necessary to cover new research and trauma-informed approaches to counseling.	1	7	100
Experiential activities are encouraged to use in the classroom to help students learn about their nervous system and to practice the skills of self-regulation.	1	7	90
Experiential, role-play, and active learning methods are always the most effective in delivering any content material, especially one as emotional and as complex as trauma.	1	7	90
To be qualified to teach this content in a culturally trauma sensitive way, I believe the faculty should have training in trauma whether in their master's or doctoral training or through continuing education.	0	7	100

Note. This table lists representative statements that reached consensus and were not referenced in the main text. IQR = Interquartile Range; % = percentage.

TRAUMA INTEGRATION VS. STAND-ALONE COURSE

The expert panel communicated an understanding of the prevalence of trauma in the clinical population and agreed that students require basic trauma counseling education. Although scholars have disagreed on how to incorporate trauma education, all panelists in this study agreed that trauma education is relevant to every course and, therefore, should be integrated throughout the curriculum and have its own dedicated course. The

panel indicated that trauma curriculum should be incorporated at the beginning of the program and continue throughout the program's entirety. In addition, trauma education should be taught in all counseling specializations (i.e., clinical mental health, marriage, couple, and family, school counseling).

Ninety percent of the group agreed that an advanced course is needed for students seeking additional trauma-focused knowledge and skills. Eighty percent agreed with the recommendation that "Trauma should comprise between 15% and 20% of every core and specialization course in the same way that ethics and cultural consideration have stand-alone courses and are also a strong part of every course". The group agreed that the stand-alone course should be separate from crisis response. APA's guidelines on trauma competencies (2015) and research describing crisis, disaster response, and trauma counseling (Gentry et al., 2017; Meyers, 2017; Webber et al., 2006) further support this assertion.

Conceptualizing program changes this way may prove valuable in initiating the change process, as programs may have already established a system to support this transition. Programs and educators may reflect on the decision-making processes and strategic planning utilized in the past to adjust the curriculum to meet the current needs of the profession. For example, program administrators may consider the process utilized when programs were required to increase credit hours from 48 to 60, to include multiculturalism as part of the core curriculum, and to adjust the curriculum to reflect new standards with each CACREP revision (Bobby, 2013).

The panel agreed that graduate programs integrating trauma education throughout the curriculum "need to be able to specify where and how trauma education was provided." They suggested that "trauma education should be linked to specific and cumulative learning objectives." They recommended that instructors "integrate established trauma competencies as baseline guides for developing trauma learning objectives for students." The panelists' recommendations are consistent with research supporting a move toward competency-based educational models (Cook & Newman, 2014; Hatcher et al., 2013).

Although the experts in this study did not specify which competencies counselor educators should integrate, the research literature offers various resources for programs that seek to incorporate trauma-specific learning objectives, benchmarks, and competencies. These resources include the Substance Abuse and Mental Health Services Administration's (SAMHSA) trauma-informed counselor competencies (2014b) and APA's trauma competencies for education and training (2015). Cook et al. (2019) also provide numerous resources including the APA website (www.apatraumadivision.org); the National Center for PTSD (https://www.ptsd.va.gov/), the International Society of Traumatic Stress Studies (2021); and the National Child Traumatic Stress Network (https://www.nctsn.org/), which offers education and resources, including the Core Curriculum on Childhood Trauma.

The panel indicated that the entire counseling faculty must be on board to effectively integrate the trauma curriculum. Building faculty consensus is often necessary to identify how best to integrate standards into the existing curriculum (Lee et al., 2013). Other stakeholders in counselor education whose endorsements may be needed for trauma curriculum integration include students, clients, ACA, CACREP, and program administration. Programs may gain stakeholder support by considering the rationale, importance, and benefits of adding new content areas (Kitzrow, 2002). The research offers ample evidence of the importance and benefits of trauma education. There will likely be conflicting opinions on this topic with the number of stakeholders involved. Therefore, open dialogue and collaboration are essential, consistent with advocacy and trauma-informed principles.

CACREP STANDARDS

To facilitate this process, all experts agreed that "CACREP needs to emphasize the importance of trauma." Ninety percent of the panel agreed that "the accrediting bodies should require proof that trauma content was addressed." Although the 2016 CACREP Standards (2015) require programs to evaluate their effectiveness and assess student learning, current standards do not require an evaluation of trauma-specific learning. The standards referenced the need for students to learn about the impact of crisis and trauma but provide programs flexibility in how those standards are incorporated. This autonomy leads to variation in content, quality, and comprehensiveness. Therefore, assessments are needed to obtain outcome data to identify where trauma-specific learning occurs and determine the most effective methods.

Since the time of this study, CACREP has developed new standards which went into effect in 2024. Although the 2016 Standards referenced trauma in three of eight foundational curriculum areas, the 2024 Standards include trauma in five curriculum areas: social and cultural identities and experiences, lifespan development, career development, counseling practice and relationships, and assessment and diagnostic processes (CACREP, 2023). Specifically, the 2024 standards require programs to educate students about multigenerational trauma, the effects of trauma across the lifespan, approaches for conceptualizing the interrelationships of various factors including trauma, trauma-informed strategies, and assessing clients' experience of trauma (CACREP, 2023).

STUDENT LEARNING AND COURSE CONTENT

The panel reached consensus on several statements that reflect the principles of constructivist learning theory and pedagogy often utilized in counselor education (Brackette, 2014). For example, the panel agreed that repeating trauma-related concepts is necessary for student learning and suggested courses include didactic and experiential learning components and activities. In addition to traditional textbooks and classroom lectures, the panel recommended guest speakers, videos, small group discussions, and non-textbook readings.

Knowledge and Skills

The panel recommended knowledge and skills that are foundational in developing an effective trauma curriculum and developing trauma competency. All panelists agreed that trauma courses should include knowledge about safety and stabilization, psycho-neuro-biological underpinnings of trauma and its epigenetic sequelae, types of trauma, treatment options, developmental and cultural contexts for trauma, immediate and long-term impacts of trauma, diagnostic features of trauma and frequent co-occurring diagnoses, unique implications for the therapeutic relationship, training on managing vicarious traumatization, key principles of trauma-informed practice, self-regulation for students while learning and for use as future counselors, new research, trauma-informed counseling approaches, an explanation of trauma/stress response in general, specific trauma topics such as suicide and child maltreatment, and the critical role of self-awareness, countertransference management, and self-care.

Most panelists agreed that "it would be helpful for courses to differentiate between types of trauma, origins of trauma, and prevention/postvention for trauma." They suggested that "trauma should be taught as a contributor with systems factors within human growth and development (i.e., teaching and practicing ACEs administration)." Additionally, 80–90% of the panel agreed that the curriculum should include Dr. Judith Herman's three phases of trauma recovery, skills practice, attachment and trauma, trauma assessments, trauma-specific theories and models, information about integrative trauma techniques and interventions throughout the

phases of trauma treatment and training, phase-specific treatments and strategies, positive utilization of supervision in trauma work, and trauma models that reflect the individualization of client treatment plans, interventions and techniques.

Each statement endorsed by the panel aligns with current literature within either the context of counselor education or in support of learning this content as part of a trauma-informed system (Adams & Riggs, 2008; APA, 2015; Chatters & Liu, 2020; Gentry et al., 2017; SAMHSA, 2014). The expert panel endorsed many statements that reflect concepts and principles outlined in the APA's *Guidelines on Trauma Competencies for Education and Training* (2015).

Cultural Diversity

The expert panel also recommended that counselor educators attend to cultural diversity as one facet of effective trauma curriculum integration. Mattar (2011) indicated that counseling professionals must consider multicultural factors as culture may influence the presentation of symptoms, the therapeutic relationship, service utilization, assessment and treatment protocols, risk factors, treatment access, and a client's perception and experiences of trauma. Scholars have emphasized the importance of attending to individual differences, cultural identity, and development in working with clients impacted by trauma (Brown, 2010; Strand et al., 2014).

The expert panel recommended that counselor educators consider cultural diversity in several courses for effective trauma curriculum integration. Ninety percent of panelists agreed that "trauma should be studied across the entirety of the lifespan, with a particular focus on the diverse cultural implications that arise." The group agreed that "cultural considerations should be highlighted not only related to socio-cultural trauma (i.e., institutionalized racism) but also the cultural differences of trauma in general (i.e., how is childhood sexual abuse different in different cultures)." Eighty percent of participants agreed that it is essential to include trauma content specific to a particular community or region (i.e., poverty, incarceration, natural disasters, military trauma, intimate partner or domestic violence, substance abuse).

Courses

The panel agreed that the cultural component of trauma should be covered in multiple classes such as Growth and Development, Career, Assessment, Psychopathology, Techniques, and Practicum/ Internship. Additionally, all participants agreed that meaningful integration of trauma-focused concepts for practice and conceptualization requires integration into numerous courses, including Diagnosis and Treatment Planning, Counseling Across the Lifespan, Multicultural Counseling, Child and Adolescent Counseling, Assessment, Techniques, Practicum, and Internship. Clinical courses provide an opportunity for trauma-focused supervision, self-reflective practice, and "to teach students useful ways to manage their own trauma and prepare them for working with clients' trauma."

TEACHING PRACTICES

The panel also considered teaching practices for safe and effective learning. Scholars have recommended a trauma-informed teaching approach (Butler et al., 2016; Cook et al., 2019; Wilson, 2017), as some pedagogical practices may result in retraumatization or secondary traumatization (Carello & Butler, 2014). Consistent with these recommendations, all panelists agreed that counselor educators "need to use a trauma-informed approach in teaching all courses." Educators should embrace and utilize a trauma-informed teaching approach of "providing structure, consistency, and safety to help students navigate through the courses." Ninety percent of the panel agreed that "educators must embrace trauma sensitive teaching practices" and "need to be able to provide supervision and assist students in becoming self-reflective."

ATTITUDES OF COUNSELOR EDUCATORS

The panel reached consensus on several statements regarding professional attitudes which may facilitate effective trauma curriculum integration. All panelists agreed that counselor educators need to acknowledge that some clients "need something other than CBT or brief SFT," and that “resilience is a thing that needs to be taught along with trauma." Ninety percent of the panel agreed, "Clients need mental health professionals to acknowledge and validate trauma as a negative event and instill clients with hope, encouragement, and specific tools for dealing with trauma and fostering resilience." These assertions are consistent with current literature on trauma-informed care and trauma competencies, highlighting the importance of fostering resilience, instilling hope, and utilizing a responsive treatment approach (APA, 2015; APA, 2017; Duncan et al., 2010; SAMHSA, 2014b).

FACULTY TRAINING AND EDUCATION

Consistent with current research (APA, 2015; Kenny & Abreu, 2015), findings from this study reflect the importance of faculty training and education for effective trauma curriculum integration. The panel agreed that counselor educators need to be both trauma-informed and trained in trauma counseling. This training may occur in master's or doctoral programs. It was recommended that "doctoral programs include coursework on trauma education in which counselor educators are taught best practice principles for trauma education delivery and trauma-informed supervision." The panel recommended professional development in this area for counselor educators who did not receive trauma training in their graduate programs.

LIMITATIONS

Several limitations must be considered when interpreting these results. The Delphi methodology lacks universal guidelines related to expert status, panel size, and the number of rounds. Therefore, the researchers make these decisions based on criteria used in similar studies, timeframe, aims and objectives of the study, and other relevant factors. All decisions are then subject to researcher bias. For example, we initially defined expert status based on criteria used in similar studies and assumptions about the years of experience needed to modify the curriculum. Although the original criteria indicated that three years of teaching experience was required, two participants did not meet this standard. However, both participants met all other criteria, including the optional research, publication, and training criteria. Since Delphi studies aim to include individuals who can speak knowledgeably on the research topic (Avella, 2016) and the experts reported significant experience in traumatology, the decision was made to modify this criterion.

We determined that a minimum panel size of 12 was appropriate for this study. Although increasing the number of participants may have generated a broader range of ideas, adding to the richness of the data, increasing the panel size may also have resulted in a lower response rate due to the amount of information to review. The time required for participants to complete each round can impact the attrition rate (Hsu & Sandford, 2007). Therefore, we determined that three rounds were sufficient for the purpose and timeframe of the study.

Each round allowed participants to share and expand on ideas which generated a significant amount of content. The content analysis and peer review process in Round 1 reduced the impact of researcher bias. However, the primary researcher had to make critical decisions about what to include in each round and independently analyzed data from Round 2, determined which participant comments to share with the panel, and constructed

new survey questions based on feedback from the group. Participant feedback that seemed relevant to the purpose of the study and related to items on the questionnaire was included. These decisions may have also influenced the outcome.

Retaining experts for the entirety of the study proved challenging. Dropout rates can be high in Delphi studies due to the number of rounds and time required for completion (Keeney et al., 2011). In this study, 12 of the initial 16 individuals who agreed to participate completed Round 1, 10 experts completed Round 2, and nine completed Round 3. It is unclear why four participants did not complete the first round. The primary researcher sent follow-up emails and offered additional time but did not receive a response. Counselor educators who declined the first invitation cited personal and professional responsibilities, along with the time of year (i.e., end of the semester), as reasons for their inability to participate. These factors may have contributed to the response rate in this study.

IMPLICATIONS FOR FUTURE RESEARCH

The results of the current study provide direction for future research in trauma-related counselor education. Research should advance our knowledge of how to integrate trauma training into master's- and doctoral-level programs. The panel agreed that the preferred structure of graduate counseling programs is to integrate trauma education throughout the curriculum and offer a stand-alone trauma course. Investigating the effectiveness of counseling programs offering this structure would be helpful. It would also be beneficial for researchers to identify programs that utilize existing competencies and evaluate the effectiveness of those programs. The program can be a model for other graduate programs, if research supports its efficacy.

On a smaller scale, researchers may also evaluate trauma integration into the specific courses identified in this and other studies. For example, Strand et al. (2014) evaluated a social work elective course on trauma offered at four different schools of social work. The course designers utilized a modified version of the National Child Traumatic Stress Network's Core Curriculum on Childhood Trauma (Layne et al., 2011). The course consisted of five case-based learning modules, which included information on the complexities of trauma; impact on children, adolescents, families, and systems; protective factors; developmental neurobiology; impact on providers; and role of culture (Strand et al., 2014). Students completing the course reported improved ability to understand trauma-related concepts and knowledge and increased confidence in working with children and adolescent trauma survivors (Strand et al., 2014).

The experts in this study agreed that faculty training and education are crucial elements in effectively integrating trauma curriculum. Future research may focus on faculty's experiences with trauma training and how training informed their teaching practices. The panel agreed that faculty need to be trauma-informed. We recommend that graduate programs create a trauma-informed, resilience-oriented culture to enhance this development. Programs may consider researching whether the institution reflects the principles of a trauma-informed system. Programs may evaluate training and educational practices, hiring and performance review, administrative support of trauma initiatives, service delivery, policies, and program procedures (Fallot & Harris, 2009). Resources are available to facilitate this research (Fallot & Harris, 2009; National Council for Behavioral Health, 2021; SAMHSA, 2014b).

CONCLUSION

This study adds to the literature by providing insight into the beliefs and experiences with trauma curriculum integration of a group of counselor educators. The expert panel offered recommendations that the counseling profession

can utilize to move forward in making trauma education a priority. The panel endorsed items that provide evidence of the urgent need for graduate counseling programs to adjust their curriculum to integrate trauma education and training. The results of this study provide support for the following: (a) faculty education and training to increase competence and efficacy in teaching trauma-focused material and utilization of trauma-informed teaching practices that enhance learning; (b) counselor educator dispositions that reflect a responsive, trauma-informed, and resilience-oriented framework to facilitate change; (c) development of course content that incorporates trauma-informed principles, trauma-specific knowledge and skills, cultural diversity, and assessment; (d) accreditation standards that support trauma education. Counselor educators may use these recommendations to promote counseling students' trauma competence and enhance professional identity. Counselor educators who oversee the development of trauma competent professionals are helping to protect future clients and counselors from harm.

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