Received: 22 November 2021 | Revised: 20 June 2022 | Accepted: 11 October 2022

DOI: 10.1002/ceas.12249

COUNSELOR PREPARATION

Creating sanctuary: A programmatic approach for trauma integration in counselor education

Jeanne M. Felter[1] | **Stephen DiDonato**[2] | **Nicole Johnson**[1] | **Yoon Suh Moh**[1] | **Angelle Richardson**[1] | **Astra Czerny**[3]

[1]Department of Counseling and Behavioral Health, Thomas Jefferson University, Philadelphia, Pennsylvania, USA

[2]College of Nursing, Thomas Jefferson University, Philadelphia, Pennsylvania, USA

[3]School of Counseling and Human/Community Service, Lenoir Rhyne University at Hickory, Hickory, North Carolina, USA

Correspondence
Jeanne M. Felter, Department of Counseling and Behavioral Health, Thomas Jefferson University, 4201 Henry Avenue, Philadelphia, PA 19144, USA.
Email: Jeanne.felter@jefferson.edu

Abstract

Most individuals receiving mental health treatment have trauma histories, yet counselors and counselor educators trained in traditional counseling programs have insufficient background in trauma and trauma-informed care. Here, we describe the literature-supported approach we use to integrate trauma knowledge and competencies across the graduate clinical mental health counseling program.

KEYWORDS

counselor education, sanctuary model, trauma, trauma-informed pedagogy, vicarious trauma

INTRODUCTION

The Adverse Childhood Experiences (ACE) study (Felitti et al., 1998) was among the first to demonstrate the high percentage of Americans with traumatic exposure in childhood. Areas where rates of poverty, community violence, and homicides are high have even greater prevalence rates and types of traumatic exposure (Cronholm et al., 2015). Prior to the pandemic, the prevalence of mass trauma, racial trauma, community and school shootings, natural disasters, military deployments, and global terrorism already created urgency for counselors to receive trauma education. The far-reaching and cumulative impacts of the pandemic heightened the need for clinical mental health counseling programs to equip professionals to identify and address trauma-related mental health needs.

GAPS IN TRAUMA COMPETENCIES IN GRADUATE TRAINING

The standard graduate clinical training curriculum offered across mental health disciplines provides insufficient knowledge and competencies to prepare students to work with trauma-exposed clients (Courtois & Gold, 2009; Layne et al., 2014). This fosters a workforce of counselor educators and supervisors unprepared to teach this critical content (Kumar et al., 2019; Webber et al., 2017). In recent

years, trauma courses or tracks are becoming more prevalent in graduate programs; however, according to a report by the American Psychological Association (APA) Division 56 Education/Training Committee, programs are adding trauma content in elective courses, often tied to faculty interests, which impedes integration in the curriculum, continuity, and accessibility (APA, 2015). Yet, the prevalence of trauma necessitates that all counselors understand its impact on development and functioning, practice evidence-based and emerging trauma-responsive treatment, and demonstrate a commitment to self-care and reflective practice (Butler et al., 2017; Moh & Sperandio, 2022).

In 2009, Courtois and Gold implored higher education faculty across mental health disciplines to incorporate trauma content in their programmatic curricula. That year, the Council for Accreditation of Counseling and Related Education Programs (CACREP) included four standards for counselor training in trauma, crisis intervention, and emergency preparedness and response in its 2009 standards (CACREP, 2008). Jones and Curreton (2014) argued that changes to the *Diagnostic and Statistical Manual of Mental Disorders*' fifth edition (DSM-5; American Psychiatric Association, 2013) fundamentally changed how traumatized clients are assessed, diagnosed, and treated, necessitating counselor educators fluent in the effects of and treatment interventions for trauma. In 2016, CACREP enhanced standards by requiring accredited programs to include instructions on the effects of trauma on individuals, couples, and families across the lifespan; and trauma-informed interventions and strategies (CACREP, 2015).

Similarly, the Council on Social Work Education published guidelines for advanced social work practice that emphasize the need for curricula to actively recognize the impact of trauma symptoms and disorders, factor in their detrimental effects, and provide students with trauma-informed and evidenced-based skills necessary for effective trauma intervention (Abrams & Shapiro, 2014. As a call to action, The New Haven Trauma Competencies Consensus Conference assembled to establish trauma-related competencies and benchmarks for graduate training programs and clinicians planning professional development. Led by Cook and Newman (2014), the Consensus Statement on Trauma Mental Health identified five broad competencies (scientific knowledge about trauma, psychosocial trauma-focused assessment, trauma-focused psychosocial intervention, trauma-informed professionalism, and trauma-informed relational and systems competencies), as well as eight competencies that cross all of these domains (e.g., demonstrating cultural competence; understanding developmental lifespan factors; and having a strength-based, resilience, and growth orientation). The broad scope of these competencies requires a comprehensive approach to teaching about trauma.

A WORKFORCE NEED: TRAUMA-COMPETENT COUNSELORS AND COUNSELOR EDUCATORS

Although the counseling profession was among the first to introduce standards related to trauma, according to Webber et al (2017), who engaged in a content analysis of three counseling journals from 1994 to 2014 that searched for traumatology topics and trends, the discipline "continues to lag behind its associated mental health professions in positioning trauma as a core issue in counseling and the broader context of mental health and wellness" (p. 256). Weber et al (2017) found that only 108 out of 2379 articles met the criteria for trauma content analysis. Included were *Journal of Counseling and Development* (JCD), the *Journal of Mental Health Counseling* (JMHC), and *Counselor Education and Supervision* (CES). Of the three, CES had the lowest rate (0.6%), considerably lower than JCD (4.7%) or JMHC (7.5%). These results are discouraging and encourage deeper reflection on the current state of trauma competency within the counseling discipline, and more specifically within counselor education and supervision.

However, while focusing on trauma content may support counselors to provide trauma-specific interventions, a broader programmatic integration, where there is deep consideration for learning environment, is warranted. In addition to equipping students with trauma knowledge, graduate training programs seeking to incorporate trauma as an embedded area of focus must also attend to the

learning environments and clinical training contexts to mitigate the potential impact of trauma exposure on trainees (Carello & Butler, 2014, 2015). To address the need for counselors trained in trauma but not harmed by that training, our graduate clinical mental health counseling program developed an approach to integrating trauma knowledge and competencies across the curriculum using literature and existing models. Here, we present its frameworks and strategies and discuss its impact and limitations.

GUIDING FRAMEWORKS FOR THE APPROACH

Trauma-informed care

While our graduate training curriculum integrates trauma knowledge and competencies throughout, trauma-informed care (TIC) serves as the foundation for our educational approach. Harris and Fallot (2001) introduced the term trauma-informed not to identify specific interventions, but to describe the organizational context required to address the mental health needs of trauma-impacted people. Trauma-informed care has emerged as a novel practice across human service sectors. According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), a unit or system that is trauma-informed:

> realizes the widespread impact of trauma and understands potential paths for recovery, recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system, responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization. (p. 9)

TIC improves quality of care and health outcomes for trauma-impacted people (Hostetter & Klein, 2016; SAMHSA, 2014) and emphasizes treating a client's individual experiences rather than applying general treatment approaches based on diagnosis (SAMHSA, 2014). It leads to positive outcomes for clients with serious mental illness; improves screening, assessment, and treatment planning; and supports identifying the appropriate level of care and placement (O'Hare & Sherrer, 2009; SAMHSA, 2014).

The Missouri and sanctuary models

Identifying and sustaining the changes required for a program, organization, or system to become trauma-informed is challenging; thus, this approach employs two applicable models. The Missouri model (Missouri Department of Mental Health and Partners, 2014), a developmental model of trauma-informed organizational change, provides a road map and observable indicators of change to assess the system's growth process. Its process continuum begins with trauma awareness, progresses to trauma sensitivity, continues to the stage of trauma responsiveness, and completes the developmental process with the trauma-informed stage (P. Carter & Blanch, 2019). As a clinical mental health counseling program committed to developing trauma-informed counselors, we apply this developmental framework to engage in a programmatic assessment process.

In a CACREP-accredited counselor education program situated within an urban environment where disparities in access to quality health care are salient, we explored guiding frameworks that prioritize safety, emotion regulation, and ongoing support to help mitigate the potential impact on counselors in training. As a consequence of working with trauma-impacted individuals and being exposed to graphic material, counselors and trainees are vulnerable to experiencing vicarious trauma (VT), meaning they may absorb clients' concerns, fears, worldview, and outlook (Hernandez-Wolf et al., 2015;

Kumar et al., 2019). To mitigate this potential impact on the trainee, we explored frameworks that prioritize safety, emotion regulation, and ongoing support.

The sanctuary model (Bloom, 2007), a trauma-informed, organizational culture approach, is well known in the authors' region and has been adopted by community organizations that train our program's students. Based on over 20 years of clinical experience supporting traumatized individuals, the sanctuary model is "evidence-supported," according to the National Child Traumatic Stress Network, and listed as a "promising practice" by the California Evidence-Based Clearinghouse for Child Welfare (2021). It has been adopted by over 90 human service delivery programs nationally and internationally (Bloom, 2007). One limitation of the model's application in higher education is that it was developed for and studied within human service organizations and programs. Because of the void in trauma-informed higher education models and our familiarity with the sanctuary model and its regional reputation for having a positive impact on organizations and the clients they serve, we applied for and received a small university grant to support faculty and staff training in this model and to work with trainers to adapt it for a novel setting, higher education.

Individually and collectively, the Missouri and sanctuary models provide tools and strategies to support program leaders and counselor educators to (1) train all stakeholders in foundational trauma competencies; (2) consider and adjust existing policies and practices that undermine health, healing, and safety; (3) incorporate trauma competencies throughout the graduate curriculum in a systemic way so they do not live within a singular course; (4) teach students about VT and skills to mitigate trauma's impact on the clinician; and (5) consider and adopt other contextual factors that promote safety, connection, and health within the training program.

A DESCRIPTION OF THE APPROACH IN PRACTICE

Following are the foundational trauma competencies we teach and reinforce within our graduate clinical mental health counseling program. We include suggestions based on our collective experiences since 2012 developing and delivering a master's-level trauma-informed clinical mental health counseling curriculum adapted from *"Incorporating Trauma-Informed Practice and ACEs into Professional Curricula—a Toolkit,"* co-authored by Felter and Ayers and supported by the Casey Foundation (2016). Examples of assignments, activities, and experiences illustrate how the sanctuary model organizes and integrates the competencies within the clinical mental health counseling program. Vignettes based on real classroom and training experience highlight successes and challenges and provide programmatic insights.

In the absence of having a dedicated course sequence on trauma, the following three concepts could be integrated within clinical supervision and within courses and content areas aligned with CACREP-lettered standards related to human growth and development, counseling and helping relationships, and assessment and testing, among others (CACREP, 2015). While the introduction of each concept is a good first step, the goal should be to integrate each concept in a meaningful, scaffolded way throughout the curriculum.

Concept 1: Coping with secondary exposure to trauma

Individuals who engage empathically in their professional or familial roles with people who have been impacted by trauma are vulnerable to emotional and psychological distress (Butler et al., 2017; Hernandez-Wolf et al., 2015; Kumar et al., 2019; Rauvola et al., 2019). To mitigate the potential impact of exposure on students, our trauma-focused clinical trainings raise students' awareness of empathy-based stress (e.g., VT) and provide supportive resources for them to monitor and address their own emotional needs.

We acknowledge the likelihood that most programs nationally focus on self-care and provider well-being. However, talking about the importance of self-care differs from tying self-care practices to a broader understanding of the neurobiology of stress. To ensure that counseling students have the knowledge and competencies to self-monitor and proactively mitigate provider stress, our clinical mental health counseling program introduces students to the critical importance of self-care and the potential cost of caring on the practitioner as early as the program's orientation, and revisits these topics in every course across the curriculum. Program faculty supports students to develop an individualized approach to self-care and self-monitoring and further models healthy practices. Counseling students are also taught about their roles as supportive colleagues to their peers, learning both to self-monitor for signs of empathy-based stress, and to embrace their critical role in doing so for peers. Policies and practices also provide a framework for students to safely self-report their own challenges or those they witness in their peers without fear of repercussions.

The seven sanctuary commitments

The sanctuary model offers several tools to address Concept 1, each embedded within the model's four pillars. The first pillar is the sanctuary commitments, which represent the seven philosophical underpinnings that qualify the dispositions, behaviors, and values all members of a sanctuary organization or team strive to embody and demonstrate. In a sanctuary organization, all stakeholders commit to supporting: (1) nonviolence, (2) emotional intelligence, (3) social learning, (4) open communication, (5) social responsibility, (6) democracy or shared governance, and (7) growth and change (Bloom, 2007). In a treatment setting, each of the commitments counter the negative effects of trauma exposure by constructing an environment that systematically provides repetitive, restorative experiences. In a training context, the commitments prioritize safety, trust, and autonomy. These commitments are deeply embedded in the fabric of our clinical mental health counseling program, having shaped the program's mission and values; standards for the program's learning spaces; and standards that guide interactions with students, colleagues, and clients. They have further shaped the instruments and approaches used to evaluate student dispositions and growth. Students are introduced to the seven sanctuary commitments during program orientation, where they are first exposed to the sanctuary model and then assigned to small groups to research one of the commitments. They present to their cohort their own definition of the chosen commitment and role-play a realistic scenario to illustrate a violation of the commitment in either an academic context (e.g., classroom, advising meeting) or a clinical setting (e.g., counseling session, supervision). The following vignette provides an overview of this strategy in action:

A group of five first-year clinical mental health counseling master's students researched the commitment to nonviolence. They defined the commitment as, "the aspiration that all members of our learning community work to promote safety for all stakeholders, and seek to consistently engage in ways that reduce physical, emotional, and psychological harm or injury." The group then presented the following roleplay:

Five students were working on a group project. One member had emigrated with her family from Nigeria in recent years. When this student spoke up to share an idea, another member laughed and repeated certain words that were pronounced differently.

The group discussed that there are many evident ways that violence can show up in learning spaces, like shouting or physical altercations, but subtle behaviors, like teasing, eye rolling, or talking behind someone's back can equally impede safety and connection.

When introduced and thoroughly processed early in graduate training, the commitments inspire intentional, positive, prosocial engagement within the community, and provide a framework to restore safety and relationships when ruptures occur. They also offer a framework for monitoring and evaluating student growth and dispositions. An excerpt from our program's statement of disposition, a document read and signed by all students at orientation, shows how professional counseling

dispositions can align with the sanctuary commitments and evidences that the commitments can frame evaluation practices:

The commitment to emotional intelligence refers to the ability to identify, understand and articulate one's own feelings, and to accurately read, understand and appropriately and safely respond to the emotional states of others. Emotional intelligence also requires that we regulate our own emotional responses and behaviors, that we demonstrate empathy for others, and that we acknowledge when we are feeling overwhelmed, fatigued or too stressed to effectively and ethically serve others. We expect our community members to demonstrate the ability to accurately identify emotions in self and others; engage in self-monitoring and practice emotion regulation skills; demonstrate empathy for others; practice self-care and ask for support when needed; establish and reinforce healthy boundaries with clients, peers, and professionals; and resolve differences and misunderstandings respectfully.

The sanctuary toolkit

The sanctuary toolkit, another pillar of the model, contains practical interventions, such as community meetings and safety plans, that reinforce the overarching model and further support safety and connection within the learning community. The community meeting serves as a standardized "icebreaker" or check-in for all gatherings where participants ask of each other and answer four questions: (1) What is your name (if they are not yet familiar); (2) How are you feeling in the moment; (3) What is your goal for our time together; and finally, (4) If you need help in this meeting/class, who will you ask? Together, these questions promote proximity and contact, emotional intelligence, and intentional interaction and engagement. They normalize help-seeking, and they help the group leader understand the group's priorities and needs and adjust the agenda if required. In settings where all parties are familiar, the first question could instead promote and reinforce self-care practices (e.g., what will you do today to take care of yourself?). Within our clinical mental health counseling program, we aspire to begin every class, faculty and staff meeting, supervision session, and advising meeting with a community meeting, or a similar tool that encourages connection and safety. Here is an example of the utility of the community meeting:

In the faculty and staff meeting that began with a community meeting, several faculty and staff members shared that they were feeling frustrated, overburdened, and anxious, and many established the goal of seeking support from peers. The program director veered from the agenda and opened the floor for the team to share more about their challenges. Faculty shared frustrations around decisions that had neglected their voices, and further highlighted a lack of transparency in certain processes. Attendees made intentional reparatory efforts, the leader modeled self-reflection and ownership, and the group emerged from the process more cohesive and better able to focus on and address the critical items on the agenda.

Another practical strategy in the sanctuary toolkit is the safety plan, which is a tangible manifestation of the commitment to nonviolence, or maintaining safety in all academic and clinical spaces. Safety plans include three individualized, concrete, practiced strategies that can be employed in the moment to promote emotion regulation and grounding. These include breathing techniques, mindfulness approaches, the use of sensory objects, common grounding exercises, progressive muscle relaxation, and visualization. All program stakeholders create safety plans, and many wear their plans on a lanyard alongside their university ID card as a visual reminder of the commitments made. Here is an illustration of safety planning in context:

During program orientation, new counseling students learn the importance of proactive and reactive strategies that promote regulation. After an initial workshop on brain-based self-care strategies, students work in pairs to create a safety plan. In this process, one paired student shared that she was a yoga instructor and found mindfulness meditation to be very supportive of regulation for her. She also shared she had a young child, and when she felt overwhelmed, she liked to close her eyes and think about her baby sleeping. Her three concrete strategies listed on her plan included a meditation practice

to locate the stress in her body and envision its release, a yoga breathing technique, and her child's name as a reminder to recall the peace she felt when holding her. The other student shared that they tended to feel more stress when attempting "internal techniques" like mindfulness or visualization, and preferred focusing on their external context. They shared a 3-2-1 grounding technique that they found useful. They also carried a sensory fidget as a means of regulation. They struggled to find a third strategy, so they asked their partner to teach them the breathing technique. After practicing the strategy and finding it useful, they added it to their plan, alongside the grounding exercise and use of the fidget tool.

The SELF framework

Another sanctuary pillar is Safety, Emotion, Loss/Letting go, and Future (SELF), a framework to support problem solving within the program and to encourage reflective practice among all team members. The categories represented by the acronym identify the four dynamic areas of focus for trauma recovery and further help to organize conversations and documentation in a simple and accessible language. Students learn the SELF framework in their first semester of coursework and how to use it for self-evaluation, shown here:

First-year clinical mental health counseling students engage in a racial and cultural literacy workshop in their initial semester of graduate training. They practice skills to remain grounded and regulated in times of stress, and then engage in a potentially stress-inducing conversation with a peer about their early experiences of race. Students are supported by faculty to remain regulated, to stay attuned to their partner, and to use their safety plan strategies or take a brief pause as needed so that they can persist in conversations when they become stressful. After the dyad work, students are provided a SELF template and instructed to spend 20 minutes reflecting on their experience within the dyad. How safe did they feel (safety) and how did they support the safety of their partner? What emotions were they experiencing, what did they notice of their partner, and how intense were the emotions (emotion)? What do they need to let go of or abandon (loss/let go) as they consider how they want to grow in their racial literacy and cultural humility (future)? Students then write a brief reflection paper on this experience using the SELF framework.

SELF also offers a clinical treatment planning and conceptualization tool, and a supportive instrument in supervision. Faculty supervisors can prompt students to consider the SELF areas as they plan their interventions and approaches with clients, or when they evaluate their own experience working with a client or group.

Three of the four pillars of the sanctuary model, including the seven sanctuary commitments, the sanctuary toolkit (e.g., community meeting and safety planning), and SELF framework, offer ways to promote safety and connection, and buffer against trauma's impact on individuals, groups, and communities. The tools discussed under Concept 1 are introduced in the program's orientation or in practicum, and are reinforced in group and individual supervision offered throughout the program to mitigate VT.

Concept 2: The impact of ACEs and implications for adulthood

Our trauma-informed clinical mental health counseling education begins with an introduction to the ACE study (Felitti et al., 1998) and its findings: (1) ACEs are common; (2) the impact of ACEs is pervasive (potential to influence development, physical health, emotional/social/psychological functioning, genetics, early death) (Shonkoff & Garner, 2012) and, as the number of ACEs increase, so does the risk for negative outcomes; and (3) most ACEs are preventable. Our curriculum also illuminates the limitations of the study, especially the sample demographics, and it introduces the Expanded ACE study (Wade et al., 2015), which offers data for an urban sample.

Some programs have provided students with the short ACE survey encouraging them to assess their own ACE scores. We suggest caution and a deep consideration of the potential consequences of doing so, as illustrated by this scenario, based on a real experience in our program:

A cohort of students composed of individuals who represent diverse backgrounds, identities, professional and familial roles, and family compositions were introduced to the ACE study in their first semester of graduate training. The instructor shared that the ACE study was a seminal study linking high ACE scores with an array of serious, chronic health and psychological conditions in adulthood, and a 20-year reduction in life expectancy. Prior to providing a full overview of the study, its findings, and its implications, students were provided a brief ACE survey to complete on their own. Kim, a student in the class who was a mother and grandmother, became very quiet and withdrawn when learning that her own ACE score was a 7. Without prompting, Kim then completed the ACE survey from her daughter's and granddaughter's perspectives to find that they, too, had very high ACE scores. She abruptly left the class, exhibiting emotional overwhelm.

Faculty are cognizant of the likelihood that one or more students will have high ACE scores and may interpret the information provided to mean that they are fated to experience negative physical and emotional health outcomes and early death. Programs where notraditional, adult learners are represented may have parents or grandparents in the room who have raised or are currently raising children with high doses of adversity. Like the student in the vignette, they may worry for their family members' future and even experience shame and regret for their perceived failure to protect those in their care from negative outcomes.

To mitigate the potential impact of this new learning on all students, faculty help students to frame a positive discussion around ACEs. While survivors of trauma frequently have immediate symptoms, most abate in the absence of clinical intervention without long-term consequences (Center for Substance Abuse Treatment, 2014, chapter 3). Further, ACEs can be detrimental to development, but positive childhood experiences also have profound effects on long-term health and well-being (Burstein et al., 2021). Finally, learning focuses on compassionate, caring relationships as fundamental to healing (Forkey & Szilagyi, 2014; Perry et al., 2010).

Concept 3: The impact of trauma on development and behavior

Training aimed at bolstering awareness of trauma's impact enables trainees to define key terms used in the literature, mainstream, and in practice. Our aim is that professionals emerge from graduate training with a command of this terminology. The emerging field of trauma has introduced many terms to depict the varying categories of adversity, and the severity and duration of stress endured in childhood (DiDonato & Berkowitz, 2018, p. 94). No single term can cover the variety of trauma experienced, yet helping professionals must be able to understand and define the prominent terms used in the literature that categorize the event (e.g., ACEs, psychological trauma) and terms used to describe the individual or collective reaction or response (e.g., developmental trauma disorder, toxic stress, epigenetic changes), acknowledging that overlap in definitions exists (National Child Traumatic Stress Network's Integrated Care Collaborative Group, 2018).

Our programmatic approach ensures that faculty, staff, and students understand that high doses of ACEs, including experiencing or witnessing violence, abuse, or neglect, often lead to substantial deficits in neurodevelopment and produce symptoms of dysregulation, hyper-arousal, sensory sensitivity, avoidance, and dissociation (Kumar et al., 2019). In particular, people with trauma histories demonstrate deficits in cognition, memory, sensory modulation, and visual processing (Fraser et al., 2017). Consequently, we introduce and reinformce the potential developmental impact of trauma, with a strong focus on neurobiological, social, and cognitive development throughout the curriculum. Without a clear understanding of these definitions and the potential impact of ACEs and/or chronic stress on the developing brain and body, students and counselors may miss important clinical cues and/or misjudge their clients' experiences.

Trauma theory

Trauma theory, the final sanctuary pillar, equips learners to understand how traumatic experiences affect the brain, and how adversity, trauma, and stress can influence the way all people in the system think, feel, and behave. Our graduate program thus includes coursework in neurobiology, human development, and psychopathology; however, training in these areas is also required of faculty, adjuncts, clinical supervisors, and program-level staff who interact consistently with students. The vignette below, based on a real supervision session early in our program's history, underscores how a faculty-supervisor who lacks competencies related to brain science and the neurobiology of stress can reinforce the potentially harmful ways that novice counselors conceptualize clients:

Laura, a first-year graduate counseling student, shared with her supervision group her experience with a client she was supporting at her practicum in an urban elementary school. Laura described the student's outbursts and aggression when being reprimanded in class as "manipulative and attention-seeking" and shared that her intervention was to ignore the child. The supervisor, a new adjunct in the program who had limited trauma knowledge despite experience working in school-based mental health, affirmed the student's assessment and approach.

Faculty and supervisors may reinforce outdated, harmful, oppressive, and racist ideas and interventions when they lack an understanding of the manifestation of stress (e.g., race-based stress; R. T. Carter, 2007). This in turn may lead to an orientation that acknowledges the impact that oppressive systems and practices have on individuals, families, and communities. Faculty and supervisors support students to understand and reframe behaviors that are indicative of a stress- and/or trauma-response; they work to eliminate language that ascribes judgment and reinforces stigma and power differentials (Granello & Gorby, 2021); and they teach interventions beyond traditional talk therapy approaches that support regulation, relationships, and healing. Didactic and clinical training is highly impactful when it includes competencies in neuroscience that help students conceptualize that behavior can communicate unmet needs and stress responses, as evidenced by the following vignette, based on a supervision session with a second-year graduate student who is completing his internship at an adolescent inpatient program:

For his internship supervisor and supervision class and with required consents, Marc played a 15-min videorecording of a group he conducted at his internship in an inpatient program, the second of four meetings with four adolescents who demonstrated challenges with angry outbursts and self-control. In the video, Marc offers the four boys play-doh. As the boys manipulate the play-doh, Marc taught them about their brains. He called the lower part of the brain the reptile brain and asked the boys. "What can lizards do?" The boys shared that lizards change colors when they're scared, and snakes can slither away and attack. Marc affirmed their responses and showed them how to make a crude brain stem and spinal cord out of the green play-doh. He called the green region the reptile brain. He then asked the boys to share what they knew about smoke detectors. One student described a time when the smoke alarm went off because his mom burned dinner. Others shared similar experiences, and Marc affirmed them. Marc then described a part of the brain as the smoke detector, always assessing the environment for danger. As he showed the boys how to make a crude mid-brain with red play-doh, he talked about how the brain works—when the red smoke detector senses danger, it alerts the green reptile brain to change colors, to hide, to run, or to fight. Finally, Marc asked the boys to talk about a time when they felt very in control, focused, and able to do really good work. The boys each shared. Marc then discussed the part of the brain that needs to be online for each of us to do all of the things the boys described—to listen, to learn, to share, or to help. He helped the boys to make a blue cortex, which he called the human brain, and they laid the blue layer on top of the other parts of the brain they had already built. Marc then asked the boys to talk about a time when their red smoke detectors sounded the "danger alarm," causing their blue brain to go offline and them to act only with their reptile green brains. One talked about feeling like a scared snake when his dad yelled loudly—how it

made him run to his room and cry. Another talked about how angry he got at school when his teacher "makes fun of him." He describes flipping his desk and fighting when he felt insulted.

In this vignette, Marc is demonstrating advanced competencies, while facilitating a healing process for the children in his group, enabling them to better understand their own brains and reactions under stress. Marc's approach is free of stigmatizing language, judgment, and blame. It inspires deep thought, connection, and likely a stronger sense of autonomy and control for each group member.

DISCUSSION

Graduate training programs face many challenges building or enhancing trauma coursework, including reluctance among faculty to teach trauma content due to their own insufficient preservice trauma training (VanAusdale & Swank, 2020). Additionally, after meeting accreditation and licensing standards, generalist training programs have little room for trauma electives or added content within existing coursework. Finally, course and program revisions often require lengthy committee processes, undermining motivation to adapt existing courses or propose new courses to meet workforce demands, especially without accreditation standards and/or licensing exam questions on trauma.

And yet, data support that counseling students and graduates from clinical mental health counseling programs will provide services to many trauma-impacted clients throughout their training and professional careers. This article describes our program's approach to integrating trauma knowledge and competencies within a trauma-informed learning context. Our aims are to inspire faculty and program leaders to make needed changes within their programs to ensure that they are graduating professionals with competencies to care for trauma-impacted people; to offer tools and strategies to support the integration of trauma content and to support the creation of trauma-informed educational and training contexts; and to share real-life teaching and training scenarios so stakeholders can learn from our deep experiences developing and delivering this curriculum since 2012.

While making even small curricular revisions in any one of the described content areas may yield important growth for counseling students, programs are encouraged to meaningfully and systematically incorporate a sustained focus throughout the curriculum on secondary exposusure to trauma and self-care practices, the broad potential impact of ACEs on individuals, families and communities, the nuances in definitions and the emerging terminology in the field of trauma studies, and the potential impact of stress and trauma on development and behavior. Evidence-based trauma interventions are important for students and counselors to learn and employ, but it is these concepts that serve as the critical foundation for ethical and effective trauma treatment.

The most recent version of the 20/20 Principles for Unifying and Strengthening the (counseling) Profession (Kaplan & Gladding, 2011; Kaplan et al., 2014) identifies seven core principles, three of which are highly relevant to this study. They include a needed expansion of the counseling research base, a requisite focus on students and prospective students to ensure the ongoing health of the profession, and the promotion of client welfare and advocacy for the diverse polulations served by counselors. This study provides a road map to support counselor education programs to bolster the training they provide current and future students in trauma and TIC, which will inspire an expansion of research by counselors and counselor educators in this needed area of study, and will further catalyze a movement by counseling professionals and trainees to provide TIC—a more healing-centered, wholistic, and individualized approach—to the myriad of vulnerable individuals, families, and communities served every day by counselors.

Further empirical support is necessary to substantiate the efficacy of our education and training approach. While limited data are available, including course evaluations, clinical supervisor evaluations, and alumni surveys, a necessary next step that will serve to further this movement is to analyze these and other data sources within a robust program evaluation framework.

Perhaps the most important lesson we have learned in our journey is that the teaching of trauma content is both insufficient and potentially harmful in the absence of a trauma-informed teaching and learning environment. The ACE data discussed in this study is generalizable, suggesting that all learning communities are composed of individuals with their own lived experiences of trauma, adversity, and stress. We have learned that teaching about trauma while simultaneously requiring that students engage in clinical training experiences within trauma-impacted organizations that serve communities with high rates of trauma exposure exacerbates students' vulnerabilities. These vulnerabilities can manifest in behavioral challenges, mental health and well-being risk, and issues related to retention and achievement. Similar negative outcomes can be experienced by faculty and staff who teach, supervise, and mentor trauma-impacted students. Trauma-informed frameworks, such as the sanctuary and Missouri models, have provided important guideposts enabling us to promote safe, supportive and nurturing learning contexts that contribute to the health and well-being of all stakeholders.

ACKNOWLEDGEMENT

The authors would like to acknowledge Dale Michaels, MS, LPC. for his many contributions to the creation of the program described in this paper.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

ORCID

Jeanne M. Felter https://orcid.org/0000-0001-8743-3770

REFERENCES

Abrams, J., & Shapiro, M. (2014). Teaching trauma theory and practice in MSW programs: A clinically focused, case-based method. *Clinical Social Work Journal*, *42*, 408–418. https://doi.org/10.1007/s10615-013-0472-z

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association Publishing. https://doi.org/10.1176/appi.books.9780890425596

American Psychological Association. (2015). *Guidelines for trauma competencies on education and training*. American Psychiatric Association. http://www.apa.org/ed/resources/trauma-competencies-training.pdf

Bloom, S. (2007). The sanctuary model of trauma-informed organizational change. *The National Abandoned Infants Assistance Resource Center*, *16*, 12–14.

Burstein Yang, C., Johnson, K., Linkenbach, J., & Sege, R. (2021). Transforming practice with HOPE (Healthy Outcomes from Positive Experiences). *Maternal and Child Health Journal*, *25*(7), 1019–1024. https://doi.org/10.1007/s10995-021-03173-9

Butler, L. D., Carello, J. C., & Maguin, E. (2017). Trauma, stress, and self-care in clinical training: Predictors of burnout, decline in health status, secondary traumatic stress symptoms, and compassion satisfaction. *Psychological Trauma: Theory, Research, Practice, and Policy*, *9*(4), 416–424.

California Evidence-Based Clearinghouse for Child Welfare. (2021). Sanctuary Model. https://www.cebc4cw.org/program/sanctuary-model/

Carter, R. T. (2007). Racism and Psychological and Emotional Injury: Recognizing and assessing race-based traumatic stress. *The Counseling Psychologist*, *35*(1), 13–105. https://doi.org/10.1177/0011000006292033

Carter, P., & Blanch, A. (2019). A trauma lens for systems change. *Stanford Social Innovation Review*, *17*(3), 48–54. https://doi.org/10.48558/ESG7-3823

Carello, J., & Butler, L. D. (2014). Potentially perilous pedagogies: Teaching trauma is not the same as trauma-informed teaching. *Journal of Trauma & Dissociation*, *15*(2), 153–168. http://doi.org/10.1080/15299732.2014.867571

Carello, J., & Butler, L. D. (2015). Practicing what we teach: Trauma-informed education practice. *Journal of Teaching in Social Work*, *35*, 262–278. https://doi.org/10.1080/08841233.2015.1030059

Center for Substance Abuse Treatment (US). (2014). *Trauma-Informed Care in Behavioral Health Services*. Substance Abuse and Mental Health Services Administration (US).

Cook, J. M., Newman, E., & The New Haven Trauma Competency Group. (2014). A consensus statement on trauma mental health: The New Haven Competency Conference process and major findings. *Psychological Trauma: Theory, Research, Practice, and Policy*, *6*(4), 300–307. https://doi.org/10.1037/a0036747

Council for Accreditation of Counseling and Related Educational Programs. (2008). 2009 Standards. http://www.cacrep.org/2009standards.html

Council for Accreditation of Counseling and Related Educational Programs. (2015). 2016 Standards. https://www.cacrep.org/for-programs/2016-cacrep-standards/

Cronholm, P. F., Forke, C. M., Wade, R., Bair-Merritt, M. H., Davis, M., Harkins-Schwarz, M., Pachter, L. M., & Fein, J. A. (2015). Adverse childhood experiences: Expanding the concept of adversity. *American Journal of Preventive Medicine*, *49*(3), 354–361. https://doi.org/10.1016/j.amepre.2015.02.001

Courtois, C. A., & Gold, S. N. (2009). The need for inclusion of psychological trauma in the professional curriculum: A call to action. *Psychological Trauma: Theory, Research, Practice, and Policy*, *1*(1), 3–23. https://doi.org/10.1037/a0015224

DiDonato, S., & Berkowitz, S. J. (2018). Childhood stress and trauma. In Driver, D. & Thomas, S. (Eds.), *Severe childhood psychiatric disorders* (pp. 93–103). Elveiser.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*(4), 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8

Felter, J., & Ayers, L. (2016). *Incorporating trauma-informed practice and ACEs into professional curricula—A toolkit*. Annie E. Casey Foundation.

Forkey, H., & Szilagyi, M. (2014). Foster care and healing from complex childhood trauma. *The Pediatric Clinics of North America*, *61*(5), 1059–1072. https://doi.org/10.1016/j.pcl.2014.06.015

Fraser, K., MacKenzie, D., & Versnel, J. (2017). Complex trauma in children and youth: A scoping review of sensory-based interventions. *Occupational Therapy in Mental Health*, *33*(3), 199–216. https://doi.org/10.1080/0164212X.2016

Granello, D. H., & Gorby, S. R. (2021). It's time for counselors to modify our language: It matters when we call our clients schizophrenics versus people with schizophrenia. *Journal of Counseling & Development*, *99*(4), 452–461. https://doi.org/10.1002/jcad.12397

Harris, M., & Fallot, R. D. (2001). Envisioning a trauma-informed service system: A vital paradigm shift. *New Directions for Mental Health Services*, *2001*(89), 3–22.

Hernandez-Wolfe, P., Killian, K., Engstrom, D., & Gangsei, D. (2015). Vicarious resilience, vicarious trauma, and awareness of equity in trauma work. *Journal of Humanistic Psychology*, *55*(2), 153–172.

Hostetter, M., & Klein, S. (2016). *In focus: Recognizing trauma as a means of engaging patients*. The Commonwealth Fund. https://www.commonwealthfund.org/publications/2016/jun/focus-recognizing-trauma-means-engaging-patients

Jones, L. K., & Cureton, J. L. (2014). Trauma redefined in the DSM-5: Rationale and implications for counseling practice. *The Professional Counselor*, *4*(3), 257–271. https://doi.org/10.15241/lkj.4.3.257

Kaplan, D. M., & Gladding, S. T. (2011). A vision for the future of counseling: The 20/20 Principles for Unifying and Strengthening the Profession. *Journal of Counseling & Development*, *89*, 367–372.

Kaplan, D. M., Tarvydas, V. M., & Gladding, S. T. (2014). 20/20: A Vision for the Future of Counseling: The New Consensus Definition of Counseling. *Journal of Counseling and Development*, *92*, 366–372.

Kumar, S. A., Brand, B. L., & Courtois, C. A. (2019). The need for trauma training: Clinicians' reactions to training on complex trauma. *Psychological Trauma: Theory, Research, Practice, and Policy*, *4*(8), 1387–1394. https://doi.org/10.1037/tra0000515

Layne, C. M., Strand, V., Popescu, M., Kaplow, J. B., Abramovitz, R., Stuber, M., Amaya- Jackson, L., Ross, L., & Pynoos, R. S. (2014). Using the core curriculum on childhood trauma to strengthen clinical knowledge in evidence-based practitioners. *Journal of Clinical Child & Adolescent Psychology*, *43*(2), 286–300. https://doi.org/10.1080/15374416.2013.865192

Missouri Model: A Developmental Framework for Trauma Informed Approaches (2014). MO Dept. of Mental Health and Partners.

Moh, Y., & Sperandio, K. R. (2022). The need to consider requiring trauma training in entry-level academic training programs in clinical mental health counseling. *Journal of Mental Health Counseling*, *44*(1), 18–31. https://doi.org/10.17744/mehc.44.1.03

National Child Traumatic Stress Network Integrated Care Collaborative Group (2018). *Glossary of terms related to trauma-informed, integrated healthcare*. https://www.nctsn.org/resources/glossary-terms-related-trauma-informed-integrated-healthcare

O'Hare, T., & Sherrer, M. V. (2009). Lifetime traumatic events and high-risk behaviors as predictors of PTSD symptoms in people with severe mental illnesses. *Social Work Research*, *33*, 209–218. https://doi.org/10.1093/swr/33.4.209

Perry, B. D., & Dobson, C. (2010). The role of healthy relational interactions in buffering the impact of childhood trauma. In Gil, E. (Ed.), Working with children to healiInterpersonal trauma: The power of play *(pp. 26–43).* The Power of Play Guilford Press.

Rauvola, R., Vega, D., & Lavigne, K. (2019). Compassion fatigue, secondary traumatic stress, and vicarious traumatization: A qualitative review and research agenda. *Occupational Health Science*, *3*(3), 297–336. https://doi.org/10.1007/s41542-019-00045-1

Substance Abuse and Mental Health Services Administration (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. Substance Abuse and Mental Health Services Administration.

Shonkoff, J. P., Garner, A. S., & Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, & Section on Developmental and Behavioral Pediatrics. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, *129*(1), e232–e246. https://doi.org/10.1542/peds.2011-2663

VanAusdale, S., & Swank, J. M. (2020). Integration of trauma-based education in counselor education. *Journal of Counselor Preparation and Supervision*, *13*(2), 5. https://doi.org/10.7729/42.1354

Wade, R., Cronholm, P. F., Fein, J. A., Forke, C. M., Davis, M. B., Harkins-Schwarz, M., Pachter, L. M., & Bair-Merritt, M. H. (2015). Household and community-level Adverse Childhood Experiences and adult health outcomes in a diverse urban population. *Child Abuse & Neglect*, *52*, 135–145. https://doi.org/10.1016/j.chiabu.2015.11.021

Webber, J. M., Kitzinger, R., Runte, J. K., Smith, C. M., & Mascari, J. B. (2017). Traumatology trends: A content analysis of three counseling journals from 1994 to 2014. *Journal of Counseling and Development*, *95*, 249–259. https://doi.org/10.1002/jcad.12139

How to cite this article: Felter, J. M., DiDonato, S., Johnson, N., Moh, Y. S., Richardson, A., & Czerny, A. (2022). Creating sanctuary: A programmatic approach for trauma integration in counselor education. *Counselor Education and Supervision*, *61,* 391–403. https://doi.org/10.1002/ceas.12249