SPRING 2022 VOL. 3

INTERNATIONAL ASSOCIATION FOR RESILIENCE AND TRAUMA COUNSELING

THE OFFICIAL NEWSLETTER OF IARTC
EDITED BY DRS. CHARMAYNE ADAMS AND K. LYNN PIERCE

Trauma-Specific and Trauma-Informed Assessments and Interventions

Celebrate with us!

JOIN IARTC!

MISSION

To enhance the quality of life for people and communities worldwide by promoting the development of professional counselors, advancing ACA, the counseling profession, and the ethical practice of counseling through trauma-informed practices, respect for human dignity, cultural inclusivity, and resilience.

DIVERSITY STATEMENT

IARTC IS COMMITTED TO DIVERSITY, EQUITY, INCLUSION, UNDERSTANDING, AND EMPATHY. WE WORK TO PROMOTE ETHNIC AND RACIAL EMPATHY AND UNDERSTANDING. IARTC CONTINUES TO ADVOCATE, ADVANCE, AND IMPROVE EDUCATIONAL, PROFESSIONAL, AND LEADERSHIP OPPORTUNITIES FOR MEMBERS FROM DIVERSE CULTURAL BACKGROUNDS. IARTC DENOUNCES ALL FORMS OF RACISM.

IARTC SPRING NEWSLETTER

In this issue:

A WORD FROM THE OUTGOING PRESIDENT

Dr. Carol Smith, PhD, LPC, NCC, CCTP

Hi My Fine IARTC Members!

As most of you know already, IARTC was approved by the American Counseling Association's Governing Council on March 24, 2022, to be ACA's newest permanent Division, and received our letter of approval under the signature of ACA President S. Kent Butler.
We went to the ACA Conference in Atlanta, April 7-9, 2022, and celebrated our first all-members meeting on Thursday, April 7. Here's a picture:

There were about fifty people at our first all-members meeting, but this intrepid group hung around long enough for Mia Reid (far left) to come up with the good idea of a group photo.

I had the pleasure of co-presenting with Dr. Peggy Mayfield (incoming President of IARTC) and Dr. Lisa López Levers (incoming President-Elect) on Friday morning about why trauma is never going away and why ACA needs a division on trauma. There were about a 100 people in the COVID/socially-distanced room, and our poor student volunteer, Emily, had to turn away about 25-50 other people who wanted to attend. The energy in the room was through the roof, and we had a good conversation about where IARTC goes from here.

A WORD FROM THE OUTGOING PRESIDENT

Ideas included things like research grants, our own trauma-focused conferences, collaborating with other ACA Divisions, scholarships to attend conferences, certifications in trauma counseling, advocating for trauma-informed CACREP standards, doing international conferences on trauma, providing ongoing professional development trainings online for trauma-informed counseling, advocating for trauma-informed public policy, sharing resources on IARTC's website, learning from diverse and international sources about diversity, equity, inclusion, and social justice in trauma-informed counseling, and partnering with world organizations for trauma-informed trainings and care.

We want to do all of these things and more! In order to make these dreams a reality, we will need good people from our IARTC membership to step up and get involved. Nothing happens unless a group of dedicated people volunteer to take ownership of an idea and make it happen. We want to make good things happen for IARTC, for ACA, and for the Profession of Counseling throughout the world.

In order to make any of these fine things happen, we also need funds. So, to that end, IARTC will start charging dues as soon as ACA can get us integrated into their membership management software. I do not know exactly when dues will take effect, but an educated guess says on or shortly after July 1, 2022, with the start of the new fiscal year. Here is our current dues structure:

Professional	**$60.00**
Regular	**$50.00**
New Professional Year 1 and 2	**$40.00**
Student or Retired	**$30.00**

ALSO, we have significant administrative tasks that need to happen in order for us to exist in the real world as a business and legal entity. We need things like a Charter from ACA, articles of incorporation, a Management Services Agreement with ACA, an Employee Identification Number, registration as a 501c3 organization, a business license to do business, a checking account, and budget and financial procedures that comport with ACA's and the IRS's legal requirements. These pieces will take quite some time to put into place (way longer than I anticipated), so please bear with us. We are working closely with ACA Staff in Alexandria, and we recognize that a lot is going on with ACA, including CEO Richard Yep's departure after 23 years of outstanding service, a physical office relocation in May or June for the entire ACA staff, progress on the national Counseling Compact (14 states and counting as of today!), and the start of a new fiscal year on July 1st.

A WORD FROM THE OUTGOING PRESIDENT

Finally, a few words on the symbolism of our IARTC colors and logo:

Our colors are dark grey, teal, lavender, and blue. The dark grey represents the darkness of traumatic stress. Teal, lavender, and blue work together as soothing colors that evoke resilience, wisdom, patience, integrity, and calm. The logo illustrates the point of contact between a person heavily affected by trauma, and a person willing to meet compassionately at the point of need.The figures are human, together at a moment of connection. **This is the moment when hope has a chance.** The jagged angles and symmetrical arcs speak to the coexistence of pain and possibility; despair and hope; fear and courage; trauma and resilience. The lower-case font underscores the cultural and interpersonal humility required for genuine compassion and competence. The circled boundary defines the therapeutic space of safety, support, and containment. The colors express the tenderness, perseverance, wisdom, and fierce hope involved in trauma-focused work, for both clients and counselors. This is a logo of contact and hope.

It has been a privilege and the honor of my professional life to serve sort of as the birth doula for IARTC. It has been a labor of love for over ten years of my life, and I stand on the shoulders of giants in ACA who have been working on this effort all the way back to the late 1970s. I look forward to the Presidencies of Dr. Peggy Mayfield (2022-2023) and Dr. Lisa López Levers (2023-2024), knowing that our baby is in very good hands. I look forward to the work that all of you do, to make IARTC grow and shine and make a good difference in the world.

Humbly yours,

A WORD FROM INCOMING PRESIDENT

Peggy Mayfield, Ph.D., LCPC, NCC, CCMHC, CCTP, CFTP, DCMHS

Dear Valued IARTC Members,

Division Status!

We are beyond elated about achieving ACA Division status on March 24th, 2022! It is the pinnacle achievement of my life and the best birthday present I have ever received! This marks the culmination of decades of work by those passionate about trauma. We are reveling in your excitement and joy as we had the chance to celebrate with many of you in person at ACA Atlanta!

ACA Conference, Atlanta—Many Fond Memories!

I was honored to be able to present 3 times at the 2022 ACA Conference & Exposition. First, I presented on Friday morning with incoming President-Elect-Elect Lisa López Levers, Ph.D., LPCC-S, LPC, CRC, NCC and outgoing President, Dr. Carol Smith, on "Why trauma is never going away, and why we need a division on trauma and resilience." Our colleagues Dr. Jane Webber and Dr. Mike Dubi likewise contributed to the presentation.Friday night, I presented for the ACA International Committee Panel, "Addressing global trauma with global practices: The essential roles of resilience and hope." Then on Saturday morning, I presented, "Toward post-traumatic growth in the aftermath of unprecedented complex trauma and loss." The highlight of the ACA conference was meeting so many of you! Thank you for attending our sessions! I loved having the chance to meet you in person and have in-person conversations!

Exceptional Summer Reading!

For those of you looking to engage in scholarly summer reading, be sure to check out our amazing President-Elect Lisa López Levers' new book-- Trauma counseling: Theories and interventions for managing trauma, stress, crisis, and disaster (2nd ed.). I would also like to point you to the stellar article she wrote for this Issue of the IARTC Newsletter-- The H-R Factor. It provides an exceptional conceptual framework for leadership that I wholeheartedly embrace. Or, check out IARTC Membership Committee member Eric Brown's article:

Adverse and Positive Childhood Experiences of Clinical Mental Health Counselors as Predictors of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress
https://tpcjournal.nbcc.org/tag/childhood-experiences/

Please be sure to keep us posted about your scholarship, too. Mayfield.peggyc@gmail.com Better yet, please think about submitting an article for publication in our next IARTC Newsletter! newsletter.iartc@gmail.com

A WORD FROM INCOMING PRESIDENT

ACA & IARTC in Toronto 2023

The next ACA Conference and Exposition will be held in Toronto March 31 – April 2, 2023. We would love nothing more than having the chance to meet you there in person, to learn from you, and to celebrate our new division! Please be sure to let us know if you plan to attend or are scheduled to present. mayfield.peggyc@gmail.com

CACREP 2024 Standards Revision—Draft 3

I want to encourage everyone to review the current iteration of the CACREP 2024 Standards and consider making suggestions to advance Trauma, Resilience, International Competencies, and DEI. Input is due by midnight on June 30, 2022. Here is the link: https://www.cacrep.org/news/cacrep-2024-standards-draft-3/

Committee Appointments—
Contact President-Elect--Lisa López Levers, Ph.D., LPCC-S, LPC, CRC, NCC

As I step into the Presidency on July 1, 2022, Dr. Levers will simultaneously step into the role of President-Elect. As such and according to our IARTC Bylaws, she will begin making committee appointments, replacing me in that role. Thank you, Lisa! Please take a moment to view our committees on the IARTC Website and contact her directly (levers@duq.edu) if you would love to serve IARTC in such a meaningful way! We ask that you submit a letter of interest specifying the committee on which you wish to serve, along with your current CV. This allows us to become acquainted with you—one of our very favorite things!

A WORD FROM INCOMING PRESIDENT

Thank You! IARTC Founding President—Dr. Carol Smith

There is simply no way to even begin to thank our amazing Founding President, Dr. Carol Smith, for her passionate leadership that lead to so many fabulous accomplishments! We are forever indebted to her for such stalwart leadership and tireless efforts on behalf of IARTC! Thank you, thank you, thank you!

Wishing you all the very best, IARTC! I will be in touch soon with updates about FY 2022-2023. Please reach out if you have any questions or suggestions! I would love to connect with you! mayfield.peggyc@gmail.com

Warmly,

Peggy

Peggy Mayfield, Ph.D., LCPC, NCC, CCMHC, CCTP, CFTP, DCMHS
Diplomate and Clinical Health Specialist in Child & Adolescent, Family, and Trauma Counseling
Incoming President & Co-Founder, International Association for Resilience and Trauma Counseling
Member, American Counseling Association International Committee
ACA Traumatology Interest Network Leadership Team

A WORD FROM THE EDITOR AND SENIOR ASSOCIATE EDITOR

For this issue, we wanted to focus on celebration...

Celebrating the division status of IARTC!

Celebrating the amazing community of practitioners educators and students this organization has created space for!

Celebrating the first year of the newsletter!

Celebrating all of the amazing work that has been done over the past year!
We hope you enjoy this issue.

Charmayne Adams, Ph.D., LIMHP, NCC
Editor
K. Lynn Pierce, Ph.D., CRC, NCC
Sr. Associate Editor

COMMITTEE AND TASK FORCE UPDATES

Advocacy Committee

Branch Committee

Budget and Finance Committee

Bylaws Committee

Communications/Media and Public Relations Committee

Conference Committee

Diversity, Equity, Inclusion, and Social Justice Committee

Ethics Committee

Graduate Student Committee

Membership Committee

Nominations, Elections, and Awards Committee

GENDER EQUITY TASK FORCE

NAOMI J. WHEELER, PH.D., LPC (VA), LMHC (FL), NCC (SHE/HER/HERS)
ASSISTANT PROFESSOR | COUNSELOR EDUCATION
DEPARTMENT OF COUNSELING AND SPECIAL EDUCATION
SCHOOL OF EDUCATION | VIRGINIA COMMONWEALTH UNIVERSITY

ACA President S. Kent Butler initiated a task force on gender equity to shed light on the inequities commonly encountered in our society associated with gender. In response, the task force (headed by co-chairs Drs. Mary Hermann and Michael Chaney) developed a plan for compiling/disseminating information and resources for counselors related to gender issues and I had the honor of representing the IARTC as a task force member.

Two themes that threaded the work of the task force included: 'breaking the binary' to deconstruct ideas around gender socialization and intersectional identities that influence gender equity issues. Overall, the task force included three work groups focused on (1) transgender and gender-expansive people, (2) girls and women, and (3) boys and men. The group spoke at ACA where we unveiled our website with resources related to each work group: https://acagenderequity.weebly.com/ and introduced the first of three articles to be published in Counseling Today online in April (https://ct.counseling.org/2022/04/breaking-the-binary-transgender-and-gender-expansive-equality/), May (https://ct.counseling.org/2022/05/counseling-girls-and-women-in-the-current-cultural-climate/), and June.

Within each CT article and subgroup discussion, the impact of gender inequality for mental health was clear, as was the connection of such inequities to trauma. In our panel discussion at the ACA conference I was struck by the very personal realities shared by several attendees for how gender inequity intersects with crisis and trauma in their own lives as well as in their clinical practice. From discussion of legislative initiatives such as the 'don't say gay' bill to anticipated shifts in rights associated with body autonomy to navigation of gender issues in the client-counselor relationship, our socio-political climate contributes to our clients (and our own) experience and is highly relevant to the work we do in counseling. That said, not all clients will come to counseling to directly address experiences of gender inequity. Yet, application of a gender equity lens to the work of counselors, including trauma counseling, provides opportunity for us to create a more holistic picture of our clients, their needs, strengths, resources, and where advocacy may be helpful. For us to make strides towards gender equity, we need to be willing to start with the self, to challenge our own internalized gender biases, and to acquire knowledge that informs new perspectives and understanding for the role of gender for human development and mental health. We hope the articles and website aid counselors in taking actionable steps towards gender equity and we invite counselors to add to our resource lists through the links accessible on the website. Finally, the task force initiated the process to develop an interest network to continue these conversations for gender equity.

GRADUATE STUDENT COMMITTEE

Christine Banks-VanAllen, MA, LPCC-S,
Chair
Kent State University

Sara Ellison, MS, LAPC, NCC
Vice-Chair
Auburn University

Kashon W. Corley, MA, NCC, LPC-S
University of the Cumberlands

Debra L. Ainbinder, PhD, LPC, NCC, ACS
Board Liaison
Lynn University

Cassandra Riedy Rush
George Washington University

Danielle Holly Johnson, MA, LCPC, NCC
Regent University

Lauren A. Steele, MS, LMHC, MCAP, NCC, QS
Florida Atlantic University

Mima Lormeus, BA
Lynn University

Pierre Nicole Patriarca
George Mason University

GRADUATE STUDENT COMMITTEE

The IARTC Graduate Student Committee (GSC) promotes greater understanding and awareness of trauma and resilience within the graduate student population, encourages graduate students in counseling to join and participate in IARTC, assists in the development of student organizations within IARTC branches and regions, and communicates the concerns and needs of graduate students to the IARTC board.

The GSC recently compiled a resource listing of trauma-focused ACA presentations to streamline attendee conference planning, spearheaded by our own Sara Ellison and Danielle Johnson. We are beginning work on a series of monthly trauma fact sheets on trauma-informed treatment modalities and special trauma topics to support graduate student needs. With our new division status, we hope to be able to provide scholarship opportunities for graduate student members to present on trauma-informed practices at professional conferences in the future. Our committee is full of energy and passion for trauma training and advocacy and is excited to meet our graduate student needs.

The IARTC Graduate Student Committee would like to get a better understanding of our members' specific interests, including member benefits and guidance towards helping students become trauma-informed clinicians. Please take the time to complete a brief survey to help our committee get a better understanding of your interests.

Survey link: https://forms.gle/yfkYZfzH1KnJvAPGA

This issue we'd like to highlight our GSC Chair, Christine Banks-VanAllen. In addition to presenting at the 2022 ACA conference in Atlanta, Christine lends her talents and time to helping the GSC to be a great resource for current and potential IARTC graduate student members. Christine is a second-year doctoral student at Kent State University and holds an LPCC-S in her home state of Ohio. Christine is certified in EMDR, trained in TF-CBT, and maintains a bucket list of other trauma modalities to learn and share with others. Christine specializes in working with adolescent girls who have experienced trauma and other adverse childhood experiences. Christine is passionate about infusing trauma-informed principles and trauma competency into all aspects of counselor education and counseling practice, and her research and advocacy interests focus on the intersections between trauma, adolescents, and social justice. Christine is honored to serve IARTC and we're thankful for her services!

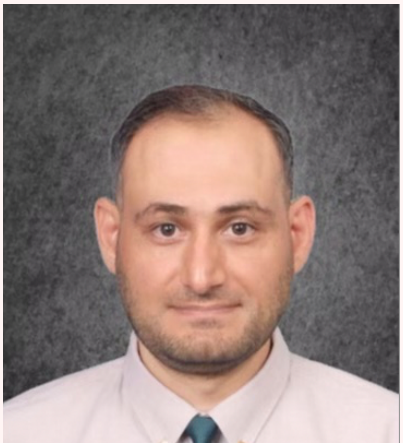
BRANCH COMMITTEE

Yoon Suh Moh
Chair

Jerry Pierson
Vice-Chair

Fariba Ehteshami
Member

Debra Ainbinder
Board Liaison



Yahyah Smadi
Member

Branch Committee Members at ACA!

BRANCH COMMITTEE

Representative: Yoon Suh Moh, Chair of Committee
Credentials: Ph.D., LPC (DC and PA), CRC, NCC, BC-TMH
Work affiliation: CACREP accredited community and trauma counseling program at Thomas Jefferson University

The Branch Committee consists of the following members:
Yoon Suh Moh (Chair), Jerry Pierson (Vice Chair), Debra Ainbinder (Board Liaison), Fariba Ehteshami (Member), and Yahyah Smadi (Member)

We are committed to:

- Seeking and considering petitions for the formation of new national, state, or regional branches of IARTC
- Making recommendations to the IARTC Board for formation and/or dissolutions of national, state, or regional branches
- Promoting cooperation and communication among branches and IARTC
- Assisting branches in coordinating efforts among each other and with IARTC
- Reviewing status of state, national, or regional branches on 5-year intervals

We are working on:

- Meeting monthly to discuss strategies to promote communication among IARTC members
- Discussing ways of recommending for creating an application process or protocol for future IARTC branches formation
- Helped increase the recognition and promotion of IARTC during the 2022 American Counseling Association conference in Atlanta, GA

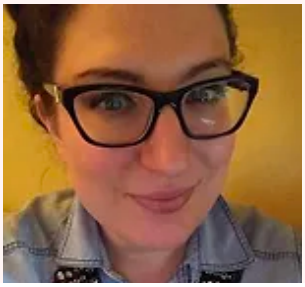
Committee highlights:

- Yoon Suh Moh, Ph.D., Chair, is a member of the IARTC Membership Committee chaired by Dr. Claire Openshaw, and the Branch and Membership Committees have been collaborating to promote IARTC's mission by voluntarily creating goods (i.e., IARTC masks, IARTC logo t-shirts, and business cards) to give away to IARTC members during the 2022 ACA conference.
- Fariba Ehteshami, Ph.D. in Counselor Education and Supervision, Ph.D. in Clinical Psychology, Member, is interested in helping strengthen collaboration between divisions of the American Counseling Association and IARTC, particularly IARTC's Branch Committee.
- Yahyah Samadi, M.D., Member, is interested in the internationalization of the IARTC, community engagement teams, public awareness-raising campaigns, and creating initiatives that enable the vision of the IARTC to come true.
- Jerry Pierson, Vice Chair, 22 years Active Duty Service member, I have served in numerous leadership roles that required leading and managing at time upward of 400 personnel. I have experience in working with military personnel experiencing various life stressors and traumas to include suicidal ideations and domestic abuse. I am currently a graduate student at Capella University, a member of the ACA, AMHCA, and CSI.

MEMBERSHIP COMMITTEE

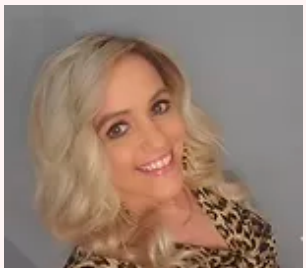
Claire Openshaw, PhD, LCPC
Chair

Lili Burciaga, LCPC, CCTP
Vice Chair



Amy Banko, MS, CPRP

Luisairis Soto, MA, LMHC, CCTP

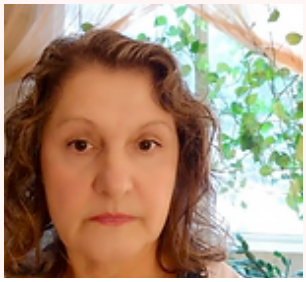


Hannah Coyt, PhD, LPCC-S, NCC, CCMHC

Eric M. Brown, PhD, LPC

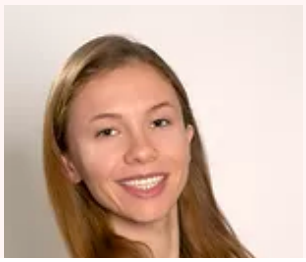
Tara Jungersen, PhD, LMHC, CCMHC, NCC

Rachel Goodman, PhD, LPC



Viorica Lazin, LPC, CAADA

Yoon Suh Moh, LPC, CRC, NCC



Jordan Mann, MA Candidate
IARTC Board Liaison

Barbara J. Shaya, MA, LPC, IATP

Francesco Dal Moro, PhD

Ashley Coombs
PhD Candidate

MEMBERSHIP COMMITTEE

Chair: Dr. Claire Openshaw, LCPC; Governors State University
Vice Chair: Dr. Lili Burciaga, LCPC, CCTP; Lewis University

The Membership Committee actively promotes IARTC membership, including leaders of IARTC Regions and Branches in the maintenance of a national and international network. The committee researches best-practices in membership recruitment and makes recommendations to the IARTC board.

The Membership Committee is continuously working on the best ways to grow our community. In doing so we have provided recommendations regarding adapting the New Member Form to make tracking membership information easier, as thus providing us with a better idea of our member demographics. The Committee has also been working on organizing our Membership List so that we can have a better idea of where our community is coming from. Recently, the Membership Committee partnered with the Branch Committee to market IARTC at the upcoming ACA Conference in April in Atlanta, where we hope to spread the awareness of IARTC with our fellow colleagues.

The Membership Committee would like to recognize Dr. Yoon Suh Moh for their continued effort in promoting IARTC. Dr. Moh not only serves as a member of our Committee, but is Chair of the Branch Committee, and was instrumental in preparing our promotions for the ACA Conference. Thank you Dr. Moh for all your time and effort-it is so very appreciated.

BECOME AN IARTC LEADER!

We are still looking for leaders to join the following IARTC Committees:

- Awards Committee: define, nominate, invite nominations, and select recipients for awards given by IARTC at the annual membership meeting at ACA Conference; first time will be in Toronto, Canada, March 2023. (need 3-5 members)
- Budget and Finance Committee: will help prepare the annual IARTC budget and reports for the annual membership meeting. Financial skills/expertise needed. (need 2-4 members)
- Communications/Media/Public Relations: help develop webinars, reports, publication briefs, white papers, website, social media content, and online interest networks. Social media and webinar experience needed. (need 7-9 members)
- Conference Committee: work with IARTC's President-Elect, Dr. Lisa López Levers, to plan ALL ASPECTS of IARTC's every-other-year conference. The first conference will be in the Fall of 2023 or 2024 depending on how quickly we can get up and running with ACA. Conference planning experience needed. (need 9-18 members)
- Nominations Committee: work with IARTC's Past-President, Carol Smith, to invite, review, and submit information to ACA for annual elections. (need 3-4 members)

PICTURES FROM 2022 AMERICAN COUNSELING ASSOCIATION CONFERENCE

Dr. Carol Smith at the Smith-Levers book signing with Dr. Lisa López Levers, and having her sign a copy of her new book **Trauma Counseling, 2nd Edition**. It just came out, and the publisher, Springer, had a book signing for Lisa in the Exhibit Hall at the ACA Conference in Atlanta.

Dr. Lisa López Levers (IARTC President-Elect-Elect) standing in front of the Meet the Author Sign with her new book Trauma Counseling, 2nd Edition, published by Springer. The book was just published and serves as an excellent text for an intro trauma course or even two (33 chapters).

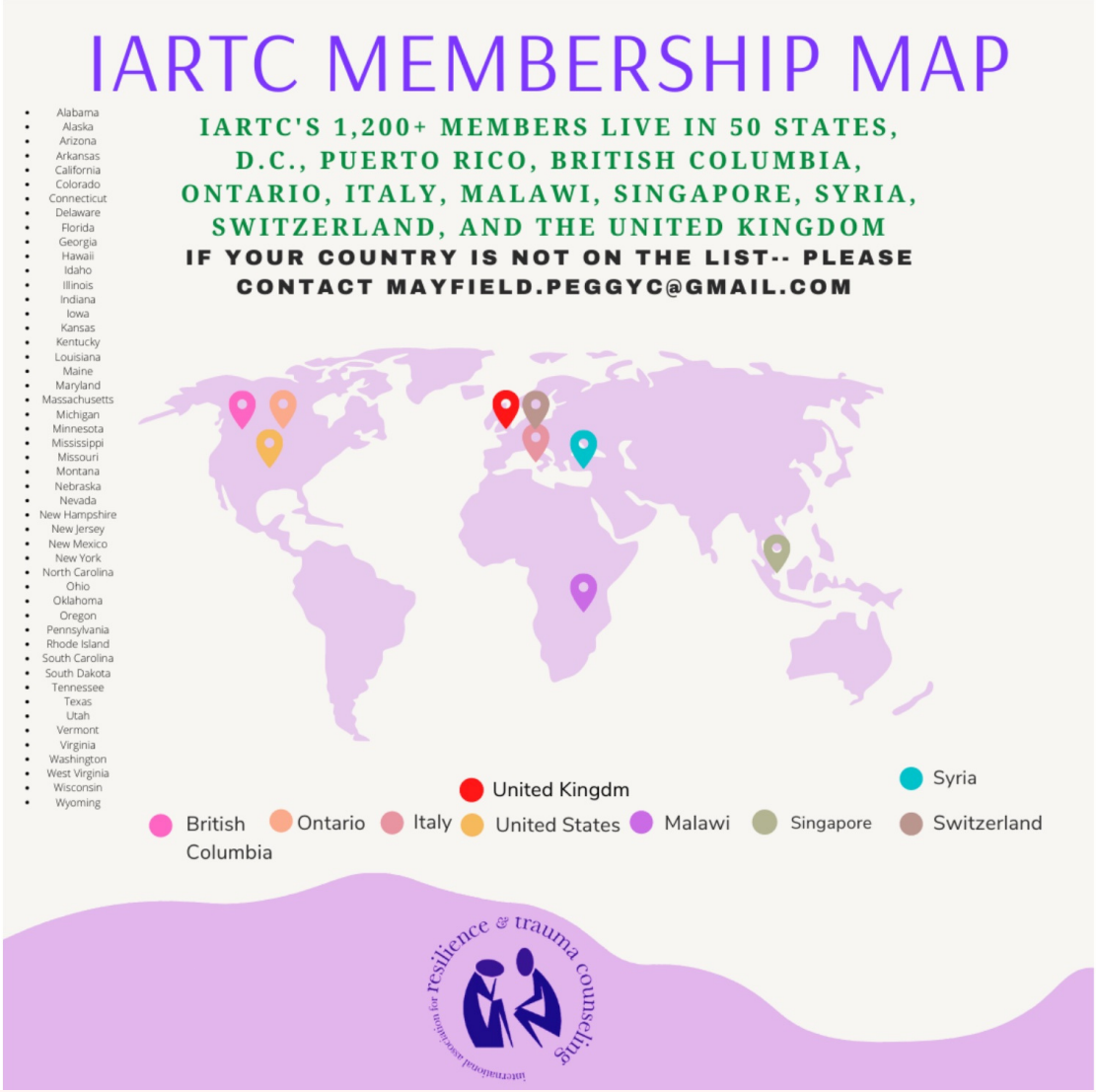
Jon Sperry, PhD; Debra Ainbinder, PhD (IARTC's Treasurer and serves on IARTC's Branch Committee and Graduate Student Committee), and Lydia Fink, B.S., presenting their poster "Trauma Informed Practices of Mental Health Providers Around the Globe" at the ACA Conference in Atlanta, April 7, 2022. They had 20 countries respond to their invitation to share practices, and the analysis shows that most practitioners do not feel equipped to deal well with trauma in their clients. They will continue and publish their research.

MEMBERSHIP MAP

EST. MARCH 24, 2022

IARTC'S MEMBERS LIVE AROUND THE GLOBE!

CONTACT MAYFIELD.PEGGYC@GMAIL.COM IF YOUR COUNTRY IS NOT LISTED



ELECTION RESULTS

IARTC President-Elect for 2022-2023
Dr. Lisa López Levers

IARTC Secretary for 2022-2024
Dr. Melinda Paige

IARTC Trustees for 2022-2025
Dr. Lisa Vinson and Dr. Misty Hatch

IARTC Governing Council Representative to ACA for 2022-2025
Dr. Joshua Kreimeyer

ARTICLES

TRAUMA AND THE USE OF THE IFS MODEL TO INCREASE RESILIENCE

Fariba Ehteshami, Ph.D.
Assistant Professor at TAMUC

Today our world is faced with many types of traumas. Counselors need to be prepared to take immediate action and apply different techniques to help traumatized individuals, communities, and the world in which we live. Resilience increases tolerance, understanding, cooperation, and emotional and mental health. Having emotional balance is one of the signs of a well-balanced personality. In both my personal life and professional work experiences, I learned about the important role of balance in our life.

According to the Internal Family System (IFS), self-discovery and having balance in the different parts of our personality is important. This is achieved through self-awareness and the development of personal leadership choices. IFS can be used to work with a variety of clients but can be especially helpful when working with clients with a history of trauma. Individuals are unique. The personality of individuals who experience trauma may become divided into an unknown number of subpersonalities which are called parts in ISF. Research has shown that everyone has a unique personality, and this uniqueness can and should connect to the individual's internal system and how they feel about themselves (Goran, et al., 2021; Weinberg, et al., 2021). When people experience traumas, the different parts of their personality do not work as an integrated self even though the changes may seem helpful at the time. Each of the parts wants to protect the individual separately and in different ways. This may cause many internal and external relationship issues.

The goal of therapy in working with clients who are suffering from trauma is to help them find an effective balance of the role of each part of themselves. This will help them to achieve a rational balance and harmony within their internal system. As individuals develop their ability to manage their personality parts, they become more resilient. They will be able to better deal with their issues and better understand their sadness, anger, hate, fear, and insecure feelings (Hughes & Narayan, 2021).

Trauma can lead to the self dividing into parts. They often become isolated from the rest of the system in an effort to protect the self from feeling pain, terror, fear, and other uncomfortable feelings (Duffy, 2021). When desperate parts are making an effort to be cared for and tell their story, they may leave the individual feeling fragile and vulnerable. In this situation the personality parts are attempting to keep the individual in control. This is done for the purpose of protecting the parts from feelings of hurt and rejection. This is a combination of parts striving, controlling, evaluating, and terrorizing. In this process, when groups of parts are activated to control feelings, they may cause self-blame and self-destruction in a number of different ways. This can include drug or alcohol use, self-mutilation (cutting), binge-eating, sex binges, and other destructive behaviors (McFetridge, et al., 2015; Wallick, et al., 2021; Yalch, et al.,2021).

Therapists can help their clients increase their resilience by using the IFS model as follows:

- Introduce the language of the IFS model and the goal of using the techniques and how IFS therapy can work

TRAUMA AND THE USE OF THE IFS MODEL TO INCREASE RESILIENCE

- Help clients become aware of their personality parts by asking them how they experience thoughts, feelings, perceptions, and images in different parts of their self
- Help individuals become aware of their own personality parts and the personality parts of their family members
- Help clients choose to make decisions based on the use of the model of their individual uniqueness, family systems, and trauma suffering
- Help clients become aware of their fears and the reasons for their fears
- Help clients learn about the goal of each part of the self and how each part feels a responsibility to protect them
- Help clients manage each part of their self
- Help clients experience integrating their self-parts through assessing their external thoughts (Thollot, et al., 1997).

To be successful in this process, we as counselors need to educate our clients to become aware of the protective role of each personality part. This will help them be able to develop a direct relationship with the parts. In this way, the emotionally injured part of personality will find the opportunity to talk about fears and concerns. In this process the therapist will help the client respect the concerns of the part through internal dialogue and by use of the IFS language (Borroni, et al., 2021; Granieri, et al., 2021; Husain, et al., 2021).

Being aware of the feelings of pain in the body is important. The pain can be caused by the emotional injury experienced by one's personality parts. Journaling, play therapy (especially Sand-tray), music and theater therapy, role playing, art therapy, and imagination therapy techniques will help clients find and connect with their different personality parts and integrate them. This will also help them build a strong self. The most important goal of applying all of these techniques is to help clients communicate internally and externally with themselves and their family members. Using both body language and verbal communication is very powerful in the process of self-acceptance and family enactment. This will also help individuals who experienced trauma to learn that "No Matter" what others are feeling, thinking, and doing, individuals are always responsible for their own personality parts (Peng, et al., 2021; Voestermans, et al., 2021).

The emphasis of taking responsibility for one's own parts will help individuals access and accept themselves as who they are and how they feel. Integration of self through the increase of resilience will also increase the individuals' ability to overcome their fear of being ignored, judged by others, worthless, and alone. They will be able to trust themselves and their abilities while they are more aware of who they are (Brill, 2000; Dunn et al., 2015; Ołdakowska-Jedynak, et al., 2021).

IFS helps individuals who experienced trauma to trust themselves and learn how to become "co-therapists" and deal with their fear. IFS is helpful for increasing clients' resilience and well-being.

TRAUMA AND THE USE OF THE IFS MODEL TO INCREASE RESILIENCE

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HEALING-CENTERED TRAUMA COUNSELING (HCTC): A STRENGTHS-BASED GROUP COUNSELING APPROACH TO TREATING TRAUMA

Donna Hickman, PhD, LPC, CSC
Texas A&M University-Commerce

Rebecca Mathews, PhD, LPC-S, LCMHC, CBGT, CHST
The University of North Carolina at Greensboro

Ubuntu is a traditional African philosophy meaning collective humanity. It is sometimes translated to 'I am what I am because of who we all are' (Thompson, 2020).

Introduction

Traumatic experiences impact neurological and cognitive processes, physiological responses, emotional reactivity, and relational connectedness (Van der Kolk, 2014). Because of this, a trauma-informed approach to counseling is becoming the gold standard to care. A trauma-informed approach includes the 4 Rs: realize, recognize, respond, and resist retraumatization (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). A trauma-informed counselor understands the impact of trauma on the individual and the systems that surround that individual. They are well-trained in recognizing the signs of trauma and responding with evidence-based approaches and practices while working to avoid the retraumatization of the client.

Trauma-informed care (TIC) should be the foundation of all client and community contact and considered a universal precaution, much like the precautions taken for blood-borne pathogens (Goddard, 2021). It creates safety for clients, whether they have identified a trauma in their life or not (SAMHSA, 2014). While TIC sets the stage for healing for the individual, it may not be sufficient in healing collective or systemic traumas.

What is Healing-Centered Engagement?

Healing-centered engagement "is holistic involving culture, spirituality, civic action, and collective healing" (Ginwright, 2020, para. 12). It underscores the experience of shared or collective traumas and uses a strengths-based approach to systemic and individual healing. While trauma-informed care shifts the conversation from "what's wrong with you" to "what happened to you," healing-centered engagement goes a step further to "what's right with you" (Ginwright, 2020).

In healing-centered engagement (HCE), a social rather than clinical approach empowers individuals to make changes in the systems that contributed to their traumatization (Ginwright, 2020). Individuals become change agents who focus on their strengths to promote health. While not originally founded as a clinical practice, healing-centered engagement can have powerful applications in promoting anti-racist practices as counselors strive to provide trauma treatment for clients who have been generationally and systemically marginalized.

Healing-Centered Trauma Counseling

Healing-Centered Trauma Counseling (HCTC) can be a new approach to counseling that merges the foundation of trauma-informed care and healing-centered engagement. Like healing-centered engagement, HCTC views individuals as catalysts for change, it is grounded in the culture of the client, and it sees healing as a process wherein the client's identity is restored (Ginwright, 2020). HCTC can be applied to clients who have identified trauma experiences. Additionally, it can be utilized to support individuals who demonstrate traumatic responses without an identified trauma source,

which is often the case with those carrying the scars of historical or intergenerational trauma. Although historical and intergenerational trauma continues to be an underdeveloped area of research (Cerdeña et al., 2021), counselors are tasked with providing quality care and ensuring competence in these areas.

Implications for Counselors

A Healing-Centered Trauma Counseling (HCTC) approach can be utilized with clients individually, in couple and family systems, or with groups across various settings. The effects of trauma are not confined to the individual (Ginwright, 2020), and therefore, group counseling can be an ideal space for collective healing. Healing-Centered Trauma Counseling empowers clinicians to expand their understanding of how to respond to trauma and offers a more holistic approach to working with clients.

Case Illustration

Marti, a high-school counselor in the midwestern United States, notices that many of her students are bringing similar themes into her office: pandemic-related trauma, racial oppression, marginalization, self-esteem, identity issues, and depression. Marti is committed to supporting anti-racist practices as a school counselor but is unsure how she can help so many students who are dealing with the same issues. Marti is struggling with her own mental health resulting from pandemic-related trauma and is feeling overwhelmed. She reads an article about Healing-Centered Trauma Counseling in a school counseling newsletter and decides to try something new. After consulting with the other counselors on her team, Marti emails her students about participating in weekly healing circles. She explains that the purpose of the healing circle is simply to share stories about their own struggles and paths to healing.

Marti is shocked when 35 students show up at her first healing circle. The word quickly spreads among her students and on social media. She enlists her counseling team and school psychologist to help so the groups can be smaller and more intimate. When she debriefs with her team over text after each healing circle, the adults report that the healing circles are just as beneficial to them. One of her colleagues shares that it's the only 30 minutes of her week that she actually feels like she is making a difference with her students. Marti recalls reading that one of the many benefits of a healing-centered approach is supporting caregivers in their own healing. Moreover, Marti's team discusses how empowered and encouraged students report feeling after sharing their experiences in a safe space (Ginwright, 2020).

Conclusion

Traumatic events can have a substantial impact on clients, students, and caregivers. A trauma-informed counselor is sensitive to the short-term and long-term effects of trauma across the lifespan. Counselors can use a TCHC approach to facilitate resilience and healing in their clients. This approach shifts the focus from trauma to healing while honoring a client's cultural identity. By utilizing this approach, counselors can create safety, build connections, and set the stage for healing.

HEALING-CENTERED TRAUMA COUNSELING (HCTC): A STRENGTHS-BASED GROUP COUNSELING APPROACH TO TREATING TRAUMA

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THE H-R FACTOR

Lisa López Levers, PhD
Duquesne University

As soon as you read "H-R," you probably are thinking that this article is going to be about Human Resources and maybe even how to use the Human Resources Office where you work or go to school. Well, this assumption is not entirely incorrect, as the article deals with a type of human resources, but not a physical place to engage them. The H-R here refers to humility and respectfulness, and the article discusses how to begin instilling and encouraging these traits in ourselves and in others. If we can accomplish this, then the H-R Factor truly can become useful human resources, for us and for those around us.

In most societies, civility once was an assumed part of the social contract. For a complexity of sociological and cultural reasons, so many shifts in contemporary living seemingly have supported a lack of civility and have gotten us off track. In fact, we are living in extremely stressful times, with so many crises, traumas, and disasters occurring nationally and globally. One result of the COVID-19 pandemic, for example, has been an increase in aggressive behavior (Killgore et al., 2021), including a spike in aggressive driving and vehicle-related deaths (Crist, 2022; Karimi, 2021). Perhaps we can use this as a moment to get back on track and reacquaint ourselves with the importance of having some humility and treating others with respectfulness, both of which can lead to a better sense of personal integrity.

Humility

We live in a society that seems to have embraced a "me-first" culture (Mix, 2018), and and we sometimes forget that the ideas and and feelings of others matter, too. Humility, very simply, involves having a modest view of our own importance; a humble person is not pretentious or arrogant. To put things into perspective, each one of us is just a speck on the planet, and Planet Earth is just a speck in the universe. Being humble involves perspective taking; it also implies that we have the ability to put the needs of others ahead of our own needs, at least sometimes.

Over the last two decades, interest in humility has increased, both among researchers and practitioners (Schaffner, 2021). Humility is considered a prosocial trait, which can be measured (Bhattacharya et al., 2017). Research has shown, for example, that organizational leaders who possess a sense of humility can empower employees toward greater productivity and innovation (Nielsen & Marrone, 2018). Additionally, possessing cultural humility is an important therapeutic asset in counseling a diverse population of clients (Hook et al., 2017).

Developing humility begins with looking at ourselves, in the most honest way possible. We need to concede that we do not have all of the answers and that we cannot know everything. In fact, a part of being humble involves the ability to accept that others may have a perspective or possess information from which we could benefit (Hill & Laney, 2017). In this way, we come to understand our limitations, but we also are able to appreciate and value all of our positive characteristics. Having humility does not equate with low self-esteem, as some people mistakenly think; rather, in the long run,

possessing a humble attitude can help us to feel better about ourselves and about the world around us. In many ways, having humility helps us to derive a better sense of fairness—about ourselves and in relationship to others.

Respectfulness

Showing a lack of respect toward other people, from mean-spirited social media comments to rude or down-right awful behavior on airplanes, seems to have become normalized in recent times. We need to take Aretha Franklin's message to heart and show each other a little more R-E-S-P-E-C-T! Showing respect can be just as simple as listening—really listening—to what another person is trying to say. And the ability to respect others begins with cultivating self-respect.

Respectfulness involves taking a courteous perspective of other people's needs, ideas, and feelings. This is true both in one-on-one relationships and among groups of people. As an example, by showing respectfulness to employees, organizational leaders can cultivate a more positive work culture (Heathfield, 2021). Of course, this same principle applies to interpersonal relationships as well, including in a mental health therapy session; when we show respect to one another, we enhance the potential for a positive experience. Being respectful is a part of being a polite and civil member of society; it involves embracing the wellbeing of self and others. We need to remember that we have to show respect in order to receive respect.

Integrity

Possessing humility and demonstrating respectfulness can lead to a more integrated sense of personal integrity. In this regard, the H-R Factor becomes the H-R+I Factor. A person with integrity strives to do the right thing or to take the best course of moral action, even if no one is watching. Having personal integrity often involves difficult decisions, like being honest, when "covering up" would be much easier. In the acceptance speech for his Nobel Peace Prize, Elie Wiesel noted that "...one person of integrity can make a difference..." (1986, "Acceptance speech," para. 12). Humility and respectfulness are traits that are associated with integrity, as are being gracious, honest, trustworthy, hardworking, responsible, helpful, and patient (Indeed Editorial Team, 2021).

Enhancing the H-R+I Factor

The synergy of humility, respectfulness, and integrity creates opportunities for developing prosocial traits and skills as well as for having a positive effect on other people and on the environment. Together, these traits may very well comprise a useful antidote for much of the current stress, crisis, trauma, and disaster swirling around us; these very traits may be efficacious in building both personal and collective resilience. A few ideas are offered here that can promote productive outcomes of this synergy.

Mindfulness Practices

A key feature of mindfulness is being present, in ways that enhance awareness of self and others, without engaging in overstimulation or

feeling overwhelmed. Similar to humility, mindfulness involves acceptance rather than judgement. We try to see ourselves and others truthfully and honestly. Various techniques that promote mindfulness are available to us, and a cursory internet search can identify such techniques. However, mindfulness practices that encourage humility, respectfulness, and integrity can be as simple as just pausing to appreciate a particular moment, being aware of and acknowledging the person walking toward us, or taking a deep breath before launching into the next activity or task. Being aware of ourselves, in the here-and-now, and trying to regard the other in a nonjudgmental way or with compassion can contribute to the synergy of humility, respectfulness, and integrity.

Revolution

The Girl Scouts (n.d.) advocates for what it calls a "respect revolution," which sounds like a great idea. We might imagine how different our social interactions could be if we just treated one another with respect. Acting with respect toward others can defuse potentially reactive or aggressive situations. For example, as mentioned above, a spike in traffic deaths during the COVID-19 pandemic is attributed to an increase in aggressiveness (Crist, 2022). Actions as simple as letting a car enter traffic in front of us, saying "excuse me" or "thank you" in a store, or telling a friend or loved one how much we appreciate them are all ways of showing respect. Perhaps we can emulate the Girl Scouts and join the revolution—the respect revolution!

Service and Stewardship

Being of service to others, in whatever ways are possible, can help to foster personal humility, respectfulness, and integrity. There are so many ways to help others. This might involve monetary contributions to a well-deserving organization, or it might be giving time to a person or group in need. Service may be as simple as offering kindness to someone or showing gratitude to another person for even the smallest act. More complex service may involve providing trauma counseling to our clients who have been harmed in some way, especially in this current environment of simultaneous multiple complex crises and humanitarian disasters that are occurring around the world (Levers & Drozda, 2022).

Stewardship is an extension of service, entailing an ethic of responsibility for conserving resources. This might mean engagement in a community project that moves unused food from a restaurant or grocery store to a food bank, allowing still-good food to be consumed by people who need it. Stewardship to the planet is more critical now than ever before. Many climate-related projects need volunteers, and each of us can make personal contributions to assist our own communities and neighborhoods in an effort toward greater ecological awareness. Service and stewardship can be as simple as appreciating and valuing all sentient beings as well as the environment. The International Association for Resilience and Trauma Counseling (IARTC) has taken a stance of

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Stewardship in our commitment to acknowledging and fostering resilience, to assisting clients who have experienced trauma, and to offering resources related to these issues to the larger helping professions and to academic units providing preservice trauma training.

If we were to try to engage the H-R Factor and to experience the synergy of the H-R+I Factor, we might end up feeling good about ourselves, along with being better citizens and assisting those around us. The H-R+I Factor also might serve to mitigate some of the turbulence and animosity around us.

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NO ONE CAN HELP ME: DETERMINING READINESS FOR REPROCESSING TRAUMA

Nicole Corey, Masters Student,
Dallas Theological Seminary, Dallas, Texas

Dr. Crystal Brasher, LPC, Assistant Professor,
Dallas Theological Seminary, Dallas, Texas

Right outside her counselor's office, the client sat in her motionless car, broken from the memory she relived so vividly moments ago. Tears flowed from her eyes, hot as they met the redness in her face. That was way too much and way too hurtful, she thought, I panicked and froze. I couldn't do anything in the moment but be thrown back into the past. Another wave of tension and grief overwhelmed her, why couldn't I say anything about how much her attempt at helping me was actually hurting me? She resolved I must never go back. She can't help me, no one can help me. No longer able to trust her counselor, she took a deep breath and buried her pain. I will be successful leaving the past in the past this time, she thought, where it belongs.

Over the next week, the pain gradually crept out of the past into the darkness of her nights, invading her mornings, and impacting her work. I thought I was done with all this, she no longer recognized the life she was living for such a short time, I can't be this self-destructive anymore. Counseling was her only option, and she knew it. She exhaled in defeat and surrendered– I will go back. But she declared to herself, I cannot and will not allow any discussion regarding my past and what happened back then. It was then that her walls went up.

Revisiting the past for the purpose of reprocessing with survivors of trauma remains a complex and delicate task. In Trauma and Recovery, Herman (1997) suggests that trauma recovery occurs in stages with three primary tasks, 1) establishment of safety, 2) remembrance and mourning, 3) reconnection with ordinary life. Her transtheoretical framework allows room in task two for most evidenced based therapies and interventions to fit in. The first task, establishment of safety, is often skipped, hurried through, and not stressed enough in many treatment plans. Moving too quickly or neglecting task one can result in client re-traumatization, dangerous and/or extreme coping strategies, loss of rapport and trust between client and clinician, and the premature ending of counseling. This can leave a survivor with the belief that counseling does not help, that counseling is not for me, and, even more dangerous, I am going to have this pain for the rest of my life. Despair often accompanies that belief. For the traumatized survivor, the symptoms are still real and present, and the need to self-protect is oftentimes at the ready. Herman (1997) asserts that survivors feel unsafe within their bodies and with people.

This article combines stage one safety tasks recommended by some of the top evidence-based trauma therapies, including Exposure Therapy (PE), Eye Movement Desensitization and Reprocessing (EMDR), Trauma-Focused Cognitive Behavior Therapy (TF-CBT), and Expressive Arts therapy (EA) into one resource. Clinicians can use the following checklist to ensure safety, protect, and assess the readiness of their clients for revisiting and reprocessing what they have survived. The following are broken up into 2 main categories, the client's interpersonal safety (with others) and intrapersonal safety (within self). The first category of interpersonal safety tasks includes the following:

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Rapport has been Established

Healing and trauma recovery can only occur within the context of a relationship (Herman, 1997). PE therapy posits that establishing a positive working alliance is a crucial part of early therapy (Kramer, 2009). EA therapy recognizes that safety and security come from the therapeutic relationship (Richardson, 2016), and EMDR therapy necessitates that the client is able to trust the counselor. Only from that place of trust can they share the truth about their experience reprocessing between sets (Shapiro, 2018).

Awareness Of Client's Presenting Symptoms

Having a thorough understanding of the survivor's unwanted and painful symptoms allows the clinician to notice when in-session activation occurs. PE therapy suggests looking at PTSD symptoms and how the client personally experiences each of these symptoms (Rauch, 2012). While presenting symptoms are usually a part of the initial intake, it is important to revisit their symptom severity regularly, as these can change in presentation and intensity during trauma reprocessing.

Client's Safety in their World

Clinicians will need to ensure their clients are able to distinguish between what is and what is not safe. This includes identifying safe objects, resources, places, and most importantly, safe people. EA therapy suggests that children should also be able to establish a difference between being safe and feeling safe (Richardson, 2016). EMDR therapy further establishes the feelings of safety by utilizing a Safe/Calm Place resourcing to help the client feel and remain safe (Shapiro, 2018).

Going without basic needs, like clean accessible water, food, secure and reliable shelter, appropriate clothing, and shoes, can further traumatize a survivor and prevent reprocessing. EA therapy stressed that clinicians ensure that their client's basic needs are being met (Richardson, 2016).

Safety From Others

Establishing proper relational boundaries is another component of client safety. PE therapy suggests that survivors separate from unsafe people who disrespect boundaries (Kramer, 2009). Additionally, EA therapy encourages safe relationships for the purpose of preventing further trauma in children and encourages the resolution of situations where safety is inhibited (Richardson, 2016).

Safety With Others

Survivors who embark on the path of healing will need people that can be a support network for them. EMDR therapy refers to these relationships as "life supports" (Shapiro, 2018, p. 89). In the case of children, EA therapy asserts that there is security in relationships between child and caregiver (Richardson, 2016).

Psychoeducation

Engaging in recovery requires many levels of psychoeducation. PE therapy encourages bringing into the client's awareness how symptoms are prolonged, not resolved, by avoiding past trauma (Rauch, 2012). TF-CBT Therapy seeks to normalize the survivor's responses by bringing to light how they

connect to early trauma experiences (Cohen & Mannarino, 2015).

Another level of psychoeducation is encouraged by EMDR therapy. The preparation stage includes explaining the theoretical approach to the therapy, describing the model, establishing expectations on what therapy will look like, and addressing any fears the client has about revisiting and reprocessing their trauma (Shapiro, 2018).

Interpersonal and intrapersonal tasks can be achieved simultaneously and are not in a particular order. The category of intrapersonal safety includes the following:

Client's Physical Safety Within

Before engaging in trauma reprocessing interventions, the safety of the survivor within themselves is crucial. PE therapy is encouraged and performed only when the client is not in danger of harming themselves or others (Rauch, 2012). EMDR therapy refers to this as personal stability, suggesting that safety measures for the survivor be put into place before entering Phase 3. EMDR therapy also acknowledges the impact of present-day life stressors that, when combined with trauma therapy, can overwhelm and threaten client safety (Shapiro, 2018).

Client's Ability to Self-Soothe

Addressing traumatic events brings with it a whole host of overwhelming emotions that can, without warning, trigger a survivor into active survival mode. One of the most important aspects of trauma care is empowering clients to return to a stable emotional state. EMDR therapy recognizes that reprocessing happens both within and outside of session, and that clients will need to be able to tolerate a moderate level of discomfort. EMDR therapy asserts that this form of therapy should only be implemented if the survivor is willing and able to "dissipate a moderate level of disturbance" (Shapiro, 2018, p. 88).

TF-CBT also recognizes the importance of self-regulation. This therapy encourages client and clinician to work together to build relaxation and affect modulation skills so that children and adults alike, are able to express and manage a variety of emotional states (Cohen & Mannarino, 2015). This includes grounding when emotional states are escalated as well as practicing self-care and mindfulness.

Another component, according to EMDR therapy, is assessing and addressing the survivor's current level of dissociation. Understanding that dissociation was helpful and adaptive for the client in the trauma, the activation of the survival response may include some level of dissociation. EMDR therapy suggests, if dissociation occurs outside of the context of the old memory, that reprocessing should be discontinued immediately (Shapiro, 2018). Active reprocessing will need to wait until the client is able to consistently recognize and re-associate with the present moment.

Client's Overall Health

Engaging in trauma therapy can be taxing on

the trauma survivor physically, and a physician referral may be necessary. EMDR therapy suggests that, due to the endurance it takes to reprocess, survivors should be able to withstand the "physical rigors" of reprocessing (Shapiro, 2018, p. 89). Drug and alcohol use should also be considered before engaging in reprocessing, according to EMDR therapy. Even if in recovery, a client may experience emotional overwhelm and physical discomfort which can trigger previous using patterns (Shapiro, 2018).

Conclusion

The hour turned. On the edge of her seat, the clinician exhaled in defeat and sat back. She had spent the week examining her session notes, researching to uncover what happened and how, learning all it takes for a survivor to be ready to reprocess their trauma, and creating a plan to do so. However, the damage was done, and she knew it. She vowed in that moment; **I will not allow anyone in here to experience that again**. Suddenly, and to her complete surprise, her client entered the session. The counselor exhaled, ready with a different plan, let's begin again.

Regardless of the clinician's theoretical approach and trauma interventions, the tasks in stage 1 involve multiple aspects. From ensuring the client is safe in their interpersonal relationships and settings, to the client's relationship and engagement with themselves and their own wellbeing, stage 1 tasks are necessary and empowering for the trauma survivor (Herman, 1997). Having been in situations where they had no control, stage one work begins to rebuild the survivor's sense of self. And from there, they are able to engage with trauma reprocessing more safely and successfully. Not every survivor will return to counseling when they are flooded and unable to stabilize themselves, but we can help clients stay in therapy by discussing that discomfort is part of the process. Working to prevent re-traumatizing through these safety parameters is how clinicians can ensure their client is ready and able to safely address their past pain.

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TRAUMA AND RESILIENCY IN FOSTER CHILDREN

Marcus Folkes Debra Perez

Childhood is an exciting time of growth and development, but for children who are placed in the foster care system, childhood can be a very difficult time. Placement in foster care typically follows a trauma, such as abuse or neglect (Leve et al., 2012). Foster children not only experience the trauma that brought them into the system, but can also experience additional traumas based on placement, peer relationships, and disruption of family relationships (Level et al., 2012). However, not all children are impacted by these various traumas the same, a concept known as resiliency (Ungar, 2015). The article explores the impact of trauma on children in foster care and the development of resiliency.

Trauma during childhood can refer to a range of adverse childhood experiences such as emotional, physical, and sexual abuse, or neglect. Research documents strong relationships between childhood trauma and negative physical health, mental health, or social-environmental outcomes later in life (Mulvihill, 2015). Hayes and O'Neil (2018) suggest that child abuse is a worldwide epidemic, causing distress to millions of children across the globe in multiple cultures. Adult psychiatric disorders such as clinical depression, suicidality, eating or other food-related disorders, sexual dysfunction, and psychotic disorders are shown to be deeply rooted in abuse during a person's childhood (Mulvihill, 2015).

According to Isobel (2016), trauma can be defined as a form of loss to the psyche that is the direct result of an upsetting event. Isobel further explains that individuals who experience a traumatic event may develop social, emotional, and physical distress due to these negative experiences. As children are exposed to traumatic events, they experience long-lasting effects such as complications in the formation of attachments, stunted developmental growth, and significant mental health ailments (Bartlett & Rushovich, 2018).

Youth in the foster care system experience similar consequences from trauma due to the removal from family and placement in multiple group or foster homes. This results in separation and loss, increasing further mental health related ailments (Bartlett & Rushovich, 2018). Research by Dorsey et al. (2012) suggests that in addition to prior abuse and neglect, children who experience consistent placement disruptions are twice as likely to exhibit behavioral problems as youth with a stable placement in foster care. Amongst youth in foster care, one of the most prevalent mental health diagnoses is post-traumatic stress disorder (PTSD). Bartlett and Rushovic reported on the results of a 2005 research study showing that at least 20 percent of children who are in foster care exhibit symptoms of PTSD versus only 11 percent of children who remained in the home.

While the impact of trauma on foster children is well documented, it is also important to note that not all of these children experience the same detrimental outcomes (Leve et al., 2012). The ability to successfully adapt to trauma, such as abuse and foster care placement, is

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known as resiliency (Bellis et al., 2018; Lete et al., 2012; Shpiegel, 2016; Walsh et al., 2010). Resiliency can be understood as a positive response to the same situation that another is negatively impacted by. Ungar (2015) reports that certain characteristics held by each child either contribute to or hinder the development of resilience, such as intelligence, personality, temperament, or genetics. However, the researcher further explains that characteristics that are part of the child's environment are more impactful on the development of resilience and include the relationships with family, friends, and the community.

While resiliency can be seen in children and adolescents in the foster care system who have experienced traumas, the measurement of resiliency changes between researchers from study to study. Many researchers focused on the avoidance of negative outcomes, such as no drug or alcohol dependence, no teen pregnancy, or no homelessness (Shpiegel, 2016; Walsh et al., 2010). However, Shpiegel reported that resiliency is seen in those who successfully navigated school despite a mental health diagnosis, referred to as a discordant pattern. **This pattern is seen throughout research demonstrating that resiliency in foster children and adolescents is best explained by success in positive domains while simultaneously avoiding negative ones (Shpiegel, 2016; Walsh et al., 2010).** Research supports the importance of strengthening the relationships between foster children and their family of origin, peers, teachers, foster family, and other important supportive adults (Shpiegel, 2016; Walsh et al., 2010). Additionally, consistent placement, physical safety, and increased access to various types of resources were all indicative of increased resiliency (Shpiegel, 2016; Walsh et al., 2010).

While preventing trauma in children placed in the foster care system is not possible, it is vital that counselors and other important adults aid in the development of resiliency in these children. The main focus should be on developing and strengthening relationships between key adults and the child. Additionally, counselors can work with foster parents, case workers, and other decision-makers to ensure consistent placements for foster children. Finally, counselors can work with each child to ensure that their basic needs are met, including safety and access to food, clothing, shelter, and healthcare.

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STRENGTHENING RESILIENCY WITH IMPROVED CRISIS COUNSELOR PREPARATION

Julia Lancaster, LPC

During a 2006 standards review process, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) received a grant from the US Department of Health and Human Services to study the needs and preparedness of crisis counselors. The counselor training in emergency preparedness CACREP standards was revised in 2009 to include crisis intervention techniques in counselor preparation programs (CPPs). This revision required that CACREP CPPs incorporate tenants of crisis training, including the traumatic effects of crises, disasters, training on theories and models of crisis intervention, suicide assessment, and psychological first aid (Chatters & Liu, 2020; Pau et al., 2020). A later 2016 revision noted that CACREP counselors in training (CITs) must learn trauma-informed strategies and learn the influences of trauma on individuals with mental health diagnoses (Adams, 2019).

These standards, while helpful, provide minimal guidance for creating and developing course content within CPPs. Counselor educators (CEs) themselves note a lack of crisis, trauma, and disaster training (Van Asselt et al., 2016). This sense of doubt and uncertainty about how to effectively train CITs on these challenging topics has led to hesitancies that perpetuate the gap between CACREP requirements and CITs' education(Adams, 2019).

Crisis, trauma, and disaster training can include the importance of self-care, secondary trauma, and compassion fatigue. When inevitably working with trauma-impacted clients, CITs may experience adverse emotional effects, self-doubt, and decreased self-efficacy. Training may alleviate the potential shock students encounter when first working with traumatic experiences. Given the ubiquitous nature of crisis and trauma, CITs and future clients will benefit from improved counselor crisis and trauma education. This education may also include an opportunity for classroom discussions about how minority groups are impacted by crisis and trauma.

Disproportionate Impact

Minority and marginalized populations are disproportionately impacted by crisis, trauma, and disaster (Albaek, 2018; Hughs, 2017). Some groups are at a higher risk of crisis and trauma, because trauma history is one of several factors that increases the intensity and potentiality for reoccurring trauma. Survivors of childhood trauma are especially vulnerable, and often childhood trauma goes unaddressed and misdiagnosed. This erroneous diagnosis can be used to explain and sometimes mistreat symptoms of early childhood trauma.

Ethnic trauma such as that experienced by many Native American communities and Black and Brown communities may carry childhood pain into adult dysfunction (Aspira, 2017). Discrimination and exploitation due to race can have lasting trauma symptoms if unaddressed. CITs and licensed professionals may work collaboratively with survivors to help them regain resilience and confidence after being diminished in voice and choice, but before this can occur proper training and

education is necessary.

Known Best Practices

When including crisis and trauma in CPPs CEs may utilize case studies, stand-alone courses, embedding or infusing content into established classroom discussion, and allying with community members who may serve as guest speakers or weekend training facilitators (Adams, 2019). CEs can also encourage students to investigate trauma counseling via thesis and dissertations. Some financial aid is available for these endeavors with research journals providing additional scholarship opportunities for topics of trauma and pedagogy, which, in turn, provides the opportunity for dialogues about research related to crisis, trauma, and disaster (Webber et al., 2017). Some other practices include increasing self-efficacy, the supervisory relationship, and self-care practices.

Self-Efficacy

A sense of preparedness increases CITs perceived self-efficacy to deliver crisis interventions (Peters et al., 2017). Higher levels of counselor self-efficacy are typically linked to positive client outcomes while lower levels are not linked as strongly to positive client outcomes (VanAusdale & Swank, 2020). Training with specific crisis and trauma content has been shown to improve confidence. This is important because counselor self-efficacy is associated with the use of suicide assessments and the use of prevention skills (Gallo et al., 2019). Self-efficacy encourages best practices because counselors and CITs are more motivated to deliver them.

Supervisory Relationship

The supervisory relationship between CITs and CEs offers a parallel process that is similar to the CITs and client relationship. Supervisors can teach CITs to look for crisis and trauma in their clients and to consider the impact of trauma while also encouraging CITs to screen themselves for vicarious trauma and compassion fatigue. Supervision can help prepare CITs to competently respond to crisis in the counseling setting (Dupre et al., 2013). With supervisors serving as gatekeepers they can also monitor supervisees for signs of crisis and trauma and can also provide supervisees with gatekeeper education who will work with clients and later supervisees of their own.

The CARE Model of Supervision (Context, Action, Response, and Activity) may improve CITs' outcomes with clients in crisis. The model was developed for counselors working in crisis, disaster, and trauma. The CARE model represents "C" for context meaning time, place, and logistical components influencing the crisis. The "A" stands for action, referencing supervisees and their clients' needs, including how they may respond to a client's crisis. The "R" stands for the response, review of the crisis, treatment, and follow-up care. The "E" represents empathy, which is initiated by the supervisor and emulated by the counselor (Abassary & Goodrich, 2014).

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Resilience and Self Care

Researchers have suggested that crisis training has the potential to build resilience in learners and practitioners by equipping them with the skills necessary to regulate psychological distress that often comes from working with crisis-impacted populations (Leitch, 2017). Burnout is already a concern for some CITs who are often working while attending school and working with trauma-impacted populations during internships and residencies. Critical incident stress management (CISM) can be an approach to mitigate the harmful effects of reactionary traumatic stress and cumulative traumatic stress (Atkins & Burnett, 2016). Suggested components for CEs to better accommodate attention to trauma work within CPPs includes self-care and coping strategies (Lu et al., 2017).

Counselor education has the opportunity and obligation to improve CITs crisis, trauma, and disaster proficiencies (Conley & Griffith, 2016). CPPs and CEs can help CITs provide effective trauma counseling in both individual and mass trauma circumstances. The next steps are for CEs and CPPs to continue to improve crisis, trauma, and disaster education by instituting changes to better prepare CITs to perform optimally in increasingly common trauma and mass trauma contexts for improved professional practice and resiliency.

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HEALING SOCIAL CLASS TRAUMA: CONFRONTING CLASSISM

Lucy Parker-Barnes
Gannon University

Introduction to Classism

Though classism is a historically and currently prevalent form of trauma, counselors are not fully trained in competencies related to helping clients with classism-related issues (Allan et al., 2021; Liu, 2013; Thompson, 2008). Classism is defined as discrimination based on a person's social class standing (Simons, Koster, Groffen, & Bosma, 2017; Thompson & Subich, 2012). Classism may be related to any social class status, including lower, middle, and upper-class statuses (Lott, 2002). When considering all forms of classism, the most prevalent form is lower-class status-related classism (Jordan et al., 2021; Liu, 2013). Discrimination against people of lower-class status is seen in our world in many ways. Examples may include political ploys about people who are homeless as being "lazy" or "addicted," as well as, other and more subtle stigmas (i.e. such as assumptions about a person based on the brand of clothes they might wear or what car they drive). Despite varying forms of discrimination, any discrimination related to class status, alone, may be categorized as traumatic. In addition to the direct trauma of experiencing class-related discrimination, researchers have noted that subsequent and systemic traumas are also related to classism (Cavalhieri & Wilcox, 2021). Various historically related traumas to classism include increased intersectional discrimination, depression, isolation, feelings of lack of worth, or behavioral and contextual aspects such as, being homelessness, being bullied, or being subject to violence (Liu, 2013).

Current Classism Related Traumas

Traumas related to experiencing classism in our COVID-19 and post COVID-19 society, include both nondeath and death losses (Rollston & Galea, 2020). Regarding nondeath losses, researchers (i.e. who identified primarily outside of the counseling field), found that people in lower class socioeconomic statuses faced elevated fears related to issues such as, less access to a primary care physician, living in an environment with added people and potentially added opportunities for rodents (i.e. simply due to added traffic), added mental exhaustion, and added work-family role conflict (Rollston & Galea, 2020).

Additionally, according to the National Center for Health Statistics (2021), clients of lower socioeconomic statuses were also affected directly by COVID-19 with increased death losses as well. These researchers elaborated that social class privilege exists, which affects peoples' chances to be exposed or not exposed to varying dangers, including COVID-19 (Dalsania et al., 2022). One example magnified during the heightened spread of COVID-19, includes that people of upper social class statuses are typically allowed larger living spaces, less obligation to travel via public transportation, more opportunities to physical and mental health care, and better working conditions than their peers with less money. Relatedly, working class adults were five times more likely to die due to COVID-19 when compared to their wealthier

peers (Dalsania et al., 2022; NCHS, 2021; Rollston & Galea, 2020). Understanding the disparities that exist due to wealth differences not only provides counselors increased awareness of such a large and historically salient issue, but catalyzes trauma-informed microscale and macroscale interventions for clients affected by both pandemic-related issues and classism.

Trauma-Informed Systemic and Client-Related Interventions

Though not a counselor, psychologist, Liu (2013), composed a clinical model for other psychologists to help clients facing classism. This SCCC model addresses that psychologists may unintentionally hold cognitive biases about clients of different social class statuses than their own. This model is known as the Social Class Counseling Consciousness Model (SCCC). In Liu's SCCC Model, counselors, like anticipated psychologists, can help clients by lessening any potential counselor-held cognitive biases to those of perceived lower social class statuses. Other microscale trauma-informed approaches include

- Explicitly adding questions asking about a client's social class status on session intake forms
- Providing additive empathy to better understand clients' struggles (i.e. such as, when experiencing complex traumas including homelessness and food insecurity)
- Providing interventions that instill hope such as, through cinematherapy (i.e. by using potentially relatable films including The Pursuit of Happiness or Real Women Have Curves)
- Increasing psychoeducation about skills that may not be privileged to clients with less money, including how to use the internet or apply to online jobs.

In addition to microscale trauma-informed interventions, a macroscale trauma-informed interventions include advocating to help states and federal agencies strengthen labor laws for clients in less recognized positions.

Concluding Thoughts

Through increased awareness in both research and clinical settings, counselors can increasingly best address and mitigate traumas catalyzed by classism. Just as trauma does not stop when clinical sessions end, neither should counselors' intrinsic advocacy for clients affected by classism. Ultimately, it is counselors' moral and ethical duty to help all clients, including clients affected by classism-related traumas.

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THE AUTONOMIC RESPONSE SCREENING TOOL FOR COUNSELORS (ARSTC)

Madeleine Morris Lowman, PhD, LCMHC, SEP

With the increased prevalence of and attention to trauma in our field, counselors need to be prepared to effectively work with clients and their symptoms (Courtois & Gold, 2009). Increasingly, researchers are connecting trauma symptoms to physiology, specifically a disruption in the regulatory processes of the autonomic nervous system (DePierro et al., 2013; Fiskum, 2019). However, little guidance is offered to practicing counselors on how to intervene with clients' regulatory processes directly in session, and instead, practitioners are left to vaguely include attention to physiology in their case conceptualization and understanding of the client. Some counselors may choose to pursue extensive training in modalities that attend to autonomic processes in sessions, such as Somatic Experiencing™, Brainspotting, or Eye Movement Desensitization and Reprocessing. While not all counselors have access to the time and finances required to learn these methods, it seems more and more likely that all counselors will work with clients who present with trauma symptoms. So, how can all counselors learn to practically attend to the physiology of all of their clients in session? The answer may begin with assessment.

There is currently no known screening tool that counselors can utilize in session to determine a client's physiologically-based trauma response, and yet this type of information seems conceptually crucial for making decisions in a session about how to intervene with the client. The emerging popularity of Porges's Polyvagal Theory (PVT; 2011) in the counseling field speaks to the interest clinicians have in attending to physiology conceptually, as the theory outlines stress physiology of the autonomic nervous system in the following responses: social engagement, fight, flight, and freeze. Based on PVT, it seems exceptionally important for counselors to attend to what a client has access to (cognitively, relationally, and emotionally) in each of these stress response states that occur in session (Dana, 2018).

Measures of autonomic regulation can be used to better identify the autonomic response states outlined in PVT, but it can be difficult for counselors to collect physiodata during a counseling session in order to gather that information. The necessary equipment (e.g., ECG equipment and electrode or chest band heart monitors) does not make that type of measurement practical in clinical settings, perhaps explaining the very limited research measuring/exploring autonomic regulation in counseling. Importantly, cues of autonomic regulation can be visually observed (Porges, 2011), though it can be a nuanced and gradual observation process to know what to look for as signs of autonomic regulation. As such, if the counseling field had a way to visually assess for autonomic regulation in order to cater interventions to clients' autonomic needs, client outcomes might improve and healing from trauma could become a familiar practice among therapists, rather than a specialty area.

To address the need for an accessible tool for counselors to attend to physiology in session, the Autonomic Response Screening Tool for

THE AUTONOMIC RESPONSE SCREENING TOOL FOR COUNSELORS (ARSTC)

Counselors (ARSTC) was created. The ARSTC is comprised of visual markers and nonverbal signs indicative of autonomic regulation related to the fight, flight, freeze, and social engagement responses outlined in Polyvagal Theory (Porges, 2011) that counselors can readily, and reliably, use during counseling sessions. The ARSTC is designed for counselors to use in sessions to screen for the stress response state of their clients to later inform their intervention choices. The 34 items of the screening tool were operationally defined, taught to a team of coders, and tested against biofeedback on heart rate variability (HRV) that corresponded to video-recorded counseling sessions. The tool is intended to support counselors in knowing what to look for in their clients' presentations to determine their stress responses. With that information, counselors may be better equipped to meet the physiological needs of their clients by selecting interventions based on the ARSTC.

To further understand the influence of the trauma response state in counseling and the application of the ARSTC, consider the following example. A teenage client named Sadie presents to counseling following an experience of physical assault. Her counselor Nala collects information about Sadie's trauma history and current symptoms and learns she is experiencing passive suicidal ideation and symptoms of dissociation and is withdrawing from her peers and family. Sadie meets the criteria for PTSD, and Nala chooses to use trauma-focused cognitive behavioral therapy (TF-CBT) with the client based on her age, presenting concerns, and trauma exposure. Nala works in the first few sessions to build rapport with Sadie and teach positive coping skills. Nala begins each session with relaxation and grounding techniques with the intention of helping Sadie feels calm at the start of the sessions. Sadie participates, and then Nala moves towards helping Sadie create her trauma narrative through the TF-CBT protocol. After engaging in relaxation exercises, the client states she does not remember what happened to her and disengages with the counselor- her voice is quiet, posture slumped, and she discontinues making eye contact. Nala attributes the disengagement to the difficulty of the tasks, and spends the next sessions focusing once more on relaxation and grounding techniques, such as deep breathing and guided meditation before attempting the trauma narrative once more.

Equipped with the ARSTC, Nala could have made different clinical decisions around how best to work with this client. Had she spent time assessing Sadie's trauma response actively in session, she may have concluded that the client was in a freeze state following her physical assault. Her tone, posture, and patterns of eye contact can together be indicative of the freeze response happening in session, that preceded her disengagement and cognitive capacity to participate in the trauma narrative intervention. From a PVT perspective, Sadie's dissociation, depression, and isolation may point to a larger pattern indicative of a freeze response (parasympathetic shut down), and so efforts to relax the client through parasympathetic relaxation exercises (i.e. deep breathing and meditation) actually were contributing to her

THE AUTONOMIC RESPONSE SCREENING TOOL FOR COUNSELORS (ARSTC)

dissociation. In this freeze response, the client did not have the capacity to socially engage with the counselor (Porges, 2011), so efforts to build rapport and begin the trauma narrative were ineffective. By correctly identifying the client's trauma response state in the session, Nala could have made more informed decisions on how to work with the client (Dana, 2018). The counselor could have chosen to use an active grounding technique, such as jumping jacks, to get the client's heart rate elevated, thus initiating sympathetic activation and pulling the client up out of her freeze response during the session. Though the counselor conducted a thorough intake assessment of the client's history and symptoms, without a way to assess the client's trauma state in session, the counselor missed opportunities to meet the client where she was physiologically and help her engage in counseling.

As illustrated in the case vignette above, the counselor's work with Sadie could have taken a much different course had the counselor's choices been informed by an initial assessment of autonomic regulation. The ARSTC can be used as an organizing tool for counselors to focus their observation of clients' nonverbals, equipping them with a checklist of cues to watch for to know how to proceed with clients. If the client demonstrates prosody, relaxed posture, even breathing, and full-face smiling, the counselor can assume the client is in a state of social engagement, in which rapport-building efforts, insight-based intervention, and relational counseling modalities will have increased efficacy. If the client instead presents with a fast pace of speech, psychomotor agitation in hands and feet, and short, shallow breaths, the client may be in a fight or flight response and benefit most from downregulating interventions like deep breathing or grounding exercises. Alternatively, a client like Sadie in a freeze response may benefit most from upregulating activities such as hula hooping or jumping rope to begin the session. These autonomic responses are flexible and fluid, but they can be barriers to the counseling process if not attended to intentionally. The development and initial validation of the ARSTC is a starting point for aiding counselors in more effectively and reliably intervening based on visual markers of autonomic regulation.

Readers interested in obtaining the ARSTC or more information about it can contact the creator, Madeleine Morris Lowman, at madeleinelowman@gmail.com

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SHIFTING THE RESILIENCE NARRATIVE: HELPING YOUTH TO STRUGGLE WELL

Rebecca L. Matthews
The University of North Carolina at Greensboro

We have experienced unprecedented stress as the COVID-19 pandemic continues to rage. The effects of the pandemic reach each human though the impact may vary. Grief, loss, and walking through the unknown have affected individuals, family systems, communities, and countries alike. We all have experienced a significant shift in routine and expectation. For adults who have the advantage of perspective, this has been overwhelming and traumatizing. For children and adolescents, the effects of COVID-19 are potentially catastrophic. Suicide rates in children and teens have risen during COVID-19 (Stephenson, 2021). Anxiety and depression are experienced by more youth yet there remains limited access to therapeutic supports (Murata et al., 2021).

Resilience

For many years, those who have worked with children (e.g., counselors, educators, psychologists, and other helping professionals) have observed the resilience of children, noting their ability to bounce back from challenging events (Moss, 2016). Yet, there is a disconnect between this definition of resilience and the results of Adverse Childhood Experiences (Centers for Disease Prevention and Control [CDC], n.d.). Researchers have demonstrated that while the behavior of children and adolescents may return to baseline, youth who are exposed to abuse and trauma at an early age are more likely to experience a disruption in their mental health and have an increased risk for heart disease, cancer, and diabetes. Substance abuse, traumatic brain injury, and infectious disease are more common. When children experience adverse childhood events, they are also more likely to have reduced access to educational and employment opportunities. It can be a confusing misnomer to state that children are resilient, and adults have increased risk.

As counseling professionals, we have an opportunity to clarify the intersection of youth with resilience to positively impact child and adolescent treatment. Another definition of resilience is that it is being able to struggle well (Falke, Goldberg, & Plumb, 2017). How might counselors approach treatment with children differently if this definition of resilience was internalized? How might parents approach meeting their child's needs if the misnomer that kids bounce back easily was replaced with, youth need support to struggle well.

As this narrative about children and resilience begins to shift, treatment planning and interventions with youth can shift as well. Rather than reactionary treatment planning for expressed symptoms, the knowledge that youth can be taught to struggle well amid darkness and difficulty, as well as before those experiences hit, can support meaningful prevention strategies. **This can change the narrative to trauma prevention instead of crisis intervention.** Additionally, when resilience is seen as the ability to struggle well, counselors can have a better understanding of their role in supporting post-

-traumatic growth in children and adolescents.

Struggling Well

How can counselors help clients to build skills to struggle well? Some people are seemingly born with the ability to endure hardships with optimism, strength, and curiosity. When they experience a potential barrier, they see an opportunity. When hard times come, they innately reach out to support others and find the struggle less burdensome for themselves. When life gives them lemons, they not only make lemonade, but they make mulch from the lemons and grow a garden. For the rest of us, however, there are strategies we can learn and strengthen to reduce the potential impact of trauma and learn to struggle well. The list below is far from exhaustive but provides a starting place for empowering youth to struggle well.

Name and Normalize The Struggle

A colleague once noted her appreciation for a doctor's approach to a health concern. The doctor had told her that the problem was significant, and her health had declined. But with a lot of work, which included procedures, physical therapy, and consistent attention to her body's needs, they would work together to improve her health. The doctor noted the reality of her struggle and communicated the amount of intentional, consistent work that was required to improve.

With clients, it can be easy to focus on one part of that equation or the other – that the concern is significant, or counseling can help. By pairing these concepts intentionally, it communicates more accurately to the client what is required for their path to wellness. And that this path may begin with counseling but that it will extend beyond the counseling session. Additionally, the strengths and protective factors they already have can leverage change, and intentional work is required. When working with children and adolescents, this normalization may need to happen early and often with the parents or guardians.

Psychoeducation For Systems

Children and adolescents do not exist in a vacuum but are part of multiple systems. This typically begins with a familial system and may include school, religious, racial, or ethnic systems, community involvement, and so on. Providing education on resilience practices, including positive parenting, social-emotional learning, and the need for skills building, to systems involved with the youth can create a trauma-informed support network (CDC, 2019). This network can begin with the counselor.

Movement

The role of movement in reducing the impact of trauma has been well-documented (van der Kolk, 2014). In times of stress or trauma, the brain signals a threat is approaching which leads to a series of physiological responses. Physical movement can reduce the "trapped" experience many have when in a challenging situation and allow the stress hormones that

have been produced to reduce. Counselors can creatively involve movement in sessions from walking during sessions, playing basketball, to coping skills activities that move the client throughout the therapy space.

Mindfulness

Counselors can equip clients with the skills to notice when they are experiencing an adjustment in adaptation or a physiological change long before they have cognitively identified what led to the change. Mindfulness practices can increase awareness and skills for calming the limbic system. The practice of mindfulness has been shown to reduce the impact of trauma both as a prevention and intervention strategy (Otiz & Sibinga, 2017).

Creativity

Creativity moves beyond art and music. It embodies an ability to look at situations from different angles, have unique approaches to problem-solving and can be a useful element that supports struggling well. Embedding creative strategies into counseling has been shown to increase treatment efficacy and reduce client symptoms (Lindsey, Robertson, & Lindsey, 2018).

Strengthening Support

One of the factors that increase resilience in youth is having positive mentors involved in their lives (Centers for Disease Control and Prevention, 2019). When youth are connected to positive adults outside of the parental structure (e.g., coaches, mentors, community, or church leaders), it can protect against stress associated with family discord, displacement, and academic challenges. Extrafamilial support is especially needed for gender and sexual minorities (Singh, Meng, & Hansen, 2014).

These are unprecedented times. Counseling professionals have a unique opportunity to lead the way in clarifying children and adolescent experiences with resilience, and in so doing, support healthy resolution of the trauma of our day. Clients can benefit from the inclusion of education, movement, mindfulness, normalization, creativity, and support.

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We sincerely hope you enjoyed this edition of the IARTC newsletter! Keep an eye out for our spring newsletter. We accept submission all year round but will have our fall call for submissions with the edition theme in September. All submissions should be relevant to resilience and trauma counseling issues that impact counselors and/or their clients. Submissions should be written in APA style, and be roughly between 1000-1500 words (including references).You do not need to be a member of IARTC to submit. Please send all submissions to newsletter.iartc@gmail.com. Feel free to reach out to me if you would like to run a proposed idea by us.

THANK YOU DR.CAROL SMITH FOR YOUR SERVICE!

Founding President

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