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**TRAUMA AND CRISIS COUNSELOR PREPARATION: THE RELATIONSHIP OF AN
ONLINE TRAUMA AND CRISIS COURSE AND COUNSELING SELF-EFFICACY**

by

Julia Leigh Lancaster

A Dissertation Submitted to the Faculty of
Old Dominion University in Partial Fulfillment of the
Requirements for the Degree of

Ph.D. in EDUCATION

COUNSELING CONCENTRATION

OLD DOMINION UNIVERSITY

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ABSTRACT

The field of trauma and crisis is growing and ubiquitous to all counseling specialties. Updates in 2009 and 2016 to the Council for Accreditation of Counseling and Related Educational Programs (CACREP) counselor preparation standards added mandated teachings on crisis, trauma, and disaster counseling in counselor preparation programs' (CPPs) curricula. Since then, some CPPs have created stand-alone crisis courses, while the majority have infused various related content and trainings into already established counseling courses. Research does, in fact, support an increased crisis, trauma, and disaster readiness with more hours dedicated to the study and practice of domain specific content, and confirms that self-efficacy is important for facilitating trauma and crisis interventions. Yet many counselors in training (CITs) have reported feeling ill prepared to offer crisis, trauma, and disaster counseling when beginning field placements and later graduating. Consequently, several researchers are calling for an investigation into the course content and CE delivery methods to assess effectiveness and self-efficacy after different delivery methods. This dissertation proposes a non-experimental design using the Crisis Counselors Self-Efficacy Scale (CCSES) to assess counseling students' self-reported self-efficacy, or perceived capability to work with crisis-impacted clients, post completion of an online trauma and crisis course. The comparative group from the same master's program did not register for the online trauma and crisis course. The results may help to inform counselor educators (CEs) and other professionals of the importance and effectiveness of including stand-alone crisis, trauma, and disaster courses in CACREP accredited CPPs.

keywords: Crisis, trauma, disaster, CACREP, counselors in training, counselor education, Self-Efficacy, Crisis Counselors Self-Efficacy Scale (CCSES)

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DEDICATION

To Penelope Quinn Isaacs and Adeline Virginia Isaacs. Since conception you have been motivation and muse. Your presence has encouraged everything from wearing my seatbelt to returning to academia and going all the way. During this time, you have undergone your own changes. Penelope, I would bottle your delicious laugh for all the inevitable rainy days and build books of all your scattered writings. You are articulate, kind, and ruthlessly opinionated. Keep it all. Adeline, I see your gift for the fine arts and how you deeply consider others. Your honesty is bold and your perceptions balanced. Keep it all. And while these gifts ebb and flow through the years, you might also consider who you want to be which might be achieved by limiting comfy things like ease and familiarity, so on occasion cast your net far in unknown waters in the hopes of finding a continuous renewal of appreciation for your abilities, life, and those you choose to share it with. *Dum spiro spero.*

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CHAPTER ONE

INTRODUCTION TO THE STUDY

The following chapter serves as an introduction to the research study. I begin by reviewing the relevant background information and then outlining the study's purpose and rationale. This chapter also includes a brief description of the study's methodology and corresponding research questions and it concludes by defining key terms from the study.

Background of the Study

During the 2006 standards review process, Council for Accreditation of Counseling and Related Educational Programs (CACREP) received a grant from the U.S. Department of Health and Human Services to study the need for counselor training in emergency preparedness. Subsequently, crisis intervention techniques were included in the 2009 revision of the CACREP standards. This revision required that CACREP counselor preparation programs incorporate tenants of crisis, trauma, and disaster training including the effects of crises and disasters, training on theories and models of crisis intervention, suicide assessment, and psychological first aid (Chatters & Liu, 2020; Pau et al., 2020; Peters et al., 2017). CACREP later updated its standards in 2016 to include the effects of trauma on individuals, couples, and families over the lifespan (Adams, 2019; Burkholder et al., 2020). Since 2016, counselors in training (CITs) and counselor educators (CEs) must learn trauma-informed strategies and better understand the influence of trauma on individuals with mental health diagnoses. Additionally, CACREP accredited programs are required to integrate specific crisis, trauma, and disaster content into the counseling specialty areas of college counseling, couples and family counseling, and school counseling (Guo et al., 2016; Land, 2018).

These CACREP standards are mandatory (2015) for CACREP elected programs, and while helpful for underscoring some general elements that all CITs need to know for entry-level positions, they provide minimal guidance for creating and delivering this information within counselor preparation programs (CPPs). In part, this explains why some counselors report only having a cursory knowledge of the impact of trauma and treatment (Cook & Newman, 2014). Researchers show the majority of counselors in all counseling specialty areas, will work with individuals impacted by crisis, trauma, and disaster (Greene et al., 2016; Kucharski, 2020). This trauma and crisis preparation is important to ensure CITs are prepared for the inevitable service to others (ACA, 2014; Van Asselt, 2016). Yet, there is a dearth of empirical research that shows how crisis, trauma, and disaster is included or infused in CITs masters level curricula (Adams, 2019; Courtois & Gold, 2009; Dean, 2016).

Crisis, trauma, and disaster counselor education is a more recent requirement, leading to some CE's feeling ill prepared to deliver this course content, but this may continue leading to hesitations to teach ubiquitous and complex material to CITs who will need the material (Van Asselt et al., 2016). This means imbalanced training among CPPs with some CEs infusing information on established core courses, some offering creative methods such as weekend trainings, while others offer stand-alone crisis, trauma, and disaster courses (Adams, 2019; Guo et al., 2016; Solmonson & Killam, 2013). Delivery methods also vary with some CEs teaching trauma and crisis more didactically, others having crisis scenarios for experiential examples, and still some having weekend suicide training courses and more community-based learning (Killian, 2017).

Additionally, CEs themselves note a lack of crisis, trauma, and disaster training and report believing this complex content to be a specialized field (Van Asselt et al., 2016). This may

explain why some CEs feel ill-suited to teach these topics or model trauma and crisis care for CITs. This sense of doubt and uncertainty about how to effectively train CITs on these challenging topics and new CACREP counseling curricula has led to hesitations that perpetuate the gap between CACREP requirements and CITs' education as well as CITs practicing counseling with individuals who have needs specific to crisis, trauma, and disaster (Chatters & Liu, 2020; Gallo, 2016). Due, in part, to the complex nature of crisis, trauma, and disaster and lack of singular definitions and competencies, no assessment exists to evaluate the trauma competency level of counselors working with trauma in mental health. This leaves the counseling profession with a lack of shared articulation of trauma and a lack of competency assessment (Dean, 2016). Above all, without competencies to help design course content and measure CITs' preparedness, CEs are left to determine how best to create and implement crisis, trauma, and disaster content in already established CPPs curricula (Greene, 2016; McAdams & Keener, 2008).

Researchers note that counselor education should continue to develop and strengthen crisis, trauma, and disaster training to meet the essential and inevitable needs of CITs in crisis counseling training to prepare future counselors of mental health, school, community, college, and family for crisis, trauma, and disaster services. (Bell et al., 2013; Green et al., 2021; Hermann-Turner et al., 2019; Kleber, 2019; Manning, 2016). Most counselors and CITs will encounter clients in crisis situations and/or clients who have experienced trauma (Guo et al., 2016; Jacobs et al., 2016; Pau et al., 2020). Considering the updated 2009 and 2016 CACREP standards, along with the pervasive impact of crisis, trauma, and disaster for our clients and communities, it is imperative to understand how CEs integrate trauma training into their curricula to meet accreditation standards and prepare CITs to practice ethically and proficiently.

Part of what makes crisis, trauma, and disaster complicated is the overlapping definitions and shared symptoms of individuals and groups experiencing these conditions or situations. Crisis, trauma, and disaster also encourages helpers to consider larger societal stories and community histories. This trauma informed approach tailors support and treatment to the whole person and their environmental context, rather than focusing on only treating individual symptoms or specific behaviors. SAMHSA (2014) outlined trauma-informed care as inclusive of collective and societal awareness and implications with a social-ecological model ranging from individual factors to period of time in history and includes societal factors as well as community and organizational factors.

Therefore, this research study aims to understand the relationship between CITs trauma and crisis training and self-reported self-efficacy by comparing the crisis counseling self-efficacy of master's level CITs who completed an online trauma and crisis elective to peers in their program who have not taken the online trauma and crisis course. This study provides data about whether CITs' crisis self-efficacy may improve after a trauma and crisis course. Using a validated instrument for specifically measuring counselors' crisis self-efficacy may serve as a reference point to future CPPs that are considering the necessity of including crisis, trauma, and disaster into current curricula and/or how to enhance the learning and training through various content delivery options such as a stand-alone course.

Self-Efficacy Study

In Fall 2021, CEs in the Counseling Department at Old Dominion University offered an online master's level elective in trauma and crisis counseling COUN 795 – Trauma and Crisis Course. This course was elective and thus not all master's students attended. The counseling students were mixed with some being in their 2nd and 3rd year. Some of the students were already

in their field placements, while a few had not yet started. There were several components to the course such as required reading from three trauma and crisis textbooks. Students were told that completion of the assigned readings were necessary for completing case presentations and class discussions. Readings were to be completed prior to class for in-class discussions and participation. An underlying goal of the course as stated in the syllabus was to increase CITs' knowledge, skills, and self-efficacy for crisis, trauma, and disaster work.

Self-efficacy is the degree to which individuals believe that they can achieve self-determined goals. Individuals are more likely to achieve those goals simply by belief in their success (Bandura, 1994). Bandura's self-efficacy research also notes that research should be domain specific such that a test measuring mathematics self-efficacy would likely not measure counselor self-efficacy. Although there are counselor self-efficacy scales, only recently has the field had a counselor's crisis self-efficacy scale (Peters, 2017; Sawyer 2013). The Counselor's Crisis Self-Efficacy Scale is a valid and reliable 42-item questionnaire divided into four subscales: 1) crisis situations 2) basic counseling skills 3) therapeutic response to crisis and post-crisis 4) and unconditional positive regard.

Purpose of the Study

The purpose of this study is to contribute to the growing body of knowledge and related literature that focuses on CITs' preparatory training in crisis, trauma, and disaster. This study examined the relationship between trauma and crisis training and higher self-reported self-efficacy from master's level students who took an online trauma and crisis course versus those who did not. In particular, this study assessed how CITs who took a stand-alone online trauma and crisis course reported self-efficacy for working with trauma and crisis-impacted individuals.

Study Design

The study used a non-experimental design with a framework of Bandura's social cognitive theory of self-efficacy. Percentages, means, and standard deviations were used to assess post-differences in participant responses regarding self-efficacy for counseling a client in crisis. An ANOVA and ANCOVA were calculated on each subscale of the CCESE to determine whether a difference existed between students' crisis counseling self-efficacy scores who did and who did not take an online trauma and crisis course in their master's level CPPs and determine if there was a self-efficacy difference between students who did and did not attend the trauma and crisis course when controlling for race, age, and gender. Results showed whether CITs who completed the trauma and crisis elective differed in self-efficacy and whether those differences were reflected by race, gender, age, and years of experience with trauma and crisis. Statistical significance was determined at the .05 level because of the small sample size, as determined by the availability of data (i.e., the number of students who took the online trauma and crisis course). A content analysis method was used to analyze the qualitative third research question.

The following questions and hypotheses guided the research process:

(RQ1): Is there difference in the crisis self-efficacy scores of CITs who took an online trauma and crisis course versus CITs from the same program who did not?

(H_a): Those who took the course show higher self-efficacy than those who did not.

(RQ2): Is there difference in the crisis self-efficacy scores of CITs' who took an online trauma and crisis course versus CITs from the same program who did not related to race, gender, and age with trauma and crisis?

(H_a): Those who took the course show higher self-efficacy than those who did not after controlling for race, gender, age.

(RQ3): How do students feel about their capabilities to successfully support a client in crisis?

Key Terms

CACREP

CACREP is the Council for the Accreditation of Counseling and Related Educational Programs. Established in 1981, CACREP promotes excellence in professional preparation through accrediting counseling and education related programs. CACREP develops standards and procedures preparing future counselors to provide services consistent with the ideal of optimal human development (CACREP, 2021).

Crisis

A crisis refers to a highly stressful event that overwhelms and limits one's perceived ability to function within one's normal coping skills (Miller, 2012; Webber, 2018). A crisis can be described as a state of disequilibrium and is often an immediate, unpredictable event that occurs in people's lives. Examples may include receiving threatening medical diagnosis, house fires, experiencing a miscarriage, a physical assault, or other overwhelming stressors. They are highly subjective experiences with people constructing their own meaning (American Counseling Association's Traumatology Interest Network). A person's reaction and interpretation of a crisis or traumatic event is often determined by factors such as time in history, socio-cultural beliefs, availability of social supports, and developmental stages (SAMHSA, 2014). Not all crises result in trauma; however, traumas are caused by a crisis (Pau et al., 2020).

Disaster

Disasters are serious disruptions to the functioning of individuals, groups, and communities that exceed preserved capacity to cope using their own resources. Disasters can be caused by natural, man-made, and technological hazards. Natural hazards are naturally occurring physical phenomena like tornadoes, wildfires, floods, and earthquakes. Man-made and technological hazards are events that are caused by humans. Some examples include complex emergencies, conflicts, industrial accidents, transport accidents, environmental degradation, and pollution (International Federation of Red Cross and Red Crescent Societies, 2022).

Self-Efficacy

Perceived self-efficacy is defined as people's beliefs about their capabilities to produce certain levels of performance. In part, beliefs of self-efficacy determine how people feel, think, motivate themselves, and behave. Self-efficacy has been studied mainly because of its high predictability factors and a strong sense of self-efficacy enhances human accomplishment and personal well-being in many ways. In fact, individuals with high assurance in their capabilities see difficult tasks as challenges that can be mastered rather than as threats that should be avoided. This outlook produces personal accomplishments, reduces stress, and lowers vulnerability to depression. Self-efficacy beliefs can be developed by four main sources of influence with the most effective way of creating a strong sense of efficacy is through mastery experiences. Vicarious experiences provided by social models strengthen self-efficacy, and self-efficacy may also be modified by reducing people's stress reactions and changing improving their negative emotional proclivities and misinterpretations of physical states (Bandura, 1994).

Trauma

Trauma refers to the emotional response an individual has to an event that was perceived to be physically or emotionally harmful. The Diagnostic and Statistical Manual of Mental

Disorders (American Psychiatric Association, 2013) defines a traumatic stressor as: exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: directly experiencing the traumatic event, witnessing, in person, the event(s) as it occurred others, learning that the traumatic event(s) occurred to a close family member or a close friend, experiencing repeated or extreme exposure to aversive details of the traumatic events(s) (p. 271).

A traumatic event, crisis, or disaster is often the catalyst for trauma. The event (crisis or disaster) is typically shocking, scary, or dangerous and affects one or groups emotionally and physically. People often focus on physical injuries when considering trauma, but people can also experience psychological trauma after being a victim to or witnessing distressing events. The reactions to trauma events and who experiences more severe symptoms of trauma is also nuanced. These reactions may be immediate or delayed and will differ in severity and duration. Presentations include a wide range of behaviors and response which are also influenced by culture (National Institute of Mental Health (NIMH), 2020).

Trauma is more of a felt experience, as defined in the literature, as a widespread harmful experience with costly public strains, but according to SAMHSA (2014) people can overcome this health problem with appropriate interventions. Trauma often occurs after traumatic experiences such as violence, motor vehicle and other accidents, abuse, neglect, disaster, and war. It is also an almost universal experience for people with addiction and mental health disorders (NIMH, 2020). Other factors that increase the likelihood of experiencing trauma and/or a slower recovery from traumatic symptoms are race, gender, socioeconomic status, substance use disorders, chronic physical status geography, sexual orientation, ethnicity, and preexisting mental health conditions. This list, like many throughout the literature review, is not exhaustive.

The need to address trauma is increasingly viewed as an important component of behavioral and mental health service delivery (SAMHSA, 2014).

Vicarious Trauma

Secondary trauma or vicarious trauma refer to symptoms that behavioral, medical, and mental health care providers may encounter when working with clients who have trauma and crisis histories (Reinbergs & Fefer, 2018; Sommer, 2008). Providers may experience similar physical, psychological, and cognitive changes and symptoms as the clients who have these trauma histories. Vicarious trauma usually refers more to specific cognitive changes or perspectives and beliefs such as in worldview and sense of self (SAMHSA, 2014). SAMHSA (2014) defines secondary trauma as trauma-related stress reactions and symptoms resulting from exposure to another individual's traumatic experiences. This is different than direct exposure to a traumatic event. Secondary trauma can occur among behavioral health and mental health care service providers across all health and mental health care settings.

Vicarious trauma is a significant concern for mental health care providers. When considering the high rates and prevalence of individuals who have experienced traumatic events as well as the high number of individual counselors who have trauma histories, this makes mental health care providers more susceptible to secondary or vicarious trauma. With trauma being so ubiquitous and with vicarious trauma potential among helping professionals, there is a need for greater understanding of the occurrence, assessment, treatment, and prevention of trauma (VanAusdale & Swank, 2020).

Summary

Chapter one discussed the background and purpose of this study on crisis, trauma, and disaster education and training. It introduced its intended methodology and presented the

research questions that guided this study. This chapter also defined several key terms that were used throughout this study. Chapter two will provide a review of the current and related literature associated with crisis, trauma, and disaster CACREP standards within CPPs, the lack of guiding competencies and empirically effective pedagogies, and the importance for ensuring CITs receive proper education and training to maintain ethical practices and provide trauma focused crisis, trauma, and disaster education and training.

CHAPTER TWO

LITERATURE REVIEW

The present chapter provides a comprehensive literature review regarding crisis, trauma, and disaster education and training in CACREP CPPs. I review the prevalence of crisis, trauma, and disaster signs, symptoms, and treatment; describe how CEs are currently teaching these complex topics; and review the best-known practices. I conclude this chapter with suggestions for future research and a summary of the overarching need for improved crisis, trauma, and disaster education and training in CACREP CPPs.

Crisis, Trauma, and Disaster Training in Counselor Preparation Programs

Problem Statement

Since 2009 crisis, trauma, and disaster have been mandated learning standards required by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) for all accredited counselor preparation programs. This was partially due to the attention received by counselors serving as responders following Hurricane Katrina. Counselors' feedback revealed a need for the incorporation of crisis training into counselor preparation programs. Subsequently, crisis intervention techniques were included in the 2009 revision of the CACREP standards. This revision required that counselor preparation programs incorporate tenants of crisis training including the effects of crises, trauma, and disasters, training on theories and models of crisis intervention, suicide assessment, and psychological first aid (Pau et al., 2020; Webber & Mascari, 2009).

The grant started after hurricane Katerina showed that counselors had not been adequately prepared for crisis and disaster counseling. These counseling professionals noticed that working with clients in crisis required training that was not being taught in counseling

preparation programs (Pau et al. 2020). Respondents from one study overwhelmingly shared the necessity to address trauma and crisis care as an essential component of CPPs, even though they themselves had not received crisis, trauma, and disaster training in their CPPs (Chatters & Liu, 2020; Land, 2018).

These new requirements specified the inclusion of crisis, trauma, and disaster counseling preparation in CACREP counseling programs by embedding related educational content into established counseling courses such as addiction and lifespan development (Adams, 2019; Chatters & Liu, 2020) versus a core stand-alone course. With CACREP's involvement, competence in these three areas is considered necessary for professional counseling, yet there is a gap between requiring the content in counselor preparation programs and counselors in training (CITs) receiving the essential preparatory education to work with clients in entry-level trauma and crisis care (Greene, 2016; Tarvydas et al., 2016). This is, in part due, to a lack of CACREP guidelines for counselor educators (CEs) to create content and teach crisis, trauma, and disaster content (Dean, 2016; Land, 2018). Instead, the 2016 CACREP Standards spirit and intent is for CPPs to utilize their own innovation methods (CACREP, 2016). In other words, CACREP does not dictate the manner in which programs choose to meet standards. When CACREP updated crisis, trauma, and disaster standards in 2016 they were written with the intention to simplify and clarify the accreditation requirements including crisis, trauma, and disaster (CACREP, 2016) not to offer pedagogical recommendation.

There is extensive research (Land, 2018) noting that the 2016 CACREP standards related to trauma require CITs to understand procedures for identifying trauma and abuse and know procedures for reporting abuse (Standard 2.F.7.d.). CACREP also requires knowledge of crisis

intervention, trauma-informed, and community-based strategies to be included in CPPs (Standard 2.F.5.m.). In a newsletter CACREP offered a guiding statement for standard 2.F.5.m:

To document this specific requirement within Standard 2F programs must show how every student has an opportunity to gain knowledge and/or skills in crisis intervention, trauma-informed, and community-based strategies. While the standard provides Psychological First Aid as an example of one approach for working with children, adolescents, adults and families in the aftermath of disasters and other forms of trauma, CACREP recognizes other well developed programs exist such as those offered through the NBCC's Mental Health Facilitator training or the American Red Cross's Disaster Mental Health training (Spring 2016 CACREP Connection).

Other standards include the effects of crisis, disasters, and trauma on diverse individuals across the lifespan are also necessary (Standard 2.F.3.g.). The impact of trauma and crisis on individuals with preexisting mental health diagnoses (Standard 5.C.2.f.) are outlined in CACREP standards, as well as the impact of trauma and crisis on individuals with disabilities (Standard 5.D.2.h.).

Counseling specialties such as college counselors and student affairs professionals need to be informed of operations within the institution that pertains to emergency management plans, and crises, disasters, and trauma (Standard 5.E.2.b.). Family, couples, and marriage counselors are also required to know the impact of trauma and crisis (Standard 5.F.2.g.). School counselors are to be aware of their roles and responsibilities regarding school emergency management plans, and crises, disasters, and trauma (Standard 5.G.2.e.; Bray, 2021; Atici, 2014). Disability is also considered when CACREP outlines standards stating CITs and professionals need to be aware and understand of the impact of crisis, trauma, and disaster on individuals with disabilities. This

includes knowing implications for emergency management preparation for those impacted by disabilities (Standard 5.H.2.g; Land, 2018).

Other learning objectives from the 2016 CACREP (2015) update include connections between neurodevelopment and trauma (Montague et al., 2020). According to CACREP standards, all entry-level counselor education graduates need to learn “biological, neurological, and physiological factors that affect human development, functioning, and behavior” as well as “effects of crisis, disasters, and trauma on diverse individuals across the lifespan” (CACREP, 2015). Still, several researchers have noted the gaps between CACREP’s updated 2016 standards and CITs crisis, trauma, and disaster education and training in CPPs (Atici, 2014; Binkley, 2018).

These CACREP standards indicate the importance of not only educating about crisis, trauma, and disaster but also the influence of external systems such as culture and history of time in which crisis, trauma, and disaster occurred (Montague, 2020; SAMHSA, 2014). CACREP also encourages CPPs to incorporate the neurodevelopment and other related content into counseling graduate courses. Counseling has evolved over the years to include a biopsychosocial perspective that addresses neuroscience with fields such as neurocounseling. It also addresses relational interactions, considers attachment, and considers cultural influences and promotes advocacy and social justice (Courtois & Ford, 2013). The biopsychosocial, neurodevelopment model is important for CITs to understand that survivors of crisis, trauma, and disaster vary widely in how they internalize and express what has also been classified as stress reactions (Everly & Lating, 2013). CACREP (2015) supported the importance for counselor-trainees to learn about neurodevelopment and trauma. Still the lack of crisis, trauma, and disaster counseling

competencies and other factors encourage unstandardized teaching methods among CPPs (Chatters & Liu, 2020).

This academic gap, professional concerns, and potentially ethical concerns arising when counselors practice outside of their training have been empirically addressed with multiple researchers interested in improving CITs' education and CPPs' ability to provide proper counseling standards and practice ethically (Greene et al., 2016; Guo et al., 2016; Kucharski, 2020; McAdams & Keener, 2008; Minton & Pease-Carter, 2011). Research outcomes illustrate insufficient crisis, trauma, and disaster training in CACREP-accredited programs, and the literature on how trauma education is integrated in counselor education program is very limited.

One 2016 study noted that of the 654 CACREP-accredited counseling programs, a total of 441 programs (67.4%) did not offer one stand-alone crisis counseling course, and 192 counseling programs (29.4%) in 118 departments did mandate students to take such a course (Guo et al., 2016). The researchers were unable to access the course descriptions of 21 programs (3.2%). This study does not account for other considerations such as whether programs with a stand-alone course offer that course as a core requirement or as an elective which would limit CITs attendance (Montague et al., 2020). Yet, researchers show that CITs who took a crisis course in their CPPs rated their didactic crisis preparation, crisis self-efficacy at graduation, and post-graduation crisis self-efficacy higher than those who did not take a crisis course (Morris & Minton, 2012). Trauma and crisis counselor education should be a bridge between CITs preparation and the clinical practice supporting competent and well-trained future counselors in addressing trauma-related issue (Chatters & Lui, 2020). An updated study using a valid and reliable instrument to measure crisis self-efficacy could continue to inform modern CPPs about the benefits of a stand-alone course.

Consequently, several researchers are calling for an investigation into the course content and CE delivery methods to assess effectiveness and self-efficacy after different delivery methods (Adams, 2019; Dean, 2016; Guo et al., 2016; Nickerson et al., 2014). Some researchers have urged CEs to investigate the effectiveness of various instructional methods for enhancing CITs crisis competency and self-efficacy (Morris & Minton, 2012) since the methods vary. Some CEs deliver the CACREP crisis, trauma, and disaster standards in CPPs curricula by embedding the information into established core courses, creating weekend trainings (Gallo, 2019), offering a stand-alone course (Minton & Pease-Carter, 2011), and creative ways such as unfolding case studies (Greene, 2016) to ensure the information is provided to prepare CITs for the inevitable experiences of working with crisis, trauma, and disaster-impacted clients (Jacobs, 2016).

This non-standardized pedagogy and lack of research supporting the effectiveness of content delivery methods are just two of several barriers limiting CITs from receiving the valuable training necessary to work with future crisis and trauma-impacted clients (Kilpatrick et al., 2013; Kucharski, 2020). It remains critical that CITs receive this knowledge and training since in field placements, residencies, and later in professional work, counselors will inevitably encounter individuals who have experienced trauma, crisis, and/ or disaster (Guo et al., 2016; Yatchmenoff et al., 2017). Additionally, CEs may continue using measurements to assess CITs crisis preparedness as CPPs continue working towards these counselor preparation improvements.

Additional Barriers

Similar research has attempted to demystify why insufficient crisis, trauma, and disaster training occurs in so many CPPs (Atici, 2014; Courtois & Gold, 2009), with one study by McAdams and Keener (2008) finding three possible reasons 1) specific curricular content is

needed for delivery of basic crisis response training and understanding, 2) CPPs are often burdened with curricular demands which may explain, in part, the lack of CIT crisis, trauma, and disaster training, 3) CEs are unprepared due to lack of training and low confidence to delivery instruction on topics for which they have not received sufficient training. This, in part, results from the current CACREP requirements and lack of standardized methods, competencies, and knowledge needed for CITs proficiency explaining the often insufficient amount of crisis, trauma, and disaster training for CITs (Van Asselt et al., 2016).

This may explain why some CEs state feeling ill-suited or untrained to deliver these topics or model trauma and crisis care for CITs since crisis, trauma, and disaster is considered specialty training (Van Asselt et al., 2016; Chatters & Liu, 2020). This sense of doubt and uncertainty about how to effectively train CITs on these challenging topics and new CACREP counseling curricula may lead to hesitancies that continue the gap between CACREP requirements and CITs education, as well as CITs practicing counseling with individuals who have needs specific to crisis, trauma, and disaster (Adams, 2019; Van Asselt et al., 2016; Dean, 2016; Land, 2018).

CACREP's Response

With the updated 2016 CACREP standards came a refined, concise standard requiring accredited programs at the master's and doctoral level students to learn the effects of trauma on individuals, couples, and families over the lifespan (Adams, 2019; Dean, 2016). CITs and future CEs must learn trauma-informed strategies and better understand the influence of trauma on individuals with mental health diagnoses. CEs have been attempting to develop effective teaching methods and ways to either integrate crisis, trauma, and disaster content into the existing curricula or have a stand-alone course since the 2009 and 2016 updates (VanAusdale &

Swank, 2020). An increased crisis and trauma counseling self-efficacy or perceived capability also encourages new counselors to initiate crisis and trauma interventions. According to Bandura's (1977) social-cognitive theory, expectations of personal efficacy stem from four main sources of information all of which may be accomplished in the CPPs classroom (1) performance accomplishments provide the most influential efficacy information because it is based on personal mastery experience (e.g., role plays, case studies, presentations), (2) other sources of efficacy information include the vicarious experiences of observing others succeed through their efforts (e.g., fishbowl demonstrations, Post-presentation Q & A illustrating peer participation, observing role play with other students, professionals invited into the classroom. and/ or relevant online recordings), (3) verbal persuasion that one possesses the capabilities to cope successfully (e.g., feedback to include constructive criticism from teachers and peers), (4) and states of physiological arousal from which people judge their level of anxiety and vulnerability to stress (e.g., the instructor may ask students to evaluate their anxiety and defenses before and after role plays and other crisis and trauma simulations, offer deactivating exercises such as breath work and visualization exercises).

The demands of crisis, trauma, and disaster counseling and the lack of CACREP guidance for implementing these standards and providing training have called for creative pedagogical approaches that attempt to present realistic clinical challenges to CITs in the supportive and safe learning environment of CPPs (Greene et al., 2016). This non-experimental design study compliments previous research, advocating for future counselors and CEs to have the necessary training in crisis, trauma, and disaster in order to better understand larger implications from a biopsychosocial lens and personalize treatment and other evidence-based practices to perform ethically within their scope of practice and training. This advocacy is

delivered by means of a non-experimental study analyzing data from the Counselor's Crisis Self-Efficacy Scale (CCSES) from CITs who took an online trauma and crisis course and those who did not. All participants are from the same program, but since the course was elective not all CITs attended the course. However, most CITs subsequently went on to begin field assignments in practicum and internships. Self-efficacy is one measure used for assessing course and course content effectiveness. Self-efficacy has been shown to help prevent academic dropout (Peguero & Shaffer, 2015), reduce learning and skill acquisition anxiety (Bandura, 1994), and academic resilience (Cassidy, 2015). This resiliency may prove especially helpful with counseling students.

Some CITs may experience overwhelm and feelings of incompetence when having limited skills and life experience (Butler et al., 2016). Crisis, trauma, and disaster are complex enough without the added lack of life experience. Unless people believe they can produce desired results they have little incentive to act or to persevere in the face of difficulties (Bandura, 2001). Having one's presumptions about how the world works challenged and experiencing others with different life experience can be unsettling and lead some to self-doubt about competency and skills. Due to this and other reasons, the National Preparedness and Response Science Board recommends that all mental health professionals be trained in crisis, disaster, and trauma mental health (Jacobs et al., 2016). Some counseling programs infuse crisis training into other courses to meet the 2016 CACREP standards. These updated CACREP standards require counseling programs to integrate an increased reference to crisis, trauma, disaster prevention and response training.

Counselor Preparation Programs' Response

Infusion or Embedding Content

The benefits of crisis training via infusion or stand-alone courses in CPPs have been surveyed, and researchers found that one third of reported participants noted having zero hours of classroom crisis training in their CPPs (Land, 2018; Morris & Minton; 2012). Despite this lack of training, most participants also noted responding to crisis during their CPPs practicum and/ or internship field work. Researchers found these insufficiencies are in part due to the historical development of trauma, significant growth in the field of traumatology due to rapid advancements in field, as well and changes in CACREP trauma related standards from 2009 to the later 2016 revisions (Webber et al., 2017).

Counselor educators can infuse crisis-related topics in appropriate courses to increase time dedicated to crisis preparation that allows students to learn and practice crisis prevention, intervention, and postvention. While some CEs take a more didactic approach when teaching crisis, trauma, and disaster in CPPs, others use more activities or case examples for students to work and address in groups, and some of these activities continue throughout the curriculum (Land, 2018). When infusing or embedding content, it is important to include theoretical knowledge and add skills that may be developed through specialized training experiences, additional certifications, and conferences.

Field experiences with multidisciplinary disaster and crisis response teams may include and not be limited to emergency drills, disaster emulations, tabletop exercises, and case studies (Tarvydas, et al., 2016). CEs might establish relationships with credentialed disaster and trauma specialists with field experience. These relationships may lead to guest speakers and/ or training opportunities. Traumatologists may be willing to share their expertise with CEs and CITs within CPPs. CEs may build a network of specialist for class presentations and other classroom

activities that might lead to specialized training of specific skills required for crisis, trauma, and disaster care, even when the CEs feel underprepared to teach the specialized topics.

CEs can also encourage students to investigate concerns related to trauma counseling via thesis and dissertations (Webber et al., 2017). 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). In addition to infusion and embedding content into CPPs, some programs utilize a case-based pedagogical approach.

Case-Based Approach

There is little research on case-based approaches for crisis response training, but literature supporting case-based approaches in teaching is favorable (Binkley, 2018; Greene, 2016). One study illustrated the helpfulness and effectiveness of using a case-based approach for teaching CITs various ways to assess and respond to crisis using the PTA model of crisis response (Binkley, 2018). Another study followed learning activities and delivery of trauma and crisis content and tested pre-, mid-, and post semester of the practicum course. The trainings during the practicum in the CPPs included instruction and class activities focused on weekly videos of a case involving one fictional character “Charlee.”

Discussion prompts and between-class assignments connected learning to “Charlee’s” case and integrated crisis counseling related issues and skills. The statistical significance of the students’ scores indicated that students’ increase in crisis knowledge was in part due to the learning activities, discussion prompts, as well as Charlee’s case with included assessment, counseling, and crisis-related issues and skills. This case-based format used within the practicum

course may offer comparable effects on crisis training in CPPs when compared with a stand-alone crisis course for CITs (Greene, 2016).

Additional Trainings

Weekend trainings are an option for some CPPs. In a study of training effectiveness, after CITs attended a weekend workshop for youth suicide prevention, students were tested on knowledge, perceived ability to help suicidal clients, prevention skills, and self-efficacy of suicide and intervention (Gallo et al., 2019). Immediately after the weekend course, participants who attended demonstrated an increase in knowledge and ability to help, in addition to a perceived increase in suicide prevention skills. This increase from baseline was also present three-months post training. A general knowledge increase was reported as well as self-reported confidence in ability to help suicidal youth. The results of this study suggest that one weekend training with an experiential component such as role playing may contribute to an increase in CITs' suicide prevention confidence since practicum and internship CITs practiced assessments and managements skills with clients (Gallo et al., 2019). When a stand-alone crisis course is not a feasible addition for CPPs curricula, these infusion model examples may be an effective alternative if appropriate amounts of time and attention are dedicated to crisis-related topics (Morris & Minton, 2012; VanAusdale & Swank, 2020).

Stand-Alone Course

While some CEs embed or infuse crisis, trauma, and disaster content into CPPs others provide stand-alone courses (Guo et al., 2016; Morris & Minton, 2012). Researchers have shown that a stand-alone crisis, trauma, and disaster course based on the 2009 CACREP standards resulted in significant improvements in students pre- and post-crisis informed knowledge (Sawyer et al., 2013). Stand-alone crisis counseling courses may ensure that beginning

counselors enter their field work sites with more security in their beliefs that they are able to handle crisis situations. After all, counseling students who participated in coursework that studied a variety of theoretical strategies for resolving crises, provided better intervention models for clients in crises situations (Montague et al., 2020; Morris & Minton, 2012; Peters et al., 2017). Furthermore, a content analysis on crisis, trauma, and disaster preparation in CPPs found the breadth of content coverage, the greater amount of time devoted to crisis training, and specifically devoted to crisis intervention or trauma-informed counseling assigned textbooks within stand-alone crisis intervention courses are unlikely to be mirrored when the CACREP standards are simply infused throughout CPPS course curricula (Greene, 2016; Minton & Pease-Carter, 2011). Finally, in a study on methods of course delivery, students who completed stand-alone crisis counseling courses reported higher self-efficacy when assessing crisis situations, using interventions, and making effective decisions for clients in crisis (Sawyer et al., 2013).

Regardless of the content delivery method, course work and professional development should have hands-on components (Greene et al., 2016; Morris & Minton, 2012; Sommer, 2008) that allow participants to practice their skills in a supervised setting. This is consistent with the CACREP 2009 Standards that require programs document that graduates receive knowledge of “crisis intervention and suicide prevention models, including the use of psychological first aid strategies” (Section II.G.5.g.), and demonstrate that they have the skills to understand normal crisis responses, intervene in crises, and assess and manage suicide risk (Liebling-Boccio & Jennings, 2013; Morris & Minton, 2012).

Needs of Counselor Preparation Programs

While the terms crisis, trauma, and disaster overlap, they also require knowledge specific to each to know how to counsel and appropriate interventions and skills to use. Without

delineation of these concepts, a set of items for assessing CITs competency is difficult (Dean, 2016). This is combined with the current required standards of CACREP without provided competencies (Adams, 2019; Dean, 2016; Kucharski, 2020; Land, 2018) to help support CEs teach crisis, trauma, and disaster. Challenges abound when trying to ensure CITs receive necessary training for the inevitable cases they will encounter.

Consequently, some CEs struggle to develop evidence-based pedagogy responsive to the CACREP (2009, 2015) standards (Morris & Minton, 2012). Without clearer guidelines for designing courses, the challenge of instructing and supervising CITs to become crisis, trauma, and disaster competent is underrepresented (Van Asselt et al., 2016). This means many CITs may graduate from CPPs without knowing evidence-based psychosocial treatments and assessments for conditions related to trauma and crisis such as PTSD (NIMH, 2020). Knowing the complexity of trauma and crisis does mean understanding appropriate evidence-based assessments and interventions. It also means having a more nuanced understanding of clients and communities and understanding their histories and how the event(s) may have changed them or shifted their worldview or sense of self, as well as other attendant psychological consequence (Cook et al., 2014; Courtois & Gold, 2009). Without CACREP competencies for crisis, trauma, and disaster in CPPs, some CEs have looked to other mental health professions for academic content.

Allied Mental Health

CEs may turn to other allied professional fields such as psychology and social work for curricula content that better captures competencies, knowledge, skills, and attitudes for CITs to show mastery of entry-level crisis, trauma, and disaster care. These mental health fields have attempted to define trauma and crisis competencies to improve education and training within

their affiliated programs of study (Adams, 2019; Dean, 2016; Land, 2018). Counseling is distinct from psychology and social work, CPPs would benefit from educational guidelines and delivery method suggestions for crisis, trauma, and disaster that compliment professional counseling values and core tenets.

The competencies and related components for trauma psychology from the New Haven Conference is one example of an attempt to develop and disseminate a comprehensive model of anecdotal and empirically informed trauma competencies without any specific model provided by an accreditation body (Cook et al., 2014). The New Haven Competencies produced trauma care guidelines, and professional counselors were not included in this dialogue (Cook et al., 2014; Land, 2018; Webber et al., 2017). Instead, sixty allied mental health experts excluding those from the counseling profession participated in a group process and created competencies in various trauma domains that now provide the basis for training of trauma-informed within psychology preparation programs (Cook et al., 2014).

The competencies and related components for trauma psychology from the New Haven Conference were developed based partially on the following five guiding assumptions (1) competencies are defined as knowledge, skills, and attitudes, (2) the competencies are expectations of entry level psychologists, (3) the competencies articulate minimal expectations meaning that all trauma psychologists seeking to practice at an entry level should be able to demonstrate acquisition of these core competencies, (4) the competencies assume that the general competencies for professional psychology have been attained, and (5) there are a number of trauma-informed and trauma-focused models, and the New Haven competencies are not specific to any one model (Cook et al., 2014).

The 2016 CACREP (2015) standards related to trauma training in CPPs are vague (Land, 2018). Consequently, CEs have turned to standards set by allied mental health fields for teaching instruction of crisis, trauma, and disaster content but while there are similarities counseling is separate from other mental health care professions such as psychology and social work. Counselors promote wellness and the profession has humanistic roots to reflect the non-hierarchical person-centered approach. This approach mirrors a trauma-informed approach (Courtois & Ford, 2013), with unconditional positive regard, empathy, warmth, and affirming responses to encourage an emotionally corrective therapeutic alliance. Counselor preparation programs may be studied to determine how crisis, trauma, and disaster standards can be applied and learned in CPPs despite the lack of structured guidance from CACREP and other aforementioned limitations.

Prevalence of clients who are crisis-impacted

While human history shows that crisis, trauma, and disaster or traumatic loss and violent events are part of the human condition, there has been a high amount over the past 15-20 years, resulting in more individuals seeking healing from traumatic loss. Crisis and disaster may be natural or unnatural. Exposure to a disaster is common, and one-third or more of individuals severely exposed may develop posttraumatic stress disorder or other disorders (North & Pfefferbaum, 2013). Some examples of natural crisis and disasters include hurricanes, floods, and wildfires, while unnatural crisis and disasters include various types of assault, wartime crisis, and arson. In the period 2000 to 2019, there were 7,348 recorded natural disasters that claimed 1.23 million lives worldwide. This is a sharp increase over the previous twenty years, and according to the United Nations Office for the Coordination of Humanitarian Affairs (2020) this devastation affected 4.2 billion people resulting in approximately 2.97 trillion US dollars in

global economic losses. In 2020, 389 natural disasters were reported killing 15,080 people, affecting 98.4 million others and costing 171.3 billion US dollars (Center for Research on the Epidemiology of Disasters, 2021). These statistics do not include COVID-19 pandemic related disasters.

COVID-19 was declared a public health emergency of international concern on January 30th 2020, with an official death toll of 171. By December 31st that same year, the death toll was thought to be 1, 813, 188 (WHO, 2021). Estimates suggest the total number of global deaths attributable to the COVID-19 pandemic is at least 3 million. With the latest COVID-19 deaths reported to WHO, the death toll now exceeds 3.3 million. Due to the excess mortality estimates produced for 2020, WHO believes there is a significant undercount of total deaths directly and indirectly attributed to COVID-19 (WHO, 2021).

Not all disasters or crisis are natural disasters. In the United States on average, nearly 20 people per minute are physically abused by an intimate partner. In one year, this means more than 10 million people are physically abused by an intimate partner (The National Intimate Partner and Sexual Violence Survey, 2010). Other statistics note that one in four women and one in nine men experience one or more of severe intimate partner physical violence, intimate partner contact sexual violence, and/or intimate partner stalking. The impacts may lead to injury, fearfulness, post-traumatic stress disorder, use of victim services, contraction of sexually transmitted diseases, and other concerns (U.S. Department of Justice, 2014). Intimate partner violence (IPV) is also known as domestic violence and is a series of actual or threatened acts of harm to physical, sexual, and/or emotional harm. This abuse differs from an assault as an assault is usually singular. With IPV multiple episodes often occur and the perpetrator is an intimate partner of the victim (Catalano, 2012). The trauma associated with this type of abuse is pervasive

or ongoing and can produce feelings of shame and lead survivors to feel faulty or less than. Feeling different or separate from others can be a signature part of experiencing most traumas. This is true whether the trauma is an individual or group experience. Other examples of commonly known unnatural crisis and disaster include homicide, suicide, rape, assault, robbery, and war-time casualties. Survivors may experience intense symptoms in addition to prolonged symptoms of PTSD such as nightmares, difficulty concentrating, and feelings of guilt (Montague, 2020; NIMH, 2020).

According to the World Health Organization (WHO, 2019), mental health care interventions after emergencies are crucial to the overall social and economic recovery of individuals, societies, and countries after emergencies. Additionally, WHO states that mental health global progress reform is more likely if, during every crisis, efforts are taken to increase the short-term attention to mental health issues combined with a surge of aid or resources which might be used for long-term mental health service development (WHO, 2019).

Disproportionate Impact

As the world continues to feel varying impacts of COVID-19 pandemic effects, evidence is mounting that quarantine and other social restrictions negatively affect mental health. While this universal public health threat has impacted all communities, some groups are at a higher risk of trauma and crisis because trauma history is one of several factors that increases the intensity and potentiality for reoccurring trauma (Taggart et al., 2021). Survivors of childhood trauma are especially vulnerable, and often childhood trauma goes unaddressed treated as other mental health diagnosis later in adulthood. This erroneous diagnosis in adulthood is used to explain and sometimes mistreats symptoms of early childhood trauma. Also, knowing that trauma amplifies

marginalization and the impact of social inequalities, survivors of childhood trauma are also at an increased risk of poverty, misogyny, and racism (Lantz et al., 2005).

The prevalence of crisis, trauma, and disaster impacts minority and marginalized populations disproportionately (Walters, 2020). Considering the current international pandemic and consequences thereof, researchers argue that survivors of childhood trauma and minority groups are at a greater risk for pandemic stress (Albaek, 2018; Aspira, 2017; Hughs, 2017; Van Der Kalk, 2013). Crisis also includes ethnic trauma such as those experienced by Native American communities, the Black and Brown communities, and others that have experienced discrimination and exploitation due to race; individuals and groups that experience ethnic trauma may feel that they do not have a voice or ability to influence policy change for more balanced state and federal systems designed to ensure public safety (Bell et al., 2013; Green et al., 2021). These impacts, in addition to others, may carry childhood pain into adult dysfunction. The healing journey may entail reconciliation by the reclamation of individual and community heritage, identity, spirituality, and correct colonization and appropriation (Aspira, 2017). Raw and complex emotions such as anger and unexpected hurt may need to be addressed and processed. Competent training and education can help CITs and mental health care professionals acknowledge the harm that racism has and will continue to inflict, in part, by engaging in critical reflection, self-awareness, and honest dialogue (Bell et al., 2013). Wide-spread prevalence of crisis, trauma, and disaster merits exploration of the signs and symptoms of distress.

Signs and Symptoms

The National Association of School Psychologists (NASP) (2015) states that trauma symptoms can include psychological disturbances such as disbelief, fear, sadness, guilt/shame, grief, confusion, anger, or pessimism. Other symptoms may present through behavioral changes

such as withdrawal from friends and family and loss of interest, thus disconnecting from previous activities or hobbies. Disturbances may also include sleep or appetite and school or work performance. Physiological symptoms might include stomachaches, headaches, and increased arousal (ICISF, Reactions to Trauma). Those experiencing trauma and crisis might have regression in behavior such as thumb sucking, revisiting a fear of the dark, and assuming fetal position.

Those experiencing crisis, trauma, and disaster may have cognitions of blame, confusion, disorientation, memory problems, time distortion, poor problem-solving abilities, and difficult concentrating. Other symptoms related to thoughts, emotions, and behaviors include disbelief, denial, anxiety, panic uncertainty, loss of emotional control, apprehension, uncertainty, outbursts, and anger (SAMHSA, 2014). Behaviors after crisis, trauma, and disaster may include withdrawal, change in speech, potential for violence, accident prone, startle reaction, appetite loss or gain, inability to rest, pacing, crying, and ritualistic behavior (International Critical Incident Stress Foundation (ICISF).

The effects of trauma, if untreated, may be perceived long after the crisis when the person's safety and well-being was threatened (SAMHSA, 2014; Van Der Kolk, 2014; Worden, 2018). With proper training from CPPs future counselors may better understand trauma symptoms and help others and themselves seek the care and support necessary to limit secondary trauma, compassion fatigue, and retraumatization (Sommer, 2008; Van Der Kolk, 2013).

Complex Trauma

Complex trauma may result from natural or unnatural events such as storms, house fires, domestic violence, discrimination, incarceration (Burkholder, 2020), racism (Green et al., 2021; Hermann-Turner et al., 2019), chronic and acute health concerns (Buzick, 2019; SAMHSA,

2014; Van Der Kolk, 2014), and sudden unemployment. Complex trauma includes qualities of trauma and results from experiencing multiple traumatic events. It is considered a pervasive impact to include developmental consequences of exposure to multiple or prolonged traumatic events (SAMHSA, 2014).

Complex trauma may involve exposure to sequential or simultaneous occurrences of maltreatment, including psychological maltreatment, neglect, early childhood trauma (e.g., Adverse Childhood Experiences; Albaek et al., 2018; Hughs, 2017), physical and sexual abuse, terrorism, refugees' loss of country, war zone trauma, trauma from interpersonal loss or grief, and domestic violence (Aspira, 2017; Catalano, 2012; American Psychiatric Association, 2013; NASP, 2016; SAMHSA, 2014). Considering the complexity of crisis and trauma and the potential effects counselors may experience when working with these individuals, one study examined the correlation between self-efficacy, training hours, self-efficacy, and secondary traumatic stress of counselors working with refugees.

The study noted a clear deficit of crisis and trauma counselor university preparation and found of the 98 participants those who received the highest amount of crisis and trauma training reported the highest self-efficacy, and importantly the counselors who reported low self-efficacy also reported higher secondary traumatic stress (Isawi & Post, 2020). This illustrates the protective dimension self-efficacy may provide counselors while they collaborate in these high-stake situations. This is also important when considering the recent Ukraine invasion and mass displacement of citizens. Ukraine citizens have been significantly displaced after the Russian attacks causing other countries, including the United States, to provide various forms of aid (Murphy et al., 2022). Regardless of political and personal opinion, these events and the following casualties do impact larger communities and society in general. The crisis and unrest

imposed by community members by police violence, shootings, and war has ignited past collective, generational traumas, and caused uncertainty towards those meant to protect community members. The exposure to these events often cause secondary and vicarious emotional dysregulation for those helping the afflicted and the individuals and groups chiefly targeted experience a loss of sense of safety, orientation, and often the ability to detect or respond to danger cues is compromised (SAMHSA, 2014).

Trauma histories may predispose individuals and communities to trauma (Fruetel, 2021; Ginwright, 2018; Hermann-Turner et al., 2019). Some have a greater risk of trauma and crisis symptoms to include past exposure trauma history, community and family stressors, and proximity to the trauma (both physical and emotional proximity: did they witness the event; did the event happen to a loved one). Substance abuse and mental health also contribute to risk factors, as well as isolation and lack of resources such as health care and enough money to comfortably meet needs (NASP, 2015). Trauma-informed care (TIC) considers the complexities of trauma on individuals and communities and seeks to prevent re-traumatization. It is important that counselors have competency and self-efficacy when treating these trauma symptoms.

Crisis Treatment Skills

Trauma and crisis care is different than the more generalized therapy treatments typically taught in CPPs (Chatters & Liu, 2020; Dean, 2016; Land, 2018). While knowing theories and models for crisis treatment such as trauma-informed care and Psychological First Aid (PFA) are important, skills specific to crisis, trauma, and disaster interventions are also essential (Bray, 2021; Chatters, 2020). Basic counseling skills learned in CPPs are foundational, but in initial treatment of crisis, the need to diagnosis and treat the typical diagnosable mental health

conditions such as depression and substance abuse is significantly less imperative (Bellamy et al., 2019; Everly & Lating, 2013).

Crisis treatment is immediate, more short-term based services. Basic care may include providing safety, stabilization, active listening, psychoeducation, and connecting to community resources or encouraging individuals to start community groups for emotional support. This basic support means meeting essential needs such as water, food, clean (as clean as the area permits) clothes and bedding as important first steps of restabilizing after a disaster (Jacobs et al., 2016; Webber & Mascari, 2018). These services may require safety checks, short-term goals, and the basic counseling skills such as attending, paraphrasing, and empathy. Crisis care may also include working alongside other professionals, typically providing care within an interdisciplinary setting with team members from various specialties. During crisis care and management it is important to connect clients with community resources specific to their needs (Land, 2018), as crisis care is meant to be short term and supplemental not replacing community mental health resources.

When delivering crisis care to those in distress, acronyms such as PIE referring to proximity, immediacy, and expectancy have been used (Everly & Lating, 2013). Proximity describes giving services wherever they are needed. This might mean sitting on the floor or being inside a building after a hurricane. Immediacy refers to the urgency behind starting to stabilize the individual. The need to find a sense of safety and agency is often immediately necessary to reorient. Expectancy reminds the provider to stabilize the acute distress, restore a steadier state of functioning, and guide the individual back to an adaptive level of functioning (Everly & Lating, 2013). Psychological first aid is an approach in crisis treatment that has been adopted by WHO and was designed with the intention to provide humane, supportive, and practical assistance for

people who are distressed. This assistance is delivered in ways that respect dignity, culture, and abilities (WHO, 2013).

Psychological First Aid

Psychological First Aid (PFA) has received endorsement from researchers and clinicians, the Office of the Assistant Secretary of Preparedness and Response, the Department of Health and Human Services, and the World Health Organization (Atkins & Burnett, 2016). It is an evidence-informed method developed to assist people, including children, in the aftermath of a crisis event in hopes of mitigating initial traumatic stress reactions, fostering adaptive functioning, and facilitating access to needed care (Atkins & Burnett, 2016; Everly et al., 2013; Jacobs et al., 2016).

A resilience building tool, PFA can be implemented by both PFA trained mental health and non-mental health professionals. Many crisis-care providers are trained on Psychological First Aid (PFA), and CACREP (2015) requires CITs understand this model and start learning similar crisis care models. Additionally, the skills of PFA and this mental health version of first aid can be taught to untrained community members who can be enlisted to help organizations address the potentially large amount to crisis-impacted individuals and begin to create community awareness of how to engage with crisis-impacted individuals after the crisis and disaster have passed (Bray, 2021; Meyers, 2017).

There are eight core actions in PFA: contact and engage, provide safety and comfort, stabilize, gather information, offer practical assistance, connect crisis-impacted individuals to social supports, give information about coping and coping skills, and provide links to needed services. PFA assumes that not everybody who experiences a crisis or disaster will develop mental health conditions (Myers, 2017). Providers can remind crisis-impacted individuals that in

a different context the psychological distress that they are experiencing may feel like a mental health concern during and in the immediate wake of crisis and disaster, but the emotional, physical, and psychological dysregulation is normal (Bray, 2021). While there is overlap with trauma and crisis, some skills are specific to trauma.

Trauma Treatment Skills

It is important to consider risk and protective factors when working with populations impacted by crisis, trauma, and disaster (SAMHSA, 2015). Knowing the risk factors such as substance abuse, physical impairments, disabilities, race, low SES, gender, etc., will give a mental red flag to the responder to ensure an adequate list of resources in the community or closest resources if the community is lacking. Goals of counseling trauma-impacted survivors are to establish and maintain safety, encourage client empowerment, and help clients find their voice throughout the healing and counseling process. Researchers of power-based partner violence (PBPV) note that the individual needs of survivors should always be taken into consideration during the treatment process (Conley & Griffith, 2016).

Trauma survivors may withhold traumatic details for fear that revealing the details may lead to persecution, prosecution, retaliation, and/ or alienation (Cook et al., 2014). Providers may benefit from knowing that conditions of trauma can also create client behaviors that make treatment difficult. These difficulties may include lack of trust for others, emotional dysregulation, and possibly wanting to maintain the favor of their counselors by trying to avoid the aforementioned fears of persecution, prosecution, retaliation, and/ or alienation. An example may be a client who presents symptoms of dependency or mistrust from a trauma or crisis. This presentation may infer with the counselor-client relationship or counseling the process (Cook et al., 2014). Without being trauma-informed the counselor may inadvertently create a problematic

therapeutic alliance by ignoring or restructuring the relationships to respond to the perceived dependency or mistrust in ways that could disempower or be reminiscent of the abuser's dynamics (Kleber, 2019; Leitch, 2017). Proper practice in trauma and crisis requires this awareness and other specialized trainings to avoid such violations.

Recognizing and learning how to address these trauma-impacted behaviors and cognitions will help counselors and CITs serve their clients and communities (Pau et al., 2020). Counselor self-care and collective agenda setting, as well as proper training on the subjects of crisis, trauma, and disaster, starting with a competency model, will help counselors improve their effectiveness when working with complex, vulnerable trauma-exposed populations (Butler et al., 2016; Cook et al., 2014; Harrichand et al., 2021). Trauma and crisis courses in CPPs may offer comprehensive material and more training hours than simply embedding this complex content throughout CPPs, better preparing CITs to work with trauma and crisis-impacted populations (Greene, 2016; Minton & Pease-Carter, 2011). The self-efficacy (Bandura, 1994) gained through this training may lead to improved client care.

Self-Efficacy

Self-efficacy is a complex concept that has been widely researched and measured in many domains such as physics, mathematics, nursing, academic achievement, and counseling and as of recently crisis counseling. Self-efficacy was researched heavily by Alfred Bandura. This social cognitive theory is Bandura's seminal work for its transferability to many domains and its predictability of success. Self-efficacy theory essentially posits that one's belief in their ability to perform certain tasks contributes to the potential of positive outcomes. The construct self-efficacy has been frequently measured in part because of its robust predictive capabilities of positive outcomes. Self-efficacy can influence thought patterns, actions, and emotional arousal.

In causal tests the higher the level of induced self-efficacy, the higher the performance accomplishments and the lower the emotional arousal. Perceived self-efficacy helps to account for such diverse phenomena as changes in coping behavior produced by different modes of influence, level of physiological stress reactions, self-regulation of refractory behavior, resignation and despondency to failure experiences, self-debilitating effects of proxy control and illusory inefficaciousness, achievement strivings, growth of intrinsic interest, and career pursuits. The more prepared someone feels, the greater their self-efficacy. Researchers have also identified a relationship between counselor self-efficacy and performance (Larson & Daniels, 1998). This means as a counselor's self-efficacy improves so does his or her performance (Sawyer et al., 2013). The influential role of perceived collective efficacy in social change is analyzed, as are the social conditions conducive to development of collective inefficacy. Self-efficacy's predictability has made it a desirable construct to measure and study.

Bandura (1977) defines self-efficacy as one's belief in their capability to complete actions required to attain various types of positive performance outcomes or desired outcomes. Academic self-efficacy may be defined as an individual's confidence that they can achieve a designated level on a specific academic task (Bandura, 1994). Bandura (1977, 1982, 1994, 2001) believed self-efficacy is a strong mechanism in human agency which influences our thought patterns, actions, and emotional arousal. Bandura believed that higher levels of self-efficacy have a strong and predictive relationship with higher performance accomplishments and lower levels of emotional arousal.

Self-efficacy has been linked to many processes including motivation, emotion regulation, and consequently improvements in coping behaviors, manageable stress reactions, and resiliency. Resiliency here meaning that self-efficacy offers a protective perspective through

which novel information is seen as a challenge versus as obstacle. Bandura also noted the value of measuring self-efficacy in each domain to better understand what specifically is required to improve self-efficacy in that academic or professional domain: “Additionally, efficacy beliefs should be assessed at the optimal level of specificity that corresponds to the criterial task being assessed and the domain of functioning being analyzed” (Bandura, 1994, p. 26).

Additionally, when one considers the motivation needed to execute domain specific tasks and to view them as a challenge versus an obstacle seems important when one considers the urgency and importance of a counselor’s position when working with trauma and crisis-impacted individuals. Thus, the current study measured the self-reported self-efficacy of CITs after taking an online trauma and crisis course versus students from the same program who did not take the course. Assessing the preparedness of CITs to start field work and later residency is important for helping CITs not only gain confidence and motivation but to also help CPP see the importance of including these courses in their curricula. Assessing CITs levels of crisis self-efficacy may inform CE and CITs necessary additional steps to improve their preparedness.

In Bandura’s research he proposed that people acquire new information through four main sources: a.) Mastery experiences b.) vicarious experience c.) verbal persuasion, and d.) physiological states. Mastery experiences refer to the experience one attains when starting a new task and completing successfully. Vicarious experience refers to observing others such as role models successfully performing activities. Verbal persuasion references the positive impact that words have on one’s belief that they can accomplish a specific task. Physiological states refer to the impact of stress levels, emotions, and mood on one’s ability performance believes (Bandura 1977, 1994). These four main sources might easily be met in a trauma and crisis counseling course when counseling courses often have empathic and encouraging teachers, experiential

learning, counseling/ intervention demonstrations from the teacher, and suggestions for self-care which may positively influence or reduce physiological stressors. Counselors' self-efficacy related to responding to crisis, trauma, and disaster impact their competency and the treatment skills they use in interventions (Albaek et al., 2018; Morris & Minton, 2012).

Counselor's Crisis Self-Efficacy Scale

In response to the growing need for better prepared crisis, trauma, and disaster counselor preparation, three professors, Cheryl Sawyer, Michelle L. Peters, and Jana Willis, from the University of Houston Clear-Lake created the Counselor's Crisis Self-Efficacy Scale (CCSES) to help assess counseling students' perception of their capability to properly counsel crisis-impacted clients. While there are other self-efficacy scales this is the first specific to crisis counseling. The authors confirmed their instrument's validity and stated the importance and growing need for counseling students' to be crisis, trauma, and disaster trained. The field of crisis, trauma, and disaster is growing with school shootings, public riots against oppressed groups, and natural disasters reeking havoc on many global regions (Sawyer et al, 2013; Peters et al. 2017).

Bandura's research also notes the importance of assessing self-efficacy in various academic/ professional domains (Bandura, 1994). This means that self-efficacy is best measured as it specifically applies to the area of interest, e.g., crisis and disaster counseling and should be measured in accordance to that domain. Bandura (1994) noted that positive self-efficacy beliefs enhance human accomplishment and personal well-being. Accordingly, people with a strong sense of personal competence in a domain approach difficult tasks specific to that domain as challenges that might be mastered rather than as threats to be avoided. Additionally:

Individuals with greater intrinsic interest in domain activities, set challenging goals and maintain a stronger commitment to them, heighten their efforts in the face of failure, more easily recover their confidence after failures or setbacks, and attribute failure to insufficient effort or deficient knowledge and skills which they believe they are capable of acquiring. (Bandura, 1994, p. 22)

In fact, it is even noted that high self-efficacy helps create feelings of serenity in approaching difficult tasks and activities. Crisis, trauma, and disaster can be difficult and challenging for clients, communities, and often the counselors who assist them, but given its ubiquitous nature it cannot be avoided, and its necessity deems its significance. The CCSES instrument potentially offers counselor researchers, faculty, and other professionals within the counseling field an opportunity to assess novice counselors' self-efficacy when working specifically with this essential group of crisis-impacted clients.

The survey is a 42-item questionnaire divided into four subscales: crisis situations, basic counseling skills, therapeutic response to crisis and post-crisis, and unconditional positive regard. The instrument's items were derived from two sources: the Social Work Self-Efficacy (SWSE) scale and from a literature review and the suggestions of licensed counseling practitioners. The SWSE items were modified by converting the format of each item from a question into a statement and renaming the subscales to reflect counselors. After the instrument was created the creators subjected the scale to two rounds of validation to ensure validity. The CCSES developers administered the scale to participants and published two studies. The first study included a sample of master's level counseling students ($n = 34$) enrolled in a Crises Intervention Preparation course for Mental Health Responders. The course was a requirement during the students last semester in the Counseling program. Participant demographics were documented

with ages ranging from 24 to 48 years. The majority were women (85.3%), and approximately 35% were Caucasian, 29.4% were Latino/Hispanic, and 26.5% were African American.

The researchers note that the Crisis Intervention Preparation course for Mental Health Responders included a strong foundation in crisis and disaster response. The crisis and disaster course used textbooks to educate about concrete crisis models for intervention. The textbooks included strategies for addressing a variety of crises and emphasized ethical and multicultural components. The course also examined cultural and racial biases, addressing assumptions to help train the counseling students to avoid unintentional labeling and inappropriate or ineffective counseling approaches (Sawyer et al., 2013). These course trainings included discussions addressing more common crises including (but not limited to) “child maltreatment, suicide, homicide, intimate partner/domestic violence, sexual assault, psychiatric crises such as post-traumatic stress disorder (PTSD), bereavement, school and workplace violence, natural disaster, and terrorism” (Sawyer et al., 2013, p. 33).

After the counseling students studied theoretical strategies for approaching various crises, they planned intervention models that might support their client base and the situation. The gathering and organizing of resources that could prove to be helpful during crisis intervention was presented as essential pre-preparation. The students were also trained on creating crisis response boxes. These boxes might prove helpful as materials specific to varying crisis would be packaged together and available for implementation during those crises. A crisis box might include appropriate literature to help one understand their immediate circumstance, list of external support organizations or resources, and personal items the counselor may need throughout the crisis and/or or mental health response. The crisis and disaster training curriculum

also emphasized the need for counselor self-care during and after the crisis situation (Sawyer et al., 2013).

The researchers imported the data from an Excel document into SPSS 20 to find percentages, means, and standard deviations to assess the participants pre- and post-differences assessing confidence to counsel a crisis-impacted client. Two-tailed paired t-tests were calculated to determine any statistically significant differences between pre- and post-self-efficacy in the four subscales regarding providing basic counseling skills, therapeutic response to crisis and post-crisis, and unconditional positive regard for crisis-impacted clients. The researchers used Cohen's d and the coefficient of determination (r^2) to assess effect size, while Cronbach's alphas were used to assess the reliability of the CCSES instrument. The two-tailed paired t-test was conducted, and all three subscale results indicated that there was a statistically significant mean difference between the pre- and post- self-efficacy scores.

In 2017 the researchers published another study using the CCSES. The sample was larger and again pre and post measures were taken. Participants consisted of 171 master's-level counseling students enrolled in the crisis intervention preparation course for mental health responders. Demographics revealed counseling students ages ranged from 24 to 50 years with the majority being women (76.8%). Participant race and ethnicity showed that 33.6% of were Caucasian, 30.1% were Latino/Hispanic, and 28.3% were African American. Additionally, 37.8% were bilingual speakers. Participants were recruited from a public Hispanic serving university on the Gulf Coast. Many of the graduating counseling students continue to work within the community post-graduation. The city has a high crime rate and is susceptible to natural disasters such as hurricanes.

After the researchers collected data, an exploratory factor analysis (EFA) was used to provide additional evidence of the CCSES' to construct validity. Other tests were also used when constructing the CCSES to document the validity included a Kaiser-Meyer-Olkin (KMO), and a scree plot of the eigenvalues and Kaiser's criterion of the eigenvalues. Once this analysis was complete, showing a validation confirmation, the researchers conducted two-tailed paired t-tests on the subscale composites to determine whether a statistically significant difference existed between pre- and post-self-efficacy in regard to three of the four subscales: providing basic counseling skills, therapeutic response to crisis and post-crisis, and unconditional positive regard to clients experiencing a crisis.

The researchers used an additional test, the Wilcoxon signed rank test to assess whether the median ranks differed significantly from pre- to post-responses per survey item. Then Cohen's d and the coefficient of determination (R^2) were calculated to assess effect size. Cronbach's alphas were calculated to assess the CCSES's reliability of the instrument and its subscales. The study results showed another large effect for this study, as it did for the first published study, in all four subscales consequently illustrating an increase of self-efficacy post crisis intervention course. While the literature regarding crisis, trauma, and disaster counselor preparation continues to grow, CACREP too has made some advancements. Still CEs are using various self-efficacy scales to measure CITs overall preparedness.

Other Counseling Self-Efficacy Scales

The Counselor Activity Self-Efficacy Scale (CASEC) measures efficacy related to utilizing various components of therapy sessions and includes subscales titled Insight, Exploration, Action, Session Management, Relationship Conflict, and Client Distress as well as a TOTAL scale score. The scale has three sections with the first 15 items of the scale measures self-

efficacy related to helping skills. The next 10 items measure self-efficacy related to session management, and the final 16 items reflect self-efficacy related to counseling challenges. Participant's rate the responses on a scale of 0 to 9 (0 no confidence at all – 9 complete confidence) (Lent et al., 2003). Lent and colleagues (2003) noted the Exploration, Insight, Action, and Session Management scales as assessing efficacy related to capability to operate tasks that are part of most counseling relationships. Researchers have shown this instrument to have high internal consistency and validity (Goreczny et al., 2015; Lent et al., 2003).

The Counselor Self-Estimate Inventory (COSE) is a 37-item questionnaire with a 6-point scale that ranges from strongly disagree to strongly agree. Participants rate their perceived ability to perform various counseling skills. In addition to the total counselor self-efficacy score there are five measurements: Microskills, Handling of Process, Difficult Client Behaviors, Cultural Competence, and Awareness of Personal Values. Research has shown this instrument to have adequate reliability and validity. The estimates of reliability range from an internal consistency of .93 for the total score to .62 for awareness of personal values (Goreczny et al., 2015; Larson et al., 1992).

Counselor Self-Efficacy Scale (CSES) is a 20-item instrument that assesses CITs' competency regarding key counseling tasks such as basic counseling skills for group and individual counseling (Melchert et al., 1996). The CSES was developed after a literature review supported a goal of identifying key types of counseling competencies for counselors. The CSES uses 5-point Likert scale responses that indicate an individual's level of confidence in his or her counseling ability. These responses include "Never," "Rarely," "Sometimes," "Frequently" or "Almost Always" answer options. Half of the items are worded in a negative fashion to avoid acquiescent response bias, requiring reverse coding. The total score of the CSES ranges from 20–

100 and is calculated by adding the responses to all 20 items with consideration given to the reverse coded items. Melchert and colleagues (1996) tested for convergent validity and reported an acceptable correlation ($r = .83$; p -value not reported) between the CSES and the Self-Efficacy Inventory (Friedlander & Snyder, 1983; Mullen et al., 2015).

The Counselor Suicide Assessment Efficacy Survey (CSAES) calculates counselors' confidence in their ability to assess clients for suicide risk as well as their confidence to intervene with a client at risk of suicide. The CSAES includes 25 items in four subscales: General Suicide Assessment, Assessment of Personal Characteristics, Assessment of Suicide History, and Suicide Intervention. The items are rated on a 5-point Likert scale from 1 (not confident) to 5 (highly confident). Scores coordinate with perceived amounts of self-efficacy such that higher scores reflect higher self-efficacy, and lower scores reflect lower self-efficacy (Becnel et al., 2021). It has been shown that suicide and crisis training increases counselor self-efficacy (Morris & Minton, 2012). However, the setback for many professions/ domains is the disparity of training.

Known Best Practices

CITs' training has improved from 2009 to the 2016 CACREP standard updates, with CACREP students reporting higher self-efficacy versus non-CACREP counseling programs (Wills, 2021). Self-efficacy is one supportive factor CITs may need to utilize to provide crisis, trauma, and disaster care. Researchers indicate that counseling students have greater levels of crisis self-efficacy following participation in a crisis intervention course, as measured by a counselor's crisis self-efficacy scale to examine the influence of a course in crisis intervention on the self-efficacy of CIT (Peters et al., 2017; Wills, 2021).

Self-Efficacy

Possessing a sense of preparedness increased the perceived self-efficacy of CITs regarding their ability to deliver crisis interventions (Becnel et al., 2021; Isawi & Post, 2020; Peters et al., 2017; Sawyers et al., 2013). 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). Trainings with specific content training have been shown to have knowledge and confidence improvements (Gallo et al., 2019). This is important because counselor self-efficacy is associated with the use of suicide assessments and the use of preventions skills (Gallo et al., 2019). Self-efficacy encourages best practices when counselors and CITs are more confident to deliver them (Sawyer et al., 2013; Wills, 2021).

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 trauma and crisis 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 (Abassary & Goodrich, 2014). With supervisors serving as gatekeepers they can monitor supervisees for signs of trauma and crisis and can also provide supervisees with gatekeeper education who will work with clients and possibly later supervisees of their own. This parallel process and psychoeducation may help alleviate undiagnosed trauma and provide preventive care. Additionally, when considering crisis course work, professional development may benefit from hands-on components that allow participants to practice their skills in a supervised setting.

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 and allows supervisors to acknowledge each aspect of their supervisee's work. The CARE model represents "C" for context, which discusses the surrounding information of time, place, logistical components that impact the crisis and intervention. The "A" stands for action, referencing supervisee and their clients' needs including how they may respond to a client's crisis. The "R" stands for 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).

Resilience and Self Care

Researchers have suggested that crisis training may have 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 (Atkins & Burnett, 2016; Leitch, 2017). After some level of exposure to a traumatic event, the goal of disaster mental health services is to mitigate disaster-related stress, which may help to prevent or reduce the incidence of compassion fatigue and burnout. Burnout is already a concern for some CITs who are often working while attending school, completing assignments, and working with crisis-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).

Crisis, trauma, and disaster training can include the importance of self-care, secondary trauma, and compassion fatigue (Butler et al., 2016). These processes may be unaddressed without crisis, trauma, and disaster education. CITs can benefit from learning how and why to practice self-care while working with complex cases of crisis, trauma, and disaster-impacted clients (Butler et al., 2016; Sommer, 2008). This awareness may also help explain their own

histories of trauma to prevent countertransference and better understand the importance and value of self-care (Lu et al., 2017). It is worth considering the impact that CITs may experience when helping clients impacted by crisis, trauma, and disaster. Understanding vicarious trauma (Butler et al., 2016; SAMHSA, 2015) and knowledge about crisis, trauma, and disaster are important for safeguarding CITs and their current and future clients.

When working with trauma-impacted clients, students 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 (Lu et al., 2017). Suggested components for CEs to better accommodate attention to trauma work within CPPs include (1) theoretical frameworks in relation to trauma and vicarious trauma, (2) what students should expect when working with trauma and crisis cases, (3) clinical skills for trauma counseling, and (4) self-care and coping strategies (Lu et al., 2017).

Counselor educators, supervisors, and counselors are encouraged to engage in wellness and self-care strategies. This self-care, especially in times of crisis, may help maintain professional practices and ethical practices and help model the importance of self-care for CITs especially during high stress (Harrichand et al., 2021). The counseling profession has both the opportunity and obligation to improve counselors' crisis, trauma, and disaster proficiencies (Conley & Griffith, 2016; Dean, 2016; Land, 2018; Kucharski, 2020; Nickerson et al., 2014). CPPs and CEs can help CITs provide current and future effective and ethical 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 (Tarvydas et al., 2017).

Needed Research

All CITs and professional mental health care workers will experience someone in a state of crisis, trauma, or disaster (Chatters & Liu, 2020; Solmonson & Killam, 2013). While the accreditation body for CPPs has acknowledged a need for counselors to be better trained in crisis, trauma, and disaster, there remains a lack of CITs preparedness (Chatters & Liu, 2020; Courtois & Gold, 2009; Liebling-Boccio & Jennings, 2013; Montague et al., 2020). This is an ethical concern as counselors and CITs should practice only within their scope of training. Yet, research shows all counselors will encounter trauma and crisis-impacted individuals.

Many CEs believe crisis, trauma, and disaster are specialty fields for which they have not been trained well enough to feel confident teaching CITs (Greene et al., 2016). Additionally, due to the pedagogical flexibility within programs and lack of impact data for programs teaching crisis, trauma, and disaster, many CEs are unsure of the most effective pedagogical methods for course content delivery and CIT training. Self-efficacy encourages CEs and CITs to share crisis, trauma, and disaster knowledge and provides the confidence to use evidence-based interventions such as using suicide assessments, however, without education, training, and practice the absence of self-efficacy impairs initiation of such evidence-based interventions (Gallo et al., 2019; Sawyer et al., 2013).

Additionally, within CPPs CITs are learning about the importance of social justice advocacy and social determinants of health with minorities and marginalized populations being disproportionately affected. It is also important for CITs to learn the biopsychosocial signs and symptoms of trauma and crisis these individuals and groups experience. This research study adds to the current literature advocating for an improved emphasis on crisis, trauma, and disaster in CPPs. This study follows previous studies such as Morris & Minton (2012) assessing

professional counselors self-efficacy post-graduation and Sawyer, Peters, and Willis (2013; 2017) measuring CITs crisis self-efficacy scale with the same instrument I will use for this research study. This is an effort to continue research outlining the value of including more CPPs crisis, trauma, and disaster training hours for CITs and the importance of self-efficacy when working with complex topics such as trauma and crisis.

Context

In Fall of 2021 Old Dominion University (ODU) in Norfolk, Virginia offered an online trauma and crisis course in their CPP. This course was elective and thus not all students completed the course. This is the first trauma and crisis course offered in ODU's CPP. The majority of the students in the course were enrolled in practicum and internship. According to the syllabus, the course offered theories and models of crisis counseling such as individual crisis intervention, trauma-informed care models, and community-based interventions (e.g., psychological first aid). The course syllabus addresses procedures for identifying trauma and abuse and how to report abuse, as well as the impact of trauma and crisis on individuals with mental health diagnoses.

There were several components to the course such as required reading from three textbooks that specifically address trauma and crisis. The syllabus stated that completion of the assigned readings were necessary for completing case presentations and class discussions. Readings were to be completed prior to class for in-class discussions and participation. Additionally, according to the trauma and crisis syllabus, students were informed about the sometimes unexpected emotions that may surface during the trauma and crisis course due to potential psychological and emotional triggers. According to the trauma and crisis syllabus, the instructor informed students that, in fact, discomfort and anxiety is expected during the course.

This is important and valuable information as CITs will need to learn how to tolerate and work with intense emotions. These emotions may be their own and/ or the clients. Students were encouraged to seek out-of-the-class help as needed. Students were also encouraged to share personal reactions to the courses content and related assignments but only if the student felt comfortable doing so, disclosure was not required. Other course requirements included a self-care plan, discussion preps, and case conceptualizations. The case conceptualizations included treatment plans and reflections. The final two trauma and crisis course components included a midterm and final as well as a reflection paper. The syllabus is attached in the Appendix B.

The Study

This study adds to trauma and crisis counselor preparation in CPPs' research by sharing the stated self-efficacy of counseling students who did and did not attend an online trauma and crisis course within the same program. I used a non-experimental design to see if a relationship existed between self-reported crisis self-efficacy of Counselors-in-training (CITs) who have taken a stand-alone online trauma and crisis course and those who have not. Instrumentation included a valid and reliable measure: the Counselor's Crisis Self-Efficacy Scale (CCSES) (Peters et al., 2017). The CCSES variables included working with individuals experiencing crisis, basic counseling skills, therapeutic response, and unconditional positive regard. This study's results may offer a reference point for educational leaders currently seeking to add crisis, trauma, and disaster into their CPPs or to better understand the importance of enhancing trauma and crisis training and education into their existing crisis, trauma, and disaster delivery methods.

The study used the following three research questions to guide the research process:
(RQ1): Is there difference in the crisis self-efficacy scores of CITs who took an online trauma and crisis course versus CITs from the same program who did not?

(H_a): Those who took the course show higher self-efficacy than those who did not.

(RQ2): Is there difference in the crisis self-efficacy scores of CITs' who took an online trauma and crisis course versus CITs from the same program who did not related to race, gender, and age with trauma and crisis?

(H_a): Those who took the course show higher self-efficacy than those who did not after controlling for race, gender, age.

(RQ3): How do students feel about their capabilities to successfully support a client in crisis?

One of several aims is to contribute to the growing body of literature and knowledge that focuses on crisis, trauma, and disaster education and training of CITs in CACREP CPPs. In particular, this study hopes to address the gaps between CACREP mandated standards and CEs and CPPs varying pedagogical approaches and attempts to properly prepare CITs for crisis, trauma, and disaster cases so that they may function ethically and be prepared to work with these inevitable presentations no matter the counseling specialty.

Summary

Chapter two provided a comprehensive literature review regarding crisis, trauma, and disaster education and training in CACREP CPPs. The chapter started with CACREP 2009 and 2016 education standards for CPPs and outlined the need for improved education and training in CPPs by acknowledging the lack of CACREP provided competencies, curricula standardization, and dearth of research illustrating effective crisis, trauma, and disaster pedagogies. The chapter also reviewed the prevalence of crisis, trauma, and disaster, signs, symptoms, and treatment, and addressed the best-known practices for including crisis, trauma, and disaster into CPPs. I discussed the importance of counselor self-efficacy, presented the Counselor's Crisis Self-Efficacy Scale, and I contextualized the online trauma and crisis course used for this study.

Chapter two concluded with suggestions for future research and introduced the study's methodology and implications.

CHAPTER THREE

METHODOLOGY

This research study used a non-experimental design to show a difference in self-reported crisis counseling self-efficacy of Counselors-in-training (CITs) who have taken an online stand-alone trauma and crisis course and those who have not. Instrumentation included a valid and reliable measure: the Counselor's Crisis Self-Efficacy Scale (Peters et al., 2017). In this chapter, I describe the methodological design of the research study. First, I explain the purpose and research questions guiding the study. Next, I briefly describe the quantitative and qualitative research design of the study. I detail information on participants, instrumentation, and data collection. Finally, I outline the data analysis procedures and close with the study's limitations.

Rationale and Research Question

This research study used a non-experimental research design to seek differences in self-reported crisis self-efficacy (DV) of CITs completing an online stand-alone trauma and crisis course (IV) and those students from the same program who did not. The Counselor's Crisis Self-Efficacy Scale is a valid and reliable 42-item questionnaire divided into four subscales: 1) crisis situations 2) basic counseling skills 3) therapeutic response to crisis and post-crisis 4) and unconditional positive regard. Demographic characteristics (IVs) included race, gender, age, and years of experience with trauma and crisis work. The research questions and alternative hypotheses guiding this study are:

(RQ1): Is there difference in the crisis self-efficacy scores of CITs who took an online trauma and crisis course versus CITs from the same program who did not?

(H_a): Those who took the course show higher self-efficacy than those who did not.

(RQ2): Is there difference in the crisis self-efficacy scores of CITs' who took an online trauma and crisis course versus CITs from the same program who did not related to race, gender, and age with trauma and crisis?

(H_a): Those who took the course show higher self-efficacy than those who did not after controlling for race, gender, age.

(RQ3): How do students feel about their capabilities to successfully support a client in crisis?

Research Design

This research study is a non-experimental posttest design. It is bound by sampling only master's level students who a) completed COUN 795 in Fall 2021, and b) students enrolled in COUN 669 (practicum), COUN 667 (internship in mental health counseling), and COUN 668 (internship in school counseling) in Spring 2022. Due to non-experimental design, I included the confounding independent variables of demographic information (race, gender, and age) for analysis inclusion. I imported data into SPSS 20 from an Excel document for further analysis. Percentages, means, and standard deviations were used to assess post-differences in participant responses regarding self-efficacy for counseling a client experiencing a crisis. An ANOVA and ANCOVA were calculated for each subscale of the CCESE for the first two research questions to determine whether a difference existed between students' crisis counseling self-efficacy scores who did and who did not take the online trauma and crisis course and determine if there was a difference in reported self-efficacy between students who did and not attend the trauma and crisis course when controlling for race, age, and gender. Results showed whether CITs differed in self-efficacy and whether those differences were reflected by race, gender, and age. Difference was determined at the .05 level because of the small sample size, as determined by the availability of

data, i.e., students who took the online trauma and crisis course. The final research question is qualitative and content analysis was used for data analysis.

Participants and Sampling

For this study, I used a purposive sampling technique to select participants (Creswell, 2014). All but one of the participants were master's level students (CITs) in the Counseling Program at Old Dominion University. All participants were 18 years of age and older. The inclusion criteria included master's level students who a) completed COUN 795 in Fall 2021, and b) students enrolled in COUN 669 (practicum), COUN 667 (internship in mental health counseling), and COUN 668 (internship in school counseling) in Spring 2022. Sixteen students completed the COUN 795 trauma and crisis elective course that was offered for the first time within ODU's master's counseling program during Fall 2021. Eleven of those students participated in this study. This inclusion included one graduate-level Clinical Psychology student who attended the COUN 795 course. In all, there were 62 students who met inclusion criteria, thus there were 46 non-course students of which 20 participated in this study. All of whom were CITs. I compared students' levels of crisis self-efficacy using a valid and reliable instrument that measures multiple variables (work with individuals experiencing crisis, basic counseling skills, therapeutic response, and unconditional positive regard). The following is a description of the instrument and its metrics.

Instrumentation

The Counselor's Crisis Self-Efficacy Scale (CCSES) (Sawyer et al., 2013; Peters et al., 2017) is designed to assess counseling students' perception of their capability to properly counsel crisis-impacted clients. While there are other counselor self-efficacy scales (Douglas & Wachter Morris, 2015; Larson et al., 1992; Lent et al., 2003; Melchert et al., 1996) this is the

first specific to crisis counseling. The survey is a 42-item questionnaire divided into four subscales: crisis situations, basic counseling skills, therapeutic response to crisis and post-crisis, and unconditional positive regard. The instrument's items were derived from two sources: the Social Work Self-Efficacy (SWSE) scale and from a literature review and the suggestions of licensed counseling practitioners. The SWSE items were modified by converting the format of each item from a question into a statement and renaming the subscales to reflect counselors.

The questions are on a 6-point Likert scale (0 = No Confidence at All; 5 = Complete Confidence) for each of the subscales. Composite scores can range from 0 to 210. The survey shows that the larger the composite score the more self-efficacious a person perceives him or herself to provide counsel to crisis-impacted individuals. Two published articles have reflected the validity and reliability of the questionnaire. In one study, the creators of the CCSES used Cronbach's alpha reliability and coefficients for the CCSES were found to be .96 for the entire instrument, .96 for Basic Counseling Skills, .97 for Therapeutic Response to Crisis and Post Crisis, and .98 for Unconditional Positive Regard subscales (Sawyer et al., 2017).

After the instrument was created the creators subjected the scale to two rounds of validation to ensure validity. An expert panel of 10 professors teaching in graduate counseling programs at various higher education institutions assessed the CCSES content and validity. Members of the expert panel were requested to comment on the content of the items. These comments included ordering and wording of the items, and if any items should be added and/or deleted from the survey (Sawyer et al., 2013). The CCSES developers administered the scale to participants and published two studies, it received one final validity review from a university Program Coordinator of Counseling and a measurement expert. Once administered, participants were asked to rank their behavior on a 6-point Likert scale (0 = No Confidence at All; 5 =

Complete Confidence) for each of the subscales. The creators noted the composite scores can range from 0 to 210; the larger the composite score the more self-efficacious a person perceives him or herself. The Cronbach's alpha reliability coefficients for the CSES were found to be .96 for the entire instrument, .96 for Basic Counseling Skills, .97 for Therapeutic Response to Crisis and Post Crisis, and .98 for Unconditional Positive Regard subscales (Sawyer et al., 2013). The CCSES developers administered the scale to participants and published two studies. The CCSES supported the current study in efforts to assess students reported crisis counseling self-efficacy.

Procedures and Data Collection

IRB consent was obtained prior to conducting the study. Recruitment occurred with the help of the Counseling Department's Graduate Clinical Coordinator, who is also a member of the dissertation committee. She identified the master's students (CITs) in practicum and internship courses during Spring 2022 semester ($n = 62$) and sent an email to their instructors prompting the instructors to invite the practicum and internship students to participate in the study. She electronically distributed the letter of introduction with the Qualtrics survey link attached for the teacher to offer them the option to participate in the study. Further, she also accessed the emails for students who took the crisis and trauma elective ($N=16$) and sent them a separate invitation and introductory letter to participate in the study. The informed consent document was included in the Qualtrics Crisis Self-Efficacy instrument.

Students were unable to complete the survey in class as originally planned as the CCSES with final qualitative questions may have taken some students 30 minutes to complete. Instead of shortening the survey and potentially losing rich qualitative information, I followed up the Graduate Clinical Coordinator's email invitations to participate with three email reminders throughout the requesting completion of the survey. During the summer semester 2022, I closed

data collection. Eleven students who took the trauma and crisis course completed the survey, and 20 who did not attend the course completed the survey. Demographic characteristics were collected including race, gender, age, and years of experience with trauma and crisis work. Confidentiality and anonymity were maintained by securing the participants' data in a password protected Qualtrics account, as well as on a password protected flash drive.

Students' participation in the study was not linked to their grades and consequently did not affect their grades in any way as their instructors did not see their responses. Additionally, when analyzing this study's qualitative research question (RQ3), pseudonyms were used in the results chapter. The fourth chapter of this study shows several student responses. This makes the study richer by providing the students' own words; however, for security all the names have been changed.

Data Analysis Procedures

Once collected, the survey data was downloaded and entered into SPSS for data analysis. The data was cleaned and analyzed to account for missing information. I began by conducting descriptive statistics to test for normality and homogeneity, identify any outliers, and assess the appropriateness of the path analysis model. I assessed for normality and homogeneity. Descriptive statistics summarized the data and included a correlation matrix of all the variables in the model. Typically, in non-experimental studies data is used to show a possible relationship (Morris & Wester, 2018).

Descriptive statistics were conducted to identify means and standard deviations, and to determine if outliers, skewness, or kurtosis are present. Cronbach alphas were performed to illustrate correlation between survey questions. The Cronbach alphas for each subscale were above .90 illustrating a high correlation. While the original CCSES is a 42-item questionnaire, I

made the mistake of omitting two questions from the second subscale, however, the Cronbach alphas for each subscale were still strong. After correlating the four CCESE subscales I found the MANCOVA was not the best technique. The threshold is .7 and correlation between subscales TR and SC measured .783 and subscales BR and SC measured .667. This high correlation determined that a MANOVA and MANCOVA were not viable tests for this small sample size. This was confirmed with the Wilk's Lambda non-significant value, $F(4, 112) = 13.74, p < .0005$; Wilk's $\Lambda = 0.450$, partial $\eta^2 = .33$.

The Wilk's Lambda measures the percent variance in dependent variables that is not explained by differences in levels of the independent variable (Glen, 2018). A value of zero is ideal and it means that there isn't any variance not explained by the independent variable. The alternative hypothesis is rejected when Wilk's lambda is close to zero, although this should be done in combination with a small p-value. Larger sample differences would need to be represented in this study's sample set for the MANOVA and MANCOVA to determine the effects of the independent categorical variables on the multiple continuous dependent variables.

Differences between groups (those who took the stand-alone online trauma and crisis course and those who did not) were thusly analyzed using an ANOVA and ANCOVA to determine if there are differences on *the* variables measured by the Crisis Self-Efficacy Scale. I determined whether CITs differed in self-efficacy and whether those differences were related to race, gender, age, and years of experience with trauma and crisis. Statistical significance was determined at the .05 level because of the small sample size, as determined by the availability of data, i.e., students who took the trauma and crisis course.

Inferential statistics with a non-experimental design can demonstrate a relationship between the independent and dependent variables even though a non-experimental research

design cannot establish a cause-effect relationships (Maheshwari, 2018). These statistics allowed me to make inferences or conclusions about the results. To determine the difference in self-reported crisis self-efficacy between CITs who did and did not take the online elective trauma and crisis course, the ANOVA was used to assess relationships between two or more groups. For this study the ANCOVA calculated the difference between the students who did and did not take the online trauma and crisis course and to find difference based on the demographics race, age, and gender. Due to the small sample size the statistical tests ANOVA and ANCOVA were most appropriate. The ANOVA was used to answer the first research question, which is a simple comparison between group of students who did and did not take the trauma and crisis course. The second research question required covariates to be controlled to understand if in the presence of demographic differences, the self-reported self-efficacy was attributable to the course and not age, race, and gender. The ANOVAs measured one dependent variable, and the ANCOVA measured one dependent variable while also controlling age, race, and gender. Analysis of Covariance (ANCOVA) is the inclusion of a continuous variable in addition to the variables of interest such as independent and dependent variables as a means of control (Tabachnick, 2013). For the second research question an ANCOVA test measured crisis self-efficacy or each of the four subscales.

The subscales were the dependent variables, the trauma and crisis course were the fixed factor, gender and ethnicity were fixed factors while age was a covariate. Covariates can be used in many ANOVA and ANCOVA analysis designs – such as between-subjects, within-subjects (repeated measures), mixed (between – and within – designs) etc. The ANCOVA test seeks to answer the question: Are mean differences or interactive effects likely to have occurred by

chance after scores have been adjusted on the dependent variable or because of the effect of the covariate (Tabachnick, 2013).

Content Analysis

To analyze and interpret the collected data from the qualitative research question, I used content analysis. Content analysis is a research tool used to determine the presence of certain words, themes, or concepts present within qualitative data (Columbia University, 2019). This research method offers a clear, flexible structure for systematically evaluating and categorizing subjective data, and can be used with a wide variety of data sources, including textual data, visual stimuli, and audio data (Stemler, 2015). Using content analysis, researchers can quantify and analyze the presence, meanings, and relationships of such certain words, themes, or concepts. (Columbia University, 2019).

Originally founded by Harold Lasswell, this research method's central concern is for the analysis of the "symbolic environment" and its consequences for human behavior (Janowitz, 1968). It is used widely among social researchers. Specifically, Lasswell (Janowitz, 1968) used content analysis to quantify political communication and to objectify the psychoanalytic interview. Consequently, content analysis can be used for making inferences from content back to the original communicator, in which case the analyst or researcher is concerned with understanding the communicator (Janowitz, 1968).

Content analysis has persisted through the years, and more recent research provides specific content analysis steps. Columbia University (2019) offers eight steps: 1) Decide the level of analysis: word, word sense, phrase, sentence, themes, 2) Decide how many concepts to code for, 3) Decide whether to code for existence or frequency of a concept, 4) Decide on how you will distinguish among concepts, 5) Develop rules for coding your texts, 6) Decide what to

do with irrelevant information, 7) Code the text, and 8) Analyze your results: draw conclusions and generalizations where possible.

For the first step I decided the level of analysis would be a word or group of categorical words that represented levels of capability. I familiarized myself with the data by reading the collected data multiple times and annotated any initial inclinations to become fully immersed with the data. I examined these pieces of evidence and recorded additional notes as I reviewed. The second step entailed deciding how many concepts I would code for. I believe the participants responses are rich and may have more concepts than I ultimately decided, but for clarity I decided on a three-part conceptual system that represented a high, middle, low categorical range. This required me to identify relevant aspects of the evidence and arrange them in a systemic fashion. These initial considerations provided context for the data so that I could begin scanning for similar concepts.

For the third step I decided to continue coding for the existence of a concept versus the frequency of a word or phrase. In other words, with deductive reasoning I considered each response and I found the response to imply one of these categorical terms even though participants did not always explicitly state a level of capability or readiness to counsel a client in crisis. The fourth step was to distinguish among concepts. I reviewed the concepts within the participants responses to ensure that they related to the three-level system before mirroring this same process for the remainder of the data set. The fifth step was to develop rules for coding. I decided that in order to place participants in categories I needed to consistently identify words or phrases related to the three categories via multiple rereads and coding by hand. I then transferred the written categories and responses into a Word document to consider rather the responses were appropriate for the assigned category or if some responses merited recategorization.

The sixth step entailed deciding what to do with irrelevant information. While I placed each participants response within a category found through content analysis, I saved all verbatim responses, using pseudonyms for confidentiality, and included them in this current study for readers to consider. Considering the reductive nature of content analysis, I felt the participants verbatim responses relevant and descriptive. I did not want to discard their words and solely represent participants with my own predetermined categories. Being a small study sample, all responses related to their perceived self-efficacy for counseling a client in crisis were able to be outlined within the current study.

The seventh step incited the actual coding or specific words or phrases I would use to represent the participants perceived self-efficacy for counseling a client in crisis. This required me to explicitly name the relevant aspects of the evidence and arrange them in a systemic fashion. The codes of confident, moderately confident, and lowly confident provided context for the data so that I continued to scan for related words and phrase to confirm this three-tier categorical system. For example, students with a label of confident would have reported a response similar to “I feel confident” but often they were less explicit. The comments labeled moderately confident included words or phrases that implied a modest amount of crisis and trauma readiness such as “somewhat capable.” While students might consider themselves lowly confident when they report feeling “under prepared” or “scared by the idea.” The labels of confident, moderately confident, and lowly confident reemerged with multiple rereads. This ongoing analysis allowed me to increase reliability as I consistently re-coded the same data in the same way over a period of time.

After analyzing and reviewing the categories, the final step was to draw conclusions and generalizations. The final categorical system of confident, moderately confident, and lowly

confident represents my generalizations. Without the participants there to give confirmation I had to make these generalizations via the subjective and systematic method of content analysis. This ongoing content analysis allowed me to move from the students' broader statements to a more specific categorical definitions that represents their perceived crisis and trauma counseling readiness.

Limitations

There are several limitations to this research study. Being a non-experimental design, there is a lack of randomization and inability to manipulate the independent variable. Additionally, due to the time of the study and the time the students took the course there is a maturation concern. Without a control group and randomized sample, it is difficult to disentangle the effects of the experimental treatment from other confounding factors. In addition, investigating crisis, trauma, and disaster education at one-setting poses challenges to the generalizability of results. The study utilized a small and specific sample of members which limits the potential for it to be applied in broader contexts. Additionally, using participant self-report data responses reflected some level of personal bias, opinion, and experience, and the content analysis might have showed stronger reliability with multiple readers. Without any course prerequisites students started with varying amounts of crisis, trauma, and disaster education training. Some students completed the course and started practicum or internships while others needed more program courses before field placements. Moreover, my inclusion criteria allowed for a varying student sample, one of which was a clinical psychology student who attended the COUN 795 course. I also unintentionally modified the CCSES by omitting the final two questions of the second subscale when typing the CCSES survey into the Qualtrics survey. While correlation measures still showed high correlation for this subscale, participants

were unable to answer the final two questions which might have impacted the scores of that subscale. Lastly, in retrospect, I believe the survey question inquiring about student's perceived ability to successfully "support" a client in crisis is not as appropriate as to successfully "counsel" a client in crisis. This wording will be changed prior to the next research study.

Despite these limitations, this study adds to trauma and crisis counselor preparation research. Being a nonexperimental study, control groups were not established, and the groups were not homogenous, as I could not control for demographic and prior crisis, trauma, and disaster experience differences. Still this research adds to existing literature and may provide insight into the bigger picture of effective academic interventions needed to properly prepare counseling students for the inevitable trauma and crisis clients, groups, and communities they will serve.

Summary

This chapter presented the rationale and research question for this non-experimental study regarding differences in self-reported self-efficacy of CITs from the same counseling program who did and who did not take a stand-alone crisis course. I outlined the research design used to answer the research questions and hypotheses. This chapter also included the rationale for design, sampling method chosen, and instrumentation used. Additionally, a discussion of the research participants, data procedure and analysis was provided. The chapter concluded with addressing limitations of the study.

CHAPTER FOUR

RESULTS

The primary purpose of this study was to ascertain if there is a relationship between self-reported crisis counseling self-efficacy scores of master's level students in a counselor preparation program who did and did not attend an online trauma and crisis course. I sought to examine whether there is statistical evidence to support the hypothesis that students who took an online trauma and crisis course would report higher levels of crisis counseling self-efficacy via a domain specific self-efficacy survey while controlling for independent variables of age, race, and gender. Three research questions guided this study.

(RQ1): Is there difference in the crisis self-efficacy scores of CITs who took an online trauma and crisis course versus CITs from the same program who did not?

(H_a): Those who took the course show higher self-efficacy than those who did not.

(RQ2): Is there difference in the crisis self-efficacy scores of CITs' who took an online trauma and crisis course versus CITs from the same program who did not related to race, gender, and age with trauma and crisis?

(H_a): Those who took the course show higher self-efficacy than those who did not after controlling for race, gender, age.

(RQ3): How do students feel about their capabilities to successfully support a client in crisis?

Data Analysis

After cleaning data for missing scores and transforming constructs race and gender into numerical values I utilized the normality test Shapiro-Wilk and Levene's Test of Equality of Error Variances, identified any outliers, and assessed the data's appropriateness.

Assumptions

Normality tests were calculated as well as skew and kurtosis. I used the Shapiro-Wilk test to determine if the dependent variables were normally distributed. For three of the subscales normality was assumed (SCScale $SW(31) = .955, p = .210$; BSSubscale $SW(31) = .942, p = .093$; TRSubscale $SW(31) = .958, p = .263$). The UPRSubscale assumption was violated, $SW(31) = .918, p = .021$. However, the skew and kurtosis values for the UPRSubscale were within normal limits. Of the four subscales only one showed high kurtosis. The kurtosis for the Specific Crisis subscale (SC Scale) showed high kurtosis (1.184). All other subscales had a normal distribution for skewness and kurtosis. The skewness for the BSsubscale variable was found to be .475 and kurtosis was found to be -.651. The skewness for the TRSubscale variable was found to be -.087 and kurtosis was found to be -.214. The skewness for the UPRSubscale variable was found to be -.149 and kurtosis was found to be -1.141. Levene's test showed non-significance for all subscales (SCSubscale $F(7,23) = 1.55, p = .200$; BSSubscale $F(7,23) = .69, p = .681$; TRSubscale $F(7,23) = 1.01, p = .451$; UPRSubscale $F(7,23) = .88, p = .540$).

Descriptive Statistics

Thirty-one master's level counseling students completed the Counselor's Crisis Self-Efficacy Scale. Of those students, 11 completed an online trauma and crisis course in Fall 2021 at Old Dominion University, while the other 20 students attended the counseling program that semester but did not take the course. Due to the small sample size and quantitative nature of SPSS, students were placed into binary identification groups for gender and race. Twenty-three participants identified as White, six identified as Black, one identified as Hispanic, and one identified as Asian. For data analysis this small sample size was separated into two race constructs. Of the 31 participants 64.5 percent identified as White and 35.5 percent identified as non-White. Additionally when analyzing the construct gender, one student identified as non-

binary but with the small sample size gender was coded into two groups, female and non-Female to distinguish the 4 male and 1 non-binary participant. Of the 31 participants 83.9 percent identified as female and 16.1 percent identified as non-Female. The average age was 32.26 years with the age range of 21-56.

An ANOVA was utilized for the first research questions and all four subscales of the CCSES showed non-significance. The second research question utilized an ANCOVA controlling for race, gender, and age. The second subscale of the CCSES, self-efficacy for counseling clients in specific types of crises, showed significance. Further analysis showed this significance was related to the covariate race. The final research question used a content analysis method and showed higher percentages of self-reported self-efficacy for students who did attend the trauma and crisis course versus those students who did not. Of the 11 participants who attended the trauma and crisis course, five participants reported confidence (45%), five reported moderate confidence (45%), and one participant reported low crisis counseling confidence (9%). Of the 20 participants who did not attend the course three participants reported confidence (15%), 11 reported moderate confidence (55%), and six participants reported low crisis counseling confidence (30%).

Findings

(RQ1): Is there difference in the crisis self-efficacy scores of CITs who took an online trauma and crisis course versus CITs from the same program who did not?

I began the inferential statistical tests by using an ANOVA on each of the four subscales for the first research question: Is there a difference in the crisis self-efficacy scores of CITs who took an online trauma and crisis course versus CITs from the same program who did not? ANOVAs seek to test if survey or experiment results are significant. In other words,

ANOVAs help users decide to accept or reject hypotheses (Glen, 2018). The ANOVA results were non-significant for all four subscales. I consequently rejected the alternative hypothesis for the first research question.

Specific Crisis Subscale

The first subscale (SC subscale) seeks to measure participants' confidence when working with clients experiencing specific types of crises. The ANOVA showed non-significance between the course and the first subscale (SC subscale), $F(1,29)=3.443$, $p=.074$, meaning that the intervention of the trauma and crisis course was not related to the crisis counseling self-efficacy. No further analysis was appropriate.

Basic Skills Subscale

The second subscale (BC subscale) seeks to measure participants' confidence in their ability to use a variety of basic counseling skills with those impacted by crisis. The ANOVA showed non-significance when measuring the trauma and crisis course as an intervention for crisis counseling self-efficacy, $F(1,29)=.224$, $p=.640$. No further analysis was appropriate.

Therapeutic Response Subscale

The third subscale (TR subscale) measures participants' therapeutic response to clients impacted by crisis. An ANOVA was performed and showed non-significance meaning that the intervention of the trauma and crisis course could not be reported to have significance for crisis counseling self-efficacy, $F(1,29)=1.762$, $p=.195$. No further analysis was appropriate.

Unconditional Positive Regard

The fourth subscale (UPR subscale) measures participants' comfort when using unconditional positive regard with crisis-impacted individuals. An ANOVA was performed and showed non-significance meaning that the intervention of the trauma and crisis course could not

be reported to have significance for crisis counseling self-efficacy, $F(1,29)=.672, p=.182$. No further analysis was appropriate.

The four ANOVAs did not show a significant difference between self-reported crisis counseling self-efficacy for the students who did and did not take the trauma and crisis course as measured by the four subscales. Consequently, the alternative hypothesis for the first research question was rejected.

(RQ2): Is there difference in the crisis self-efficacy scores of CITs' who took an online trauma and crisis course versus CITs from the same program who did not related to race, gender, and age with trauma and crisis?

The second research question controlled for the independent variables race, gender, and age on the average crisis counseling self-efficacy between the students who did and did not take the online trauma and crisis course. Is there difference in the crisis self-efficacy scores of CITs' who took an online trauma and crisis course versus CITs from the same program who did not related to race, gender, and age with trauma and crisis?

Specific Crisis Subscale

The first subscale (SC subscale) showed a significant result for higher reported crisis counseling self-efficacy, $F(1,26)=6.452, p=.017$. The students' who attended the online trauma and crisis course had a higher mean score of 4.083 (SD 1.508) versus the lower mean score of the participants who did not attend the course 2.957 (SD .934). Further analysis showed that race influenced the higher crisis counseling self-efficacy scores with the other group showing higher means. Race is the only covariate that showed significance, $F(1,26)=6.199, p=.020$. Counseling research literature shows that marginalized populations experience disproportionate amounts of trauma and crisis (Walters, 2020). This personal experience may lead to a sense of awareness

subsequently increasing rates of counseling confidence when working with trauma and crisis-impacted groups. The parameters table below shows reported significance.

Table 1

Parameter Estimates for SC Subscale

	<i>b</i>	SE	<i>t</i>	<i>p</i>	Lower Band	Upper Bound	Partial Eta Squared
Course	-1.126	.443	-2.540	.017	-2.037	-.215	.199
Age	-.004	.020	-.209	.836	-.046	.037	.002
Gender	.038	.573	.067	.947	-1.138	1.215	.000
Race	1.099	.442	2.490	.020	.192	2.007	.193

Basic Skills Subscale

The second subscale (BC subscale) showed non-significance, $F(1,26)=1.953$, $p=.174$. No further analysis was appropriate.

Therapeutic Response Subscale

The third subscale (TR subscale) showed non-significance, $F(1,26)=2.040$, $p=.165$. No further analysis was appropriate.

Unconditional Positive Regard

The fourth subscale (UPR subscale) also showed non-significance, $F(1,26)=.241$, $p=.627$. No further analysis was appropriate.

(RQ3): How do students feel about their capabilities to successfully support a client in crisis?

The survey also included a qualitative question. A content analysis allowed me to identify three categorical words as I moved from the students' broader statements to more specific

definitions that represented their perceived crisis and trauma counseling readiness. I separated the data set into two main categories: those who did and those who did not take the course. I then read, annotated, and categorized students from each data set into confident, moderately confident, and lowly confident based on their subjective responses. Of the 11 participants who took the trauma and crisis course, five students reported words and/or phrases that paired with feeling confident. Five CITs documented words and phrases that paired with feeling moderately confident. Only one CIT who took the trauma and crisis course used words or phrases that paired with the label of lowly confident in their capability to support someone in crisis.

Each response was carefully considered as I searched words and phrases that coalesced into the theme of confident, moderately confident, and lowly confident for each group. All responses are below. The first three subsets represent the students who did attend the trauma and crisis course while the second three subsets represent the students who did not attend the course. Each of the two groups are divided into: confident, moderately confident, and lowly confident. Content analysis is inherently reductive, and the process has human error. To accurately represent each participant, I have included all participants' verbatim responses using pseudonyms for confidentiality.

Each response was carefully considered as I searched words and phrases that coalesced into the theme of confident.

Table 2

Trauma and Crisis Course Participants Rated Confident

Anna	I honestly feel so much better about supporting a client with trauma after taking this class. Learning about what to do with a client with trauma and what NOT to do really opened my eyes. I learned about the therapeutic window, and how to pump the gas and the breaks in the session. I learned to watch for dissociation or numbing. I learned PTSD and C-PTSD. Additionally, I learned how important it is to let the brain heal itself
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	immediately after trauma occurs. And how to give proper psychoeducation to keep the client empowered and informed.
Phillip	I feel very confident in supporting a client in crisis, specifically because it doesn't seem as daunting as it did before taking the course. I realize that simply being there for a person in crisis as someone to listen, ensure safety, and minimize isolation can be so powerful.
Latasha	I feel confident in my ability to assist with more common crisis situations, provide psychological first aid, and assess/intervene in active suicidality. The trauma counseling course had high concordance with my previous training and elaborated on points of theory that increased my training self-efficacy.
Sean	My participation in 12-step programs gave me moderate confidence in dealing with people in crisis through experience. The Trauma and Crisis course led by Dr. Richards gave me much-needed tools and provided me with greater confidence to support a client in crisis.
Kendra (Clinical Psychology student)	I feel confident in my ability to assist with more common crisis situations, provide psychological first aid, and assess/intervene in active suicidality. The trauma counseling course had high concordance with my previous training and elaborated on points of theory that increased my training self-efficacy.

Five students' words and phrases implied a moderate level of trauma and crisis counseling readiness.

Table 3

Trauma and Crisis Course Participants Rated Moderately Confident

Sebastian	I feel more equipped to help others and my current clients since I am in practicum. I learned from the trauma and crisis course so many different modalities for treatment in relation to specific traumas. Further, I gained tools to create a safe space and help those in acute crisis.
Crystal	At this point, I think it is best to meet the client where they are at. You don't want to re-traumatize the client or over-function for them. Ultimately, I feel my capabilities are where they should be at this stage in my internship due to the experience at my site. The courses CACREP requires do not prepare us for crisis situations that we will inevitably see. The COUN 795 was informative, but it was

	too much information for one class. Ideally, this class would be broken up into more than one class.
Kimtrese	I feel more comfortable being present with a client in crisis, staying calm and responding to what they need in the moment. Also a client who experienced past trauma, I feel more confident in my abilities helping them stay grounded while also exploring past trauma
Albert	I feel adequate in my capabilities. Many of the courses touched on crisis but COUN 795 discussed specific crisis and specific groups.
Quinn	I am capable of active listening and paraphrasing to assist in validating the client. I am new to the field but I have a calm demeanor and that puts people at ease.

One student from the trauma and crisis course used words that implied low crisis counseling confidence.

Table 4

Trauma and Crisis Course Participant Rated Lowly Confident

Bret	I feel fairly confident in the knowledge of supporting a client, but without much or any practice it is hard to say I am confident in my capabilities of actually providing support.
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After analyzing the first data set for themes of confident, moderately confident, and lowly confident, I familiarized myself with the written data of the students who did not attend the course. I annotated and searched for similarity among the responses to find specific words and phrases that aligned with the themes. This took multiple rereads and content analysis steps while I searched for evidence of these categorical themes. Consequently, I found that of the twenty students who did not take the online trauma and crisis course, three CITs reported feeling confident to support an individual in crisis counseling.

Table 5

Non-Course Participants Rated Confident

Kyle	I feel really good about my supporting a client in crisis because I have received training in TF-CBT and I am always seeking helping from my peers and supervisors.
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Phillip	I still keep a book that was utilized during one of my classes about crisis I found it to be very helpful and great resource for my current and future practice. I work in an agency that deals with all sorts of trauma. Some clients who come in are in crisis mode. I am comfortable to say I have been well trained to manage such a situation and have a great book resource to go to when I need too
Jessica	I feel confident because I genuinely care a lot, so that will help me the most to support them in crisis.

With the content analysis, I found 11 CITs who did not attend the trauma and crisis course that noted feeling moderately confident of supporting an individual in crisis counseling.

Table 6

Non-Course Participants Rated Moderately Confident

Jennifer	I feel like I require more training because crises are very in depth and complex scenarios that would be easier to handle with intensive training. Touching on topic in other counseling coursework.
Cassandra	I feel that through first-hand experience at my practicum site, I have started learning how to support clients in crisis. Prior to this, I felt very "thrown in the deep end" and completely unprepared for handling trauma and crisis with clients.
Maddie	I feel that I still am working on my capabilities, but I do feel that I could do well with supporting them!
Carlos	I feel I am still a work in progress since I am still learning day by day how to be the best support system I can be. I will say that I feel confident enough to use what I have learned to help others.
Sue	I feel that I demonstrate empathy, active listening, reflection, and some practical work experience and work related training to support a client in crisis. Have the ability to maintain a calm demeanor and direct others in how to move forward with handling situations.
Brian	I personally feel more confident handling crises such as grief and loss because I have personally experienced those. However, I do not feel confident in how to best handle other crises I have never experienced (such as sexual assault). I do feel a fair amount of confidence in navigating a crisis such as SI, as I have encountered this multiple times in my internship.

Maddox	I feel I am knowledgeable about dealing with clients in crisis but we are not trained per se in Crisis Counseling and at this level there is still plenty of time to grow. I was and many others are required to do Psychological First Aid and I recently took this for a requirement of my Practicum site. So, I feel more confident than someone who hasn't recently taken the PFA training if that makes sense.
Montana	I feel pretty confident due to experience working in the mental health field before pursuing my Master's degree.
Preston	Although I have not had any formal training specific to supporting a client in crisis, I feel somewhat confident in my capabilities to support a client in crisis. Through my internship, I have had to deal with clients in crisis and feel that I have a core of practitioners to consult with concerning supporting clients in crisis to supplement the skills I have learned.
Kathleen	Throughout my program, I've learned to actively listen and the importance of this component to effectively assist a client. I believe my capabilities of building relationships and creating a safe space for clients increases retention.
Karli	I feel somewhat confident. We talked some about crisis in COUN 634 [Advanced Counseling and Psychotherapy Techniques], but only to a point.

Continued content analysis isolated words and phrases that alluded to six students who did not attend the trauma and crisis course expressing low crisis counseling confidence.

Table 7

Non-Course Participants Rated Lowly Confident

Deborah	I do not feel completely comfortable in my ability to do this. I believe that the classes I have taken have helped me with general, outpatient, private practice type clients, but not for more "intense" presentations. Most of my learning I feel has come from my practicum/internship experience which is where I first had to deal with clients in crisis and it was frightening. I did not feel like I had school material to fall back on at that time, instead, I had to contact my supervisors and learn from there.
Leigh	I feel under prepared we do not cover this in our course, and this makes it harder to handle these kind of topics.
Kyoto	I feel like I require more training because crises are very in depth and complex scenarios that would be easier to handle with intensive training.

Luke	I have not had an opportunity to intervene, so I do not know how I would react or what skills I would use.
Clayton	I am scared by the idea.
Skylar	I feel like I would be basically winging it.

These findings support previous research that shows increased self-efficacy post trainings and courses. These findings may also support that more hours dedicated to course assignments may improve self-efficacy, however, without a comparative group that has taken a course and one that has taken a weekend training or received information infused in established course content or curricula this cannot be determined from this study. While the crisis, trauma, and disaster literature is robust, few studies have measured course and training effectiveness in CPPs. This study supports the effectiveness of including a preparatory course to better prepare CITs in crisis and trauma education and training which may also include information specific to disaster.

The qualitative data in this study shows CITs words expressing more crisis counseling readiness post course versus the students who did not attend the course. The students who took the course had five CITs report feeling confident, five report feeling moderately confident, and one report feeling lowly confident. While the non-course students reported three feeling confident, 11 feeling moderately confident, and six students report feeling lowly confident in their ability to be able to support a client in crisis. The following table denotes the percentage of each group across confidence levels based on the content analysis showing a higher confidence report for the participants who attended the online trauma and crisis course despite the smaller sample size (11) compared to the 20 participants who did not attend the course.

Table 8

Comparison of Content Analysis Results by Percentage

Trauma and Crisis Course Participants	Non-Trauma and Crisis Course Participants
45% Confident	15% Confident
45% Moderately Confident	55% Moderately Confident
9% Lowly Confident	30% Lowly Confident

Additionally, the students who reported feeling lowly confident in the non-course group had more evocative statements such as “I feel like I would basically be winging it” and “I am scared by the idea [of supporting a client in crisis].” These statements exemplify a lack of crisis counseling readiness and concern for entering the field unprepared.

Summary

This chapter summarized the data results for the ANOVAs and ANCOVAs tests for the four Crisis Counseling Self-Efficacy Survey subscales. I found significance with the second research question in the first subscale related to race and higher reports of crisis counseling self-efficacy. This shows that independent factors regardless of course or training intervention may influence crisis counselor self-efficacy. The chapter concluded with a content analysis interpretation of the third research question which sought student’s written account of their perceived crisis counseling capability. This content analysis showed higher rates of self-reported crisis counseling self-efficacy for the students who did take the online trauma and crisis course versus those who did not. The content analysis also showed higher rates of reported unpreparedness of students who did not take the trauma and crisis course.

CHAPTER FIVE

DISCUSSION

This study aimed to discuss the relationship between crisis counseling self-efficacy of master's level counseling students who did and did not complete an online trauma and crisis course at Old Dominion University in the fall of 2021. In this chapter, I discuss the results and implications related to student demographics and to trauma and crisis education within counselor preparation programs. Finally, I end the chapter with a discussion of the study's limitations and provide suggestions for future research.

Population Demographics

Concerning the demographics of race and gender, the sample in the current study is comparable to other studies measuring perceived crisis counseling capability. The majority of similar studies used more homogeneous student samples. This homogeneity may lead to reoccurring study results and may not calculate some other influential factors such as race and gender when measuring intervention effectiveness. In all, I found six studies seeking to measure the perceived crisis counseling effectiveness post educational intervention (Gallo et al., 2019; Greene et al., 2016; Keller-Dupree, 2011; Murphey, 2004; Peters, 2017; Sawyer, 2013). Two studies were completed by the creators of the CCSES and both reported the highest diversity percentages among all the six studies (Peters et al., 2017; Sawyer et al., 2013). This is reflective of their university's diverse student body. Their race demographics show more variation than my study and similar gender demographics.

Another study by the same authors utilized a higher sample size of master's-level counseling students ($n = 171$). The sample was more racially diverse than my sample, but gender was comparable. Future studies may intentionally diversify student samples to research if and

possibly how race plays a role in crisis counseling self-efficacy. More purposeful study samples may show other factorial explanations for students self-reported crisis counseling self-efficacy. In the current study the ANCOVA showed race as an influential factor.

More diversified sample groups may help determine how race influences crisis counseling self-efficacy. With research reporting higher rates of crisis, trauma, and disaster within marginalized groups this might not be a surprise, but more precise studies may elucidate other explanations. Without more diverse study samples researchers unintentionally limit study results consequently limiting implications for future studies and providing readers with typical explanations that describe otherwise more complicated phenomena to readers. Researchers seek to explain phenomena, but without more diverse study samples, we only describe the experiences of some while often unintentionally omitted non represented participants.

ANOVA Subscale Discussion

All four ANOVAs from this current study showed non-significance. These results are different than six other studies measuring crisis counseling intervention effectiveness. One researcher used an ANOVA while the other five studies utilized means, standard deviations, and t-test results to illustrate significant differences between pre and post intervention (Gallo et al., 2019; Greene et al., 2016; Murphey, 2004; Peters, 2017; Sawyer, 2013). The ANOVA study found significant results with the researcher stating the results of the one-way, within-group, repeated measures ANOVA supported the hypothesis that school counselors-in-training reported a greater sense of preparedness to intervene in an unexpected crisis situations following the trauma and crisis training (Keller-Dupree, 2011). The 2011 study had 69 participants while the current study had 31 participants. The higher sample may have yielded significant results.

The current study concluded that the intervention of the online trauma and crisis course could not be reported to have significance for crisis counseling self-efficacy. It may, however, be attributed to a type II statistical error from the small sample size. When a power test was used with G*Power software to determine the most appropriate sample size at 0.05 alpha and 0.20 beta, or a power of 0.80, 128 students were suggested for this study. Due to the nature of the current study, that number of participants was impossible. The small sample size in this study provided low power and potentially imprecise estimates; therefore, it may have led to an inaccurate rejection of the alternative hypothesis.

ANCOVA Subscale Discussion

Further analysis showed the covariate ethnicity influenced the higher crisis counseling self-efficacy scores with the “other” group showing higher means. In other words, when controlling for age, race, and gender race is the only covariate that showed significance, $F(1,26)=6.199, p=.020$. This significant ANCOVA result may be attributed to a Type I statistical error for which significance is attributed to a variable that might have occurred by chance. This potential error would again be attributed to the small sample size. Type I errors occur when a statistically significant difference is observed, despite there being no difference in reality (McLeod, 2019). In other words, if something other than the intervention causes the significant outcome of the test, it can cause a "false positive" result where it appears the intervention acted upon the subject, but the outcome was caused by chance. While this is one possibility another explanation may also support this significant ANCOVA result as it relates to crisis and trauma impacting individuals from black, indigenous, and people of color groups.

Counseling researchers show that marginalized populations experience disproportionate amounts of trauma and crisis (Lantz et al., 2005; Taggart et al., 2021). This personal experience

may lead to a sense of understanding increasing rates of counseling confidence when working with trauma and crisis-impacted groups. Considering the current international pandemic and consequences thereof, researchers argue that survivors of childhood trauma and minority groups are at a greater risk for pandemic stress (Albaek, 2018; Aspira, 2017; Hughs, 2017; Van Der Kalk, 2013). Ethnic trauma results from the direct and indirect actions of racism and discrimination. Native American, indigenous communities, and the Black and Brown communities have disproportionately experienced discrimination and exploitation due to race (Aspira, 2017). Experiencing more trauma and crisis may lead to a sense of being prepared to address trauma and crisis symptoms in others, such as the ability to stay calm during heightened situations. Personal experience in this case may lead to an increased sense of trauma and crisis counseling capability.

Additionally, the SCSSubscale measured student's self-efficacy related to specific crisis situations. The students who took the course may have scored higher in this area as the course addressed specific examples, treatments plans, and case conceptualizations. This awareness may have increased as specific examples improved perceived capability to address categorical trauma and crisis examples versus a more holistic or broader conceptualization of trauma and crisis.

Content Analysis Discussion

Of the 11 students who did take the course, five CITs reported feeling confident, five reported feeling moderately confident, while only one reported feeling lowly confident compared to the non-course group. Higher rates of confidence post course and/or training have also been affirmed in other studies. Researchers Minton and Pease-Carter's (2011) preformed a content analysis on crisis, trauma, and disaster preparation in CPPs and found the breadth of content coverage, the greater amount of time devoted to crisis training, and specifically devoted to crisis

intervention or trauma-informed counseling assigned textbooks within stand-alone crisis intervention courses are unlikely to be mirrored when the CACREP standards are simply infused throughout CPPS course curricula. A few students spoke directly to the class as a crisis counseling contributing factor. While the sample size of the course-taking students is lower than the non-course sample, only one student reported a lowly crisis counseling confidence compared to six non-course students who reported a low crisis counseling confidence. This is important, as self-efficacy research shows that students who feel more confident are more likely to utilize trauma and crisis interventions (Becnel et al., 2021; Isawi & Post, 2020; Peters et al., 2017; Sawyers et al., 2013). Additionally, higher levels of counselor self-efficacy are typically linked to positive client outcomes and stronger therapeutic alliance while lower levels are not linked as strongly to positive client outcomes and the client-counselor relationship (VanAusdale & Swank, 2020).

The content analysis showed that of the twenty students who did not take the online trauma and crisis course, only three CITs reported feeling confident of supporting an individual in crisis counseling (15%). Eleven CITs noted feeling moderately confident of supporting an individual in crisis counseling (55%), and six CITs reported lowly crisis counseling confidence (30%). In comparison, while more students represent the non-course group, five participants from the sample of students who did attend the trauma and crisis course reported confidence (45%), five participants reported moderate confidence (45%), and only one student reported low confidence (9%). Researchers report increased crisis, trauma, and disaster readiness and increased reports of self-efficacy with more hours dedicated to the study and practice of domain specific content. Researchers have shown that CITs who took a crisis course in their CPPs reported higher levels of self-efficacy versus CITs who did not take a stand-alone course (Greene

et al., 2016; Morris & Minton, 2012). Morris and Minton's (2012) research study found that CITs who took a crisis course during their graduate programs reported higher levels of self-efficacy than students who did not take the stand-alone course. The authors also reported a positive correlation between the number of hours of crisis preparation and higher levels of crisis self-efficacy (2012). In other words, the number of crisis preparation clock hours was positively correlated with higher levels of crisis counseling self-efficacy for students who did take a crisis course.

While crisis, trauma, and disaster counseling research has emphasized the need for an increased infusion of crisis, disaster, and trauma competencies into counselor training, it is also important to examine the effectiveness of instructional methods for enhancing this education in counselor preparation programs (Greene et al., 2016; Morris & Minton, 2012). To date, many studies (Chatters et al., 2020; Guo et al., 2016; Lu et al., 2017; Montague et al., 2020) have investigated the prevalence of various trauma and crisis courses and trainings in preparation programs, and research continues to advocate for increased courses and trainings by expressing the prevalence and inevitability that students will work with trauma and crisis impacted individuals or groups. Yet limited empirical research exists on the effectiveness of these courses and trainings in counselor preparation programs. My extensive literature search found only six studies measuring crisis counseling course or training effectiveness (Gallo et al., 2019; Greene et al., 2016; Keller-Dupree, 2011; Murphey, 2004; Peters, 2017; Sawyer, 2013).

The more prepared someone feels, the greater their reported self-efficacy. This may mean as a counselor's self-efficacy improves so does their performance which is often intervening on behalf and supporting their clients which takes initiative (Sawyer et al., 2013). Consequently, several researchers are calling for an investigation into the course content and CE delivery

methods to assess effectiveness and self-efficacy after different delivery methods (Adams, 2019; Dean, 2016; Guo et al., 2016; Nickerson et al., 2014). Self-efficacy has been linked to many processes including motivation, emotion regulation, and consequently improvements in coping behaviors, manageable stress reactions, and resiliency. Resiliency here meaning that self-efficacy offers a protective perspective through which novel information is seen as a challenge versus as obstacle.

Implications

This study found that race may influence crisis counseling self-efficacy. More specifically it may be due to the disproportionate amount of crisis, trauma, and disaster individuals from Black, Brown, and indigenous communities are more likely to experience higher accounts of crisis, trauma, and disaster which may lead to a sense of preparedness. This hypothesis needs to be further studied. Perhaps a replication of this study will confirm higher rates of self-efficacy related to race incentivizing a closer examination. When the current study controlled for race to assess the effectiveness of the trauma and crisis course, the ANCOVA showed significant results implying that participants of diverse racial backgrounds (i.e., Black, Indigenous, and People of Color), regardless of the course intervention, led to reports of higher crisis counseling self-efficacy compared to the larger White group of students. Additionally, the content analysis affirmed previous literature which shows an increase in confidence post course or educational training (Binkley, 2018; Greene et al., 2016; Keller-Dupree, 2011; Murphy, 2004; Sawyer et al., 2013; Peters et al., 2017). The content analysis showed that more students who took the course reported crisis counseling confidence compared to the non-course students. This was reported via students open-ended question responses. For smaller studies, perhaps a mixed methods approach is more sensitive for qualifying overall results. The sample size was small and

this may explain the ANOVA non-significant results; however, the content analysis showed that the course intervention did influence crisis counseling self-efficacy as self-reported by the students.

Limitations

This research study had several limitations. The design is a retrospective non-experimental. The study results might have been stronger with pre- and post- measures. The sample size was also small. Additionally, the survey might have received more participants if the students were permitted to complete during class time versus being posted on Blackboard for the students to complete during their personal time. The sample might have been collected from other universities as well versus being bound to Old Dominion University procuring a larger student sample and ideally a more diverse sample. Additionally, I would have liked to complete the data collection at the end of the fall semester when the trauma and crisis course concluded. Many of the participants completed the survey after starting practicum and thus their field work experiences may have influenced their trauma and crisis counseling preparedness. Also, without any course prerequisites students started with varying amounts of crisis, trauma, and disaster education training, and my inclusion criteria allowed for a varying student sample including a clinical psychology student who attended the COUN 795 course. I also would change the wording of the open-ended survey question from assessing the students perceived capability to successfully “support” a client in crisis to perceived capability to “counsel” a client in crisis. Some responses implied that if basic counseling skills are mastered, a counselor can help trauma and crisis-impacted groups and this thinking may have been attributed to my open-response question. Finally, the content analysis might have stronger reliability with multiple readers or raters, and a research team of multiple raters will be used in a recreation of this study.

Other limitations include the broad topic of crisis, trauma, and disaster. While there is much overlap there are also distinguishing features and consequently different knowledge and skills sets for each. The study used crisis, trauma, and disaster terms and yet the self-efficacy is designed to assess crisis counseling and the course was designed to teach trauma and crisis. The intent was to provide a background of the development of crisis, trauma, and disaster standards within the field of counselor preparation to speak to current trends of CITs being unprepared, but I believe the information might have been better researched and organized by considering only crisis since a crisis self-efficacy scale was used, or only trauma and crisis since the course focused on each. I also wonder how the ODU online trauma and crisis course might have been different in the classroom versus online. This may not be a limitation, but it is something to consider as we continue to measure course effectiveness. A final limitation is the modification of the second subscale caused when I omitted the last two questions in the original survey from the Qualtrics survey.

Future Research

I plan to repeat this study with other researchers, advocating for in-class time to complete which I believe will increase participant numbers. I plan to start the study at the beginning of the semester and end that same semester. This study's data collection extended into the following semester. I will also ensure all questions from the CCSSES four subscales are in the survey and will seek professional consultation when designing open-ended questions to measure crisis counseling capability more specifically.

The ANCOVA results of this study found race to be an influential factor in crisis counseling self-efficacy. This supports researchers' literature that shows minority groups experience more acts of crisis, trauma, and disaster. It is worth including more minority groups

into studies assessing crisis, trauma, and disaster counseling self-efficacy. This may mean comparing students from predominantly White counselor preparation programs to predominantly Black, Brown, or Indigenous schools that would likely have higher rates of minority students and consequently individuals who have experienced more crisis, trauma, and/or disaster in their counselor preparation programs. Additionally, more research may examine self-efficacy and skill acquisition. Tests measuring crisis counseling effectiveness post course or training may help differentiate skills students studied and which skills students later felt competent using as licensed therapists.

Other ideas include measuring the constructs of crisis, trauma, and disaster separately which may mean also creating a self-efficacy scale for trauma counseling and disaster counseling. A final research suggestion is to continue evaluating crisis, trauma, and disaster education and training for effectiveness. There are many conceptual papers on these topics in counseling; however, there are just a few studies that attempt to measure the delivery method's effectiveness. There are even fewer studies that test skills acquisition versus perceived capability like this study has attempted to measure. Additionally, to date, this study is the only study I know that used a comparison group. This may be added to research ideas, not only measuring effectiveness with one group, usually a pre and post intervention design, but also having a comparison sample to measure intervention effectiveness.

Summary

This chapter discussed the three research questions and the study results in relation to current counselor education and self-efficacy research. Suggestions were made for future research and implications for CEs and CITs were offered.

CHAPTER SIX

Publication for the Journal of Traumatic Stress

Implications from a Non-Experimental Study Measuring the Effectiveness of a Crisis and Trauma Counseling Course

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Abstract

The field of trauma and crisis is growing and relevant to all counseling specialties, highlighting it as a needed area of research for improved core crisis, trauma, and disaster education and training of counselors in training (CITs) in counselor preparation programs (CPPs). This non-experimental study design uses the Crisis Counselors Self-Efficacy Scale (CCSES) to assess counseling students' self-reported self-efficacy, or perceived capability to work with crisis-impacted clients, post completion of an online trauma and crisis course. The comparative group from the same master's program did not register for the online trauma and crisis course. The results may help to inform counselor educators (CEs) and other professionals of the effectiveness of including stand-alone crisis, trauma, and disaster courses in CACREP accredited CPP.

keywords: Crisis, trauma, CACREP, counselors in training, counselor education, Self-Efficacy, Crisis Counselors Self-Efficacy Scale (CCSES)

Implications from a Non-Experimental Study Measuring the Effectiveness of a Crisis and Trauma Counseling Course

Researchers note that counselor education should continue to develop and strengthen crisis, trauma, and disaster training to meet the inevitable needs of future counselors in mental health, school, community, college, and family for crisis, trauma, and disaster services. Most counselors and counselors in training (CITs) will encounter clients in crisis situations and/or clients who have experienced trauma (Guo et al., 2016; Jacobs et al., 2016; Pau et al., 2020). Considering the updated 2009 and 2016 CACREP standards, along with the pervasive impact of crisis, trauma, and disaster for clients and communities, it is imperative to understand how CEs integrate trauma training into their curricula to meet accreditation standards and how programs are measuring crisis, trauma, and disaster course/ training effectiveness to ensure necessary entry-level preparedness.

Therefore, this research study aims to add to the sparse literature measuring crisis and trauma course and training effectiveness for CITs in counselor preparation programs (CPPs) by measuring the relationship between CITs trauma and crisis training and self-reported crisis counseling self-efficacy to peers in the same program who did not take the online trauma and crisis course. This study provides data about whether CITs' crisis self-efficacy may improve after a trauma and crisis course. Using a validated instrument for specifically measuring counselors' crisis counseling self-efficacy may serve as a reference point to future CPPs that are considering the necessity of including crisis, trauma, and disaster into current curricula and/or how to enhance the learning and training through various content delivery options such as a stand-alone course.

Literature Review

Since 2009 crisis, trauma, and disaster have been mandated learning standards required by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) for all accredited counselor preparation programs. This was partially due to the attention received by counselors serving as responders following Hurricane Katrina. Counselors' feedback revealed a need for the incorporation of crisis training into counselor preparation programs. Subsequently, crisis intervention techniques were included in the 2009 revision of the CACREP standards. These new requirements specified the inclusion of crisis, trauma, and disaster counseling preparation in CACREP counseling programs by embedding related educational content into established counseling courses such as addiction and lifespan development (Adams, 2019; Chatters & Liu, 2020) versus a core stand-alone course.

While some CEs embed or infuse crisis, trauma, and disaster content into CPPs others provide stand-alone courses (Guo et al., 2016; Morris & Minton, 2012). Researchers have shown that a stand-alone crisis, trauma, and disaster course based on the 2009 CACREP standards resulted in significant improvements in students pre- and post-crisis informed knowledge (Sawyer et al., 2013). Stand-alone crisis counseling courses may ensure that beginning counselors enter their field work sites with more security in their beliefs that they are able to handle crisis situations. After all, counseling students who participated in coursework that studied a variety of theoretical strategies for resolving crises, provided better intervention models for clients in crises situations (Montague et al., 2020; Morris & Minton, 2012; Peters et al., 2017).

Perceived self-efficacy helps to account for such diverse phenomena as changes in coping behavior produced by different modes of influence, level of physiological stress reactions, self-

regulation of refractory behavior, resignation and despondency to failure experiences, self-debilitating effects of proxy control and illusory inefficaciousness, achievement strivings, growth of intrinsic interest, and career pursuits. The more prepared someone feels, the greater their self-efficacy. Researchers have also identified a relationship between counselor self-efficacy and performance (Gallo et al., 2019; Keller-Dupree, 2011). This means as a counselor's self-efficacy improves so does his or her performance (Sawyer et al., 2013).

This is important because self-efficacy is a complex concept that has been widely researched and measured in many domains such as physics, mathematics, nursing, academic achievement, and counseling and as of recently crisis counseling. Self-efficacy was researched heavily by Alfred Bandura. This social cognitive theory is Bandura's seminal work for its transferability to many domains and its predictability of success. Self-efficacy theory essentially posits that one's belief in their ability to perform certain tasks contributes to the potential of positive outcomes.

Bandura also noted the value of measuring self-efficacy in each domain to better understand what specifically is required to improve self-efficacy in that academic or professional domain: "Additionally, efficacy beliefs should be assessed at the optimal level of specificity that corresponds to the criterial task being assessed and the domain of functioning being analyzed" (Bandura, 1994, p. 26). Thus, the current study measured the self-reported self-efficacy of CITs after taking an online trauma and crisis course versus students from the same program who did not take the course. Assessing the preparedness of CITs to start field work and later residency is important to help CPP see the importance of including these courses in their curricula.

Context

In Fall of 2021 Old Dominion University (ODU) in Norfolk, Virginia offered an online trauma and crisis course in their masters CPP. This course was elective and thus not all students from the program completed the course. This is the first trauma and crisis course offered at ODU. It was elective without any prerequisites, and many of the attending students were already practicing in practicum and internships. According to the syllabus there were several components to the course such as required reading from three textbooks that specifically addressed trauma and crisis. Students were informed that completion of the assigned readings were necessary for completing case presentations and class discussions. Readings were to be completed prior to class for in-class discussions and participation. Additionally, the syllabus informed students about the sometimes unexpected emotions that may surface during the trauma and crisis course due to potential psychological and emotional triggers. The syllabus states that discomfort and anxiety should be expected during the course.

CITs will need to learn how to tolerate and work with intense emotions. These emotions may be their own and/ or the clients. Students were encouraged to seek out-of-the-class help as needed. Students were also encouraged to share personal reactions to the courses content and related assignments but only if the student felt comfortable doing so, disclosure was not required. Other course requirements included a self-care plan, discussion preps, and case conceptualizations. The case conceptualizations included treatment plans and reflections. The final two trauma and crisis course components included a midterm and final as well as a reflection paper.

The Study

This study utilized a non-experimental post-test design to see if a relationship existed between self-reported crisis self-efficacy of Counselors-in-training (CITs) who took a stand-alone online trauma and crisis course thus showing course effectiveness and those who did not. Instrumentation included a valid and reliable measure: the Counselor's Crisis Self-Efficacy Scale (CCSES) (Peters et al., 2017). The CCSES is sectioned into four subscales included 1) working with individuals experiencing specific crises, 2) basic counseling skills, 3) therapeutic response, and 4) unconditional positive regard. This study's results may offer a reference point for educational leaders currently seeking to add crisis, trauma, and disaster into their CPPs or to better understand the importance of enhancing trauma and crisis training and education into their existing crisis, trauma, and disaster delivery methods and encourage measuring outcomes.

The current study used the following three research questions to guide the research process:

(RQ1): Is there difference in the crisis self-efficacy scores of CITs who took an online trauma and crisis course versus CITs from the same program who did not?

(H_a): Those who took the course show higher self-efficacy than those who did not.

(RQ2): Is there difference in the crisis self-efficacy scores of CITs' who took an online trauma and crisis course versus CITs from the same program who did not related to race, gender, and age with trauma and crisis?

(H_a): Those who took the course show higher self-efficacy than those who did not after controlling for race, gender, age.

(RQ3): How do students feel about their capabilities to successfully support a client in crisis?

Method

Using a non-experimental, posttest design, the study was bound by sampling only master's level students enrolled at Old Dominion University (ODU) in Norfolk, Virginia fall 2021. Students from the same CPP who completed the stand-alone crisis course versus those who did not will report crisis counseling self-efficacy. The COUN 795 course did have one non-degree seeking and one graduate clinical psychology student enrolled. The graduate clinical psychology student did participate in this study. While pseudonyms were used to conceal identity, the psychology student's response was labeled to distinguish from CITs responses. Additionally, due to non-experimental design, I calculated the confounding independent variables of demographic information (race, gender, and age) and prior trauma and crisis experience/ training for analysis inclusion. I imported data into SPSS 20 from an Excel document for further analysis. Percentages, means, and standard deviations were used to assess post-differences in participant responses regarding self-efficacy for counseling a client experiencing a crisis. An ANOVA and ANCOVA were calculated for each subscale of the CCESE for the first two research questions to determine whether a difference existed between students' crisis counseling self-efficacy scores who did and who did not take the online trauma and crisis course and determine if there was a difference in reported self-efficacy between students who did and not attend the trauma and crisis course when controlling for race, age, and gender. Results showed whether CITs differed in crisis counseling self-efficacy and whether those differences were reflected by race, gender, age, and years of experience with trauma and crisis. Difference was determined at the .05 level because of the small sample size, as determined by the availability of data, i.e., students who took the online trauma and crisis course. The final research question was qualitative and content analysis procedure was used for data analysis.

Participants

All but one of the participants were master's level students (CITs) in the Counseling Program at Old Dominion University. All participants were 18 years of age and older. The inclusion criteria included master's level students who a) completed COUN 795 in Fall 2021, and b) students enrolled in COUN 669 (practicum), COUN 667 (internship in mental health counseling), and COUN 668 (internship in school counseling) in Spring 2022. Sixteen students completed the COUN 795 trauma and crisis elective course that was offered for the first time within ODU's master's counseling program during Fall 2021. Eleven of those students participated in this study. This inclusion included one graduate-level Clinical Psychology student who attended the COUN 795 course. In all, there were 62 students who met inclusion criteria, thus there were 46 non-course students of which 20 participated in this study. All of whom were CITs. I compared students' levels of crisis self-efficacy using a valid and reliable instrument that measures multiple variables (work with individuals experiencing crisis, basic counseling skills, therapeutic response, and unconditional positive regard). The following is a description of the instrument and its metrics.

Procedure

IRB consent was obtained prior to conducting the study. Recruitment occurred with the help of the Counseling Department's current Graduate Clinical Coordinator, who is also a member of the dissertation committee. She identified the master's students (CITs) in their Spring 2022 semester ($N = 62$), including those who took the online trauma and crisis course offered in Fall 2021 ($n = 16$) and sent an email to their instructors. She electronically distributed the letter of introduction with the Qualtrics survey link attached for the teacher to offer them the option to

participate in the study. The informed consent document was included in the Qualtrics Crisis Self-Efficacy instrument.

Students were unable to complete the survey in class as originally planned as the CCSES and final qualitative questions may have taken some students 30 minutes to complete. Instead of shortening the survey and potentially losing rich qualitative information I sent both sets of students, those who took the course and those who did not, three email reminders throughout the semester to complete the survey. I waited until the first week of the following semester to collect data in the hopes of having more participants complete the survey. During the summer semester 2022 I closed data collection. Eleven students who took the trauma and crisis course completed the survey, and twenty who did not attend the course completed the survey. Demographic characteristics were collected including race, gender, age, and years of experience with trauma and crisis work. Confidentiality and anonymity were maintained by securing the participants' data in a password protected Qualtrics account, as well as on a password protected flash drive.

Students' participation in the study was not linked to their grades and consequently did not affect their grades in any way as their instructors did not see their responses. Additionally, when reporting this study's qualitative research question results pseudonyms were used. The qualitative data makes the study richer by providing the students' own words, however, for security all the names have been changed.

Measures

Once collected, the survey data was downloaded and entered into SPSS for data analysis. The data was cleaned and analyzed to account for missing information. I began by conducting descriptive statistics to test for normality and homogeneity, identify any outliers, and assess the appropriateness of the path analysis model. I assessed for normality and homogeneity.

Descriptive statistics summarized the data and included a correlation matrix of all the variables in the model. Typically, in non-experimental studies data is used to show a possible relationship (Morris & Wester, 2018).

Descriptive statistics were conducted to identify means and standard deviations, and to determine if outliers, skewness, or kurtosis are present. Cronbach alphas were performed to illustrate correlation between survey questions. The Cronbach alphas for each subscale were above .90 illustrating a high correlation. While the original CCSES is a 42-item questionnaire, I made the mistake of omitting two questions from the second subscale, however, the Cronbach alphas for each subscale were still strong. By correlated the subscales I found the MANCOVA was not the best technique. The threshold is .7 and correlation between subscales TR and SC measured .783 and subscales BR and SC measured .667. This high correlation determined that a MANOVA and MANCOVA were not viable tests for this small sample size. This was confirmed with the Wilk's Lambda non-significant value, $F(4, 112) = 13.74$, $p < .0005$; Wilk's $\Lambda = 0.450$, partial $\eta^2 = .33$.

The Wilk's Lambda measures the percent variance in dependent variables that is not explained by differences in levels of the independent variable (Glen, 2018). A value of zero is ideal and it means that there isn't any variance not explained by the independent variable. The alternative hypothesis is rejected when Wilk's lambda is close to zero, although this should be done in combination with a small p-value. Larger sample differences would need to be represented in this study's sample set for the MANOVA and MANCOVA to determine the effects of the independent categorical variables on the multiple continuous dependent variables.

To determine the difference in self-reported crisis counseling self-efficacy between CITs who did and did not take the online elective trauma and crisis course, the ANOVA was used to

assess relationships between two or more groups, while the ANCOVA calculated the difference between the students who did and did not take the online trauma and crisis course and to find difference based on the demographics race, age, and gender. The ANOVA and ANCOVA measured differences in the four subscales: 1) specific crisis, 2) basic counseling skills, 3) therapeutic response to crisis and post-crisis, 4) and unconditional positive regard. Due to the small sample size the statistical tests ANOVA and ANCOVA were most appropriate. Statistical significance was determined at the .05 level because of the small sample size, as determined by the availability of data, i.e., students who took the trauma and crisis course.

The subscales were the dependent variables, the trauma and crisis course were the fixed factor, gender and ethnicity were fixed factors while age was a covariate. Covariates can be used in many ANOVA and ANCOVA analysis designs – such as between-subjects, within-subjects (repeated measures), mixed (between – and within – designs) etc. The ANCOVA test seeks to answer the question: Are mean differences or interactive effects likely to have occurred by chance after scores have been adjusted on the dependent variable or because of the effect of the covariate (Tabachnick, 2013).

Content Analysis

To analyze and interpret the collected data from the qualitative research question I used content analysis. Content analysis is a research tool used to determine the presence of certain words, themes, or concepts present within qualitative data (Columbia University, 2019). This research method offers a clear, flexible structure for systematically evaluating and categorizing subjective data, and can be used with a wide variety of data sources, including textual data, visual stimuli, and audio data (Stemler, 2015). Using content analysis, researchers can quantify

and analyze the presence, meanings, and relationships of such certain words, themes, or concepts. (Columbia University, 2019).

Originally founded by Harold Lasswell, this research method's central concern is for the analysis of the "symbolic environment" and its consequences for human behavior (Janowitz, 1968). It is used widely among social researchers. Specifically, Lasswell (Janowitz, 1968) used content analysis to quantify political communication and to objectify the psychoanalytic interview. Consequently, content analysis can be used for making inferences from content back to the original communicator, in which case the analyst or researcher is concerned with understanding the communicator (Janowitz, 1968).

Content analysis has persisted through the years, and more recent research provides specific content analysis steps. Columbia University (2019) offers eight steps: 1) Decide the level of analysis: word, word sense, phrase, sentence, themes, 2) Decide how many concepts to code for, 3) Decide whether to code for existence or frequency of a concept, 4) Decide on how you will distinguish among concepts, 5) Develop rules for coding your texts, 6) Decide what to do with irrelevant information, 7) Code the text, and 8) Analyze your results: draw conclusions and generalizations where possible. This ongoing content analysis allowed me to move from the students' broader statements to a more specific categorical definitions that represents their perceived crisis and trauma counseling readiness.

Results

Data Analysis After cleaning data for missing scores and transforming constructs race and gender into numerical values I utilized the normality test Shapiro-Wilk and Levene's Test of Equality of Error Variances, identified any outliers, and assessed the data's appropriateness.

Assumptions

Normality tests were calculated as well as skew and kurtosis. I used the Shapiro-Wilk test to determine if the dependent variables were normally distributed. For three of the subscales normality was assumed (SCScale $SW(31) = .955, p = .210$; BSSubscale $SW(31) = .942, p = .093$; TRSubscale $SW(31) = .958, p = .263$). The UPRSubscale assumption was violated, $SW(31) = .918, p = .021$. However, the skew and kurtosis values for the UPRSubscale were within normal limits. Of the four subscales only one showed high kurtosis. The kurtosis for the Specific Crisis subscale (SC Scale) showed high kurtosis (1.184). All other subscales had a normal distribution for skewness and kurtosis. The skewness for the BSsubscale variable was found to be .475 and kurtosis was found to be -.651. The skewness for the TRSubscale variable was found to be -.087 and kurtosis was found to be -.214. The skewness for the UPRSubscale variable was found to be -.149 and kurtosis was found to be -1.141. Levene's test showed non-significance for all subscales (SCSubscale $F(7,23) = 1.55, p = .200$; BSSubscale $F(7,23) = .69, p = .681$; TRSubscale $F(7,23) = 1.01, p = .451$; UPRSubscale $F(7,23) = .88, p = .540$).

Descriptive Statistics

Thirty-one master's level counseling students completed the Counselor's Crisis Self-Efficacy Scale. Of those students, 11 completed an online trauma and crisis course in Fall 2021 at Old Dominion University, while the other 20 students attending the counseling program that semester did not take the course. Due to the small sample size students were placed into binary identification groups for gender and race. Of the 31 participants 64.5 percent identified as White and 35.5 percent identified as other. For gender 83.9 percent identified as female and 16.1 percent identified as other. The average age was 32.26 years with the age range of 21-56.

Hypothesis Testing

(RQ1): Is there difference in the crisis self-efficacy scores of CITs who took an online trauma and crisis course versus CITs from the same program who did not?

(H_a): Those who took the course show higher self-efficacy than those who did not.

I began the inferential statistical tests by using an ANOVA on each of the four subscales for the first research question: Is there a difference in the crisis self-efficacy scores of CITs who took an online trauma and crisis course versus CITs from the same program who did not? ANOVAs seek to test if survey or experiment results are significant. In other words, ANOVAs help users decide to accept or reject hypotheses (Glen, 2018). The ANOVA results were non-significant for all four subscales. I consequently rejected the alternative hypothesis for the first research question.

Specific Crisis Subscale

The first subscale (SC subscale) seeks to measure participant's confidence when working with clients experiencing specific types of crises. The ANOVA showed non-significance between the course and the first subscale (SC subscale), $F(1,29)=3.443$, $p=.074$, meaning that the intervention of the trauma and crisis course was not related to the crisis counseling self-efficacy. No further analysis was appropriate.

Basic Skills Subscale

The second subscale (BC subscale) seeks to measure participant's confidence in their ability to use a variety of basic counseling skills with those impacted by crisis. The ANOVA showed non-significance when measuring the trauma and crisis course as an intervention for crisis counseling self-efficacy, $F(1,29)=.224$, $p=.640$. No further analysis was appropriate.

Therapeutic Response Subscale

The third subscale (TR subscale) measures participants therapeutic response to clients impacted by crisis. An ANOVA was performed and showed non-significance meaning that the intervention of the trauma and crisis course could not be reported to have significance for crisis counseling self-efficacy, $F(1,29)=1.762, p=.195$. No further analysis was appropriate.

Unconditional Positive Regard

The fourth subscale (UPR subscale) measures participants comfort when using unconditional positive regard with crisis-impacted individuals. An ANOVA was performed and showed non-significance meaning that the intervention of the trauma and crisis course could not be reported to have significance for crisis counseling self-efficacy, $F(1,29)=.672, p=.182$. No further analysis was appropriate.

The four ANOVA's did not show a significant difference between self-reported crisis counseling self-efficacy for the students who did and did not take the trauma and crisis course as measured by the four subscales. Consequently, the alternative hypothesis for the first research question was rejected. The second research questions required and ANCOVA to control for race, age, and gender.

ANCOVA

(RQ2): Is there difference in the crisis self-efficacy scores of CITs' who took an online trauma and crisis course versus CITs from the same program who did not related to race, gender, and age with trauma and crisis?

(H_a): Those who took the course show higher self-efficacy than those who did not after controlling for race, gender, age.

The second research question controlled for the independent variables race, gender, and age on the average crisis counseling self-efficacy between the students who did and did not take the online trauma and crisis course.

Specific Crisis Subscale

The first subscale (SC subscale) showed a significant result for higher reported crisis counseling self-efficacy, $F(1,26)=6.452, p=.017$. The mean of the students who took the online trauma and crisis course vs those who did not was 4.083 (SD 1.508) versus 2.957 (SD .934). Further analysis showed that race influenced the higher crisis counseling self-efficacy scores with the other group showing higher means. Race is the only covariate that showed significance, $F(1,26)=6.199, p=.020$. Counseling research literature shows that marginalized populations experience disproportionate amounts of trauma and crisis. This personal experience may lead to a sense of understanding increasing rates of counseling confidence when working with trauma and crisis-impacted groups. The parameters table showing significance is below.

Table 1

Parameter Estimates for SC Subscale

	<i>b</i>	SE	<i>t</i>	<i>p</i>	Lower Band	Upper Bound	Partial Eta Squared
Course	-1.126	.443	-2.540	.017	-2.037	-.215	.199
Age	-.004	.020	-.209	.836	-.046	.037	.002
Gender	.038	.573	.067	.947	-1.138	1.215	.000
Race	1.099	.442	2.490	.020	.192	2.007	.193

Basic Skills Subscale

The second subscale (BC subscale) showed non-significance, $F(1,26)=1.953$, $p=.174$. No further analysis was appropriate.

Therapeutic Response Subscale

The third subscale (TR subscale) showed non-significance, $F(1,26)=2.040$, $p=.165$. No further analysis was appropriate.

Unconditional Positive Regard

The fourth subscale (UPR subscale) also showed non-significance, $F(1,26)=.241$, $p=.627$. No further analysis was appropriate.

Content Analysis

(RQ3): How do students feel about their capabilities to successfully support a client in crisis?

The qualitative data was coded with labels of confident, moderately confident, and lowly confident after a content analysis where I searched for words and phrases that described their perceived level of capability. Of the 11 students who did take the course five CITs reported feeling confident. Five CITs reported feeling moderately confident. Only one CITs reported feeling lowly confident in their capability to support someone in crisis. A few students spoke directly to the class as a crisis counseling contributing factor.

Anna (took the trauma and crisis course) said:

“I honestly feel so much better about supporting a client with trauma after taking this class. Learning about what to do with a client with trauma and what NOT to do really opened my eyes. I learned about the therapeutic window, and how to pump the gas and the breaks in the session. I learned to watch for dissociation or numbing. I learned PTSD and C-PTSD. Additionally, I learned how important it is to let the brain heal itself immediately after trauma occurs. And how to give proper psychoeducation to keep the

client empowered and informed.”

Phillip (took the trauma and crisis course) said:

“I feel very confident in supporting a client in crisis, specifically because it doesn't seem as daunting as it did before taking the course. I realize that simply being there for a person in crisis as someone to listen, ensure safety, and minimize isolation can be so powerful.”

Latasha (took the trauma and crisis course, Clinical Psychology Student) said:

“I feel confident in my ability to assist with more common crisis situations, provide psychological first aid, and assess/intervene in active suicidality. The trauma counseling course had high concordance with my previous training and elaborated on points of theory that increased my training self-efficacy.”

The other students attributed their confidence to previous and current training in practicum and internships. One student noted the value of a trauma and crisis textbook assigned in their first COUN 633 counseling skills course. One student noted feeling “adequate” and that trauma and crisis were only mentioned in other counseling courses in the counseling program and the course discussed trauma and crisis more specifically.

Of the twenty students who did not take the online trauma and crisis course three CITs reported feeling confident to support an individual in crisis counseling. Eleven CITs noted feeling moderately capable of supporting an individual in crisis counseling, and six CITs reported low crisis counseling confidence.

Derek (did not take the trauma and crisis course) said:

“I feel really good about my supporting a client in crisis because I have received training in TF-CBT and I am always seeking helping from my peers and supervisors. I am currently enrolled in Practicum 669.”

Desiree (did not take the trauma and crisis course) said:

“I do not feel completely comfortable in my ability to do this. I believe that the classes I have taken have helped me with general, outpatient, private practice type clients, but not for more "intense" presentations. Most of my learning I feel has come from my practicum/internship experience which is where I first had to deal with clients in crisis and it was frightening. I did not feel like I had school material to fall back on at that time, instead, I had to contact my supervisors and learn from there. The only training/education received was from the advanced techniques class where crisis was very briefly discussed. I did not take the COUN 795 Trauma and crisis course.”

Jennifer (did not take the trauma and crisis course) said:

“I feel like I require more training because crises are very in depth and complex scenarios that would be easier to handle with intensive training. Touching on topic in other counseling coursework”

Leigh (did not take the trauma and crisis course) said:

“I feel under prepared we do not cover this in our course and this makes it harder to handle these kind of topics. In a classroom setting it was the crisis intervention book and trauma book in our advance techniques course however they were not a focal point. Outside of the classroom I learned through doing practicum/internship in an IBH setting and asking our supervisors questions.”

Some CITs also attributed their confidence to prior education and/ or training.

Derek (did not take the trauma and crisis course) said:

“I feel really good about my supporting a client in crisis because I have received training in TF-CBT and I am always seeking helping from my peers and supervisors. I am currently enrolled in Practicum 669.”

Maddie (did not take the trauma and crisis course) said:

“I feel that I still am working on my capabilities, but I do feel that I could do well with supporting them! In practicum”

Some responses were mixed expressing a moderate crisis counseling capability

Carlos (did not take the trauma and crisis course) said:

“I feel I am still a work in progress since I am still learning day by day how to be the best support system I can be. I will say that I feel confident enough to use what I have learned to help others. I’m in practicum.”

Table 2

Comparison of Content Analysis Results by Percentage

Trauma and Crisis Course Participants	Non-Trauma and Crisis Course Participants
45% Confident	15% Confident
45% Moderately Confident	55% Moderately Confident
9% Lowly Confident	30% Lowly Confident

Discussion

This study’s significant ANCOVA result may be attributed to a Type 1 statistical error for which significance is attributed to a variable that might have occurred by chance. This potential error may be attributed to the small sample size. Type I errors occur when a statistically

significant difference is observed, despite there being no difference in reality (McLeod, 2019). In other words, if something other than the intervention causes the significant outcome of the test, it can cause a "false positive" result where it appears the intervention acted upon the subject, but the outcome was caused by chance. While this is one possibility another explanation may also support this significant ANCOVA result.

Counseling researchers show that marginalized populations experience disproportionate amounts of trauma and crisis (Lantz et al., 2005; Taggart et al., 2021). This personal experience may lead to a sense of understanding increasing rates of counseling confidence when working with trauma and crisis-impacted groups. Ethnic trauma such as those experienced by Native American communities, the Black and Brown communities, and others result from experienced discrimination and exploitation due to race (Aspira, 2017; Bell et al., 2013; Green et al., 2021). Experiencing more trauma and crisis may lead to a sense of being prepared to address trauma and crisis symptoms in others, such as the ability to stay calm during heightened situations. Personal experience in this case may lead to an increased sense of trauma and crisis counseling self-efficacy.

Concerning the demographics of race and gender, the sample in the current study is comparable to other studies measuring perceived crisis counseling capability. The majority of similar studies used more homogeneous student samples. This homogeneity may lead to reoccurring study results and may not calculate some other influential factors such as race and gender when these demographics. In all, I found six studies seeking to measure the perceived crisis counseling effectiveness post educational intervention (Gallo et al., 2019; Greene et al., 2016; Keller-Dupree, 2011; Murphey, 2004; Peters, 2017; Sawyer, 2013). Two studies were completed by the creators of the CCSSES and both reported the highest diversity percentages

among all the six studies (Peters et al., 2017; Sawyer et al., 2013). This is reflective of their university's diverse student body.

More purposeful study samples may show other factorial explanations for students self-reported crisis counseling self-efficacy. To date this study may be the only research study measuring crisis counseling self-efficacy with a comparative group versus pre and post-test design. In the current study the ANCOVA showed race as an influential factor. This may lead to other studies seeking to determine how race influences crisis counseling self-efficacy. With research reporting higher rates of crisis, trauma, and disaster within marginalized groups this might not be a surprise, but more precise studies may elucidate other explanations. Without more diverse study samples researchers unintentionally limit study results consequently limiting implications for future studies and providing readers with typical explanations that describe otherwise more complicated phenomena to readers. Researchers seek to explain phenomena but without more diverse study samples we only describe the experiences of some while often unintentionally omitted non represented participants.

Additionally, the SCSSubscale measured student's self-efficacy related to specific crisis situations. The students who took the course may have scored higher in this area as the course addressed specific examples, treatments plans, and case conceptualizations. This awareness may have increased as specific examples improved perceived capability to address categorical trauma and crisis examples versus a more holistic or broader conceptualization of trauma and crisis. Of the 11 students who did take the course, four CITs reported feeling confident. Six CITs in the current study reported feeling moderately confident. One CITs who took the trauma and crisis online course reported feeling lowly confident in their capability to support someone in crisis. A few students spoke directly to the class as a crisis counseling contributing factor. This is

important as self-efficacy research shows that students who feel more confident are more likely to utilize trauma and crisis interventions (Becnel et al., 2021; Isawi & Post, 2020). Additionally, 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).

Of the twenty students who did not take the online trauma and crisis course, three CITs reported feeling confident to support an individual in crisis counseling. Eleven CITs noted feeling moderately confident of supporting an individual in crisis counseling, and six CITs reported low crisis counseling confidence. This research supports other trauma and crisis counseling research that has shown CITs who took a crisis course in their CPPs reported higher levels of self-efficacy versus CITs who did not take a stand-alone course (Greene et al., 2016; Morris & Minton, 2012).

While crisis, trauma, and disaster counseling research has emphasized the need for an increased infusion of crisis, disaster, and trauma competencies into counselor training it is also important to examine the effectiveness of instructional methods for enhancing this education in counselor preparation programs (Greene et al., 2016; Morris & Minton, 2012). To date, studies have investigated the prevalence of various trauma and crisis courses and trainings in preparation programs, and research continues to advocate for increased courses and trainings by expressing the prevalence and inevitability that students will work with trauma and crisis impacted individuals or groups. Yet limited empirical research exists on the measured effectiveness of these courses and trainings in counselor preparation programs. Researchers confirm that self-efficacy as a measurement is important for predicting utilization of trauma and crisis interventions, and the number of crisis preparation clock hours is positively correlated with higher levels of crisis counseling self-efficacy.

Summary

There remains a clear need to increase crisis, trauma, and disaster education within CPP even if this increase is not a stand-alone class more hours of trauma and crisis might be embedded or infused throughout curricula prior to field placements. Since the first 2004 study I found, few studies have sought to measure the effectiveness of trauma and crisis courses and other interventions within counseling programs. Consequently, several researchers are calling for an investigation into the course content and CE delivery methods to assess effectiveness and self-efficacy after different course content delivery methods to better understand and ensure the preparedness of future counselors to work with the inevitable trauma and crisis impacted individuals and populations they will serve. Additionally, when evaluating effectiveness diverse student samples may possibly underscore other potential factors leading to crisis counseling self-efficacy beyond the course content intervention. This may also be achieved with comparative study sample designs.

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Appendix A

Counselor's Crisis Self-Efficacy Scale

1. Work with (i.e. refer, counsel, support) a Client Experiencing a Specific C...

	No Confidence At All	A Little Confidence	A Fair Amount of Confidence	Much Confidence	Very Much Confident	Complete Confidence
1. Initiate and sustain empathetic, culturally sensitive, non-judgmental, disciplined relationships with clients in crisis.						
2. Utilize knowledge to plan for intervention for client in crisis.						
3. Intervene effectively with individuals in crisis.						
4. Intervene effectively with families in crisis.						
5. Effectively debrief with groups impacted by crisis.						
6. Maintain self-awareness in practice, recognizing your own personal values and biases, and preventing or resolving their intrusion into practice.						
7. Critically evaluate your own practice, seeking guidance appropriately and pursuing ongoing professional development.						
8. Practice in accordance with the ethics and values of the profession.						
9. Define the client's crisis related problems in specific diagnostic terms.						
10. Collaborate with clients-in-crisis in setting intervention goals.						
11. Define crisis related treatment objectives in specific terms.						
12. Effectively terminate counseling relationships.						
13. Maintain professional boundaries during, and after crisis related						

Counselor's Crisis Self-Efficacy Scale

intervention.

14. Utilize non-violent crisis intervention skills to promote the care, welfare, and safety of both the client and the helper.



15. Employ personal care after a crisis so as to reduce secondary traumatization or burnout.



3. Therapeutic Response to Crisis and Post-Crisis

Please rate your confidence in your current ability to successfully complete the following tasks.

[illegible]

Counselor's Crisis Self-Efficacy Scale

4. Unconditional Positive Regard

Please rate your confidence in your current ability to successfully complete the following tasks.

	No Confidence At All	A Little Confidence	A Fair Amount of Confidence	Much Confidence	Very Much Confident	Complete Confidence
1. Utilize reflection to help clients feel understood.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Utilize reflection to help clients feel validated.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Employ empathy to help clients feel that they can trust you.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Provide emotional support and safe holding environment for clients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Help clients feel like they are safe to share emotions with you.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Validate client successes to increase their self-confidence.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Appendix B

COUN 795 Trauma and Crisis Counseling Course Syllabus

Fall 2021 (Aug 28 – Dec 10)

Thursdays 4:20 – 7:00 pm

Online Weekly

All students are required to read and have a thorough understanding of the syllabus.

There may be several times in which personal narratives, stories, and videotaped material depicting or discussing violence, trauma, and/or trauma-related symptoms are presented in class or assigned as homework. Therefore, course material is inherently sensitive and may activate personal issues.

Students should carefully assess if they are currently able to face the emotional challenge of this material at the current time.

Purpose

The purpose of this course is to provide an overview of trauma therapy to include some of the major contexts within traumatization often occurs and consider the intersecting roles of race, class, gender and power in those contexts. Students will learn about the conceptualization/assessment, amelioration/treatment, and prevention of psychological distress and trauma.

While you may learn about yourself and reflect on your experiences, *this course is NOT a substitute for psychotherapy.*

CACREP Required Competencies:

Section 2. Professional Counseling Identity

F. 3. g. effects of crises, disasters, and other trauma-causing events on persons of all ages

F. 5. a. theories and models of counseling

F. 5. f. counselor characteristics that influence the counseling process

F. 5. m. crisis intervention, trauma-informed, and community-based strategies, such as

Psychological First Aid

F. 7. c. procedures for identifying trauma and abuse and for reporting abuse

Section 5. Clinical Mental Health Counseling

C. 2. f. impact of trauma and crisis on individuals with mental health diagnoses

Required Texts

Briere, J. N., & Scott, C. (2015). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment* (2nd ed.). Sage Publications, Inc. ISBN: 978-1-4833-5124-7

Ford, J. D., & Courtois, C. A. (Eds.). (2020). *Treating complex traumatic stress disorders in adults: Scientific foundations and therapeutic models* (2nd ed.). The Guilford Press. ISBN: 978-1-4625-4362-5

Levers, L. L. (Ed.). (2012). *Trauma counseling: Theories and interventions*. Springer Publishing Company, LLC. ISBN: 978-0-8261-0683-4

Reading assignments in red will be provided on Bb.

Student Responsibilities and Conduct

Completion of the assigned readings is a necessary prerequisite for meaningful participation in case presentations and class discussions. Therefore, students are expected to complete the assigned readings prior to each class. Discussion and participation are expected.

It is expected that all class members, professor, and any teaching assistants, will treat one another with respect in all discussions. It is of utmost importance that we observe and discuss matters raised in this course with empathic consideration and courtesy for everyone involved.

Psychological trauma involves strong, unpleasant emotions. This holds true both for those who are traumatized, and for those who work with traumatized persons. The content of this course may have a strong emotional impact on you at times, especially if you have experienced one or more traumatic events personally (as most people have). Even those of you who have not personally experienced some type of trauma may feel anxious or uncomfortable at times with some of the material in this course. To be clear: it is expected you will experience discomfort and anxiety during this course.

As counselors in training, it is imperative that class members learn how to tolerate and work with intense affect, including your own. It is expected that students will struggle, learn, and seek help as needed.

Please be aware: despite being a licensed professional counselor, my role in this course is as professor. Teaching assistants, if available for this course, may also be practicing counselors outside of class; however, for the purpose of this course, their role is to teach, not counsel.

If it is observed that a student is unable to cope with the material, having troubling reactions, and/or otherwise unable to engage in the discussions and assignments fully, faculty may approach the student to consider receiving additional support and/or dropping the course.

As part of the learning process, some disclosure of personal reactions and how they are experienced and managed may be invited and encouraged. Please feel free to share, if it feels safe for you do so. Disclosure is not required. You do not need to disclose anything in class or to the professor in which you are not comfortable sharing.

Students do not have the right to engage in behavior which is disruptive or inappropriate in the classroom (e.g. hostility, sarcasm or any form of disrespect, including verbal or nonverbal expressions, shown toward any of the class members or the instructor). Faculty do have the right to immediately confront any student causing disruptive or inappropriate behavior, and request cessation of the behavior. Should any student choose not to respond to a request to cease disruptive or inappropriate behavior, the faculty member can request that the student leave the classroom to prevent further disruption to the class. Disruptive students are reported to the vice president for student services and to the university hearing officer for disciplinary action under the Code of Student Conduct.

The Code of Student Conduct applies to online behavior as well as in-person or classroom behavior. You are expected to be professional and respectful when attending class on ZOOM.

Course Requirements

All materials, unless otherwise specified, submitted for evaluation will be assessed on their adherence to assignment guidelines, grammar, style, clarity, and depth of reflectiveness. Grammar and spelling are mandatory. Poor grammar usage or misspelled words will seriously detract from your grade.

Unless otherwise specified, all assignments should be submitted on Blackboard.

*No late submissions will be accepted unless prior arrangements with the instructor have been made. Please turn all assignments in on time. Assignments should be turned in on Blackboard one hour prior to class on the day the assignment is due.

Class Format

We will meet during our regular class time using the ZOOM meeting platform. You should register using the link sent as an announcement via Bb. The weekly ZOOM meeting will be utilized to review the assigned chapter reading and apply the information to a case scenario. Attendance and participation are required for points. The following etiquette is expected:

- Stay focused. Please stay engaged in class activities. Close any apps on your device that are not relevant and turn off notifications.
- Turn on your video when possible. It is helpful to be able to see each other, just as in an in-person class.
- Keep it clean. Remember that, even though you may be alone at home, your professor and classmates can SEE you!
- Be aware of your surroundings. Your professor and classmates can also see BEHIND you. Make sure that there is nothing in the background (traffic, other people, a pile of laundry) that may distract from the class. You can employ a Virtual Background to hide what you don't want seen.
- Be in a quiet place when possible. Find a quiet, distraction-free spot to log in. Turn off any music, videos, etc. in the background.

- Mute your microphone when you are not talking. This helps eliminate background noise.
- Raise your hand and wait to be called upon. If you wish to speak, either physically raise your hand or use the "Raise Hand" button at the center of the bottom of your screen. Once the professor calls on you, unmute yourself and begin speaking. When you have finished speaking, indicate you are done by saying something like "That's all" or "Thank you" and then mute your microphone again.
- Stay on topic. Side conversations are very distracting. Please do not use the chat window for questions and comments; I'd prefer you to just unmute and make your comment or ask your question. Further, the chat window is not a place for socializing or posting comments that distract from the course topic.

Graded Assignments

Self-Care Plan

Complete a self-care plan and submit to Blackboard within the first week of class; due no later than Sept 9th at 3:20 pm. Respond to the following prompts:

- What are your current known triggers/antecedents for distress?
- What do you anticipate being a trigger for distress during this course?
- What do you recognize arises physically, mentally, and emotionally when you are experiencing distress?
- What strategies and resources do you have available to care for each of the following domains of self: physical, cognitive/mental, emotional, spiritual, relationship, academic?
- What might get in the way of you taking care of your Self this semester?
- What negative strategies do you need to avoid?
- What are the benefits if you implement your strategies and engage your resources for self-care?

Discussion Preps

Discussion preps (DPs) are notes that you take while completing the assigned reading for each class. DPs should be entered into Blackboard each week and submitted no later than one hour prior to class (3:20 pm). In these notes you will (1) briefly summarize the ideas that are most interesting to you and (2) list any concerns, thoughts, reactions, and/or questions you have about the material.

You should bring your DP with you to each class to facilitate discussion of topics that you found most interesting or perplexing.

If your DP is very well written (without grammar or spelling difficulties), and shows you read and successfully comprehended the readings, you will earn full credit (i.e., all 25 points). I grade these reflections with only three levels of points: 25, 10 or 0. I will not accept any late reflections (unless you have written documentation of an unavoidable emergency). These will provide an excellent review for the exam and for class discussions.

You need only do 8 of the 10 offered reflections. I will not accept extra reflections.

Mid-Term/Final

It is expected that the student are prepared each week by having read the material assigned by the instructor. The Mid-Term and Final will be available via Bb and should be completed on the date assigned.

Case Conceptualization

This assignment requires students to apply relevant theories and research to clinical “cases” depicted in characters from one of the selected feature films:

Araki, G. (Director). (2004). *Mysterious Skin* [Film]. Fortissimo Films; Antidote Films; Desperate Pictures.

Weir, P. (Director). (1993). *Fearless* [Film]. Warner Bros. Pictures.

With permission from the professor, the student may select a different film or book. This assignment is NOT a summary of the film.

You may submit all three sections together on Bb under “Case Conceptualization: All 3 Sections Together” or submit separately. PLEASE do not submit twice.

Part 1. Worth 75 points. A conceptualization that includes the following:

- Summarize the presenting problems and symptoms (not the plot).
- Analyze whether/which DSM-5 diagnoses are appropriate.
- Discuss the etiological, developmental, and cultural factors influencing the experience and expression of symptoms.

Part 2. Worth 100 points. Create a Treatment Plan for the case that includes the following:

- Describe relevant research findings and theoretical approaches.
- Provide a list of symptoms/concerns for treatment (i.e. behaviorally define the symptoms for treatment).
- Identify the client’s strengths and resources.
- Recommend research-supported assessment(s) to use for this client.
- Create short-term and long-term treatment goals and corresponding objectives. Please note: *The Crisis Counseling and Traumatic Events Treatment Planner* can be used as a guide; however, goals and objectives must be individualized and tailored to the client.
- The detailed theory and research based strategies, techniques, and intervention approaches that will be used to achieve the treatment goals.

Part 3. Worth 75 points. A reflection that includes:

- Questions or concerns that should be taken into account with this client and the therapeutic approach selected.
- Any countertransference reactions the student anticipates that might be encountered in working with this client.

Reflection Paper

Reflect on the following questions and write out your responses using complete sentences and appropriate formatting: what has been the most challenging information to learn or hear about this semester? What has been the most inspiring to learn about? How does what you have learned about trauma change you, the way you relate to others, and the way you view the world?

Attendance

Attendance is an integral part of learning and reflection. Students are expected to be in class at the start of class and remain until the end of class. Students who come in late or leave early may receive partial attendance credit dependent on the quality and quantity of material missed. Students whose absence or tardiness affects the quality of their work or the work of the class may be given a lower grade at the discretion of the faculty instructor.

Participation

Throughout the semester students will engage in discussions and case study analyses in class. It is expected that the student will come to class prepared by having read the assigned chapters or material assigned by the instructor. Students are expected to participate in class discussions, demonstrating knowledge gained from the reading. Points are awarded for engagement each week, asking questions of others, sharing information, attentiveness, and professional communication with peers and instructor. A person who clearly does not participate in discussions and activities may lose participation points. The criteria used to evaluate class participation will be:

- a) Attendance as described above
- b) Quality of participation (e.g., integration and consideration of course readings)
- c) Respect for others' views and lived experiences
- d) Balancing verbal contributions in class with active listening to classmates
- e) Professionalism during the class. This includes, but is not limited to, visibly not paying attention or sleeping during class, etc.

Grading

A combination of objective and subjective evaluation procedures will be employed; the stress will be on fairness to all. The distribution of weight given to graded components of the course:

1.	Self-Care Plan	50 points
2.	Discussion Preps	200 points
3.	Mid-term	150 points
4.	Case Conceptualization	250 points
5.	Final Exam	150 points
6.	Reflection paper	50 points

7. Participation and Attendance Grade	150 points
TOTAL	1000 points

Assignment Criteria

The general criteria for evaluation of assignments is as follows:

1. Organization – Evidence of a logical and meaningful consistency in the structure of the response to the structure of the assignment. Evidence of planned presentations having a clear flow from the beginning, through the middle, to the conclusion.
2. Completeness – Evidence of having covered all parts of the assignment in the response.
3. Content – Evidence of having developed the response from significant concepts and insights gained from the readings and citing sources in APA form and style as appropriate.
4. Relevance – Maintenance of pointed and clear relationships in response to the assignment, avoidance of digression from the main points of assignment, avoidance of boilerplate or filler material, and avoidance of redundant matter and educational jargon.
5. Cogency – Depth and breadth of insight, reasoning, and understanding exhibited in response through the integration of thought and argument.

Grades will be assigned as follows:

92.51 – 100%:	A
90 – 92.5%:	A-
88.5 – 89.99%:	B+
82.51 – 88.49%:	B
80 – 82.5%:	B-
78.5 – 79.99%:	C+
72.51 – 78.49%:	C
70 – 72.5%:	C-
68.5 – 69.99%	D+
62.51 – 68.49%:	D
60 – 62.5%	D-
59.99 and Below:	F

A = EXCEPTIONAL – Student's performance consistently exceeds the usual expectations and is outstanding in a number of areas.

B = VERY GOOD – Student's performance is consistently above average in most areas.

C = SATISFACTORY – Student consistently performs at an acceptable level in all areas.

F = FAILURE – Student has not demonstrated the level of knowledge, values and skills appropriate for the course.

I = INCOMPLETE – The grade of Incomplete (I) presupposes that the student is doing passing work, but because of illness or another emergency situation which is beyond the student's control, is

unable to complete all course requirements by the end of the semester.

W = WITHDRAW – The grade of Withdrawn (W) indicates that the student has officially withdrawn from the course after the first week and before the end of the eighth week of the semester.

Students who withdraw must reapply for a later semester.

“I pledge to support the Honor System of Old Dominion University. I will refrain from any form of academic dishonesty or deception, such as cheating or plagiarism. I am aware that as a member of the academic community it is my responsibility to turn in all suspected violations of the Honor Code. I will report to a hearing if summoned. “

Accommodating Students with Special Learning Needs

Old Dominion University is committed to ensuring equal access to all qualified students with disabilities in accordance with the Americans with Disabilities Act. The Office of Educational Accessibility (OEA) is the campus office that works with students who have disabilities to provide and/or arrange reasonable accommodations.

- If you experience a disability which will impact your ability to access any aspect of my class, please present me with an accommodation letter from OEA so that we can work together to ensure that appropriate accommodations are available to you.
- If you feel that you will experience barriers to your ability to learn and/or testing in my class but do not have an accommodation letter, please consider scheduling an appointment with OEA to determine if academic accommodations are necessary.

The Office of Educational Accessibility is located at 1021 Student Success Center and their phone number is (757) 683-4655. Additional information is available at the OEA website: <http://www.odu.edu/educationalaccessibility/>

Course Timeline

	Date	Reading(s)	Class Topic(s)	Assignments Due
1	Sept 2	Trauma Counseling Ch 30, 31 & 32	Syllabus Review Ethics Vicarious traumatization Therapist self-care	

2	Sept 9	Principles of Trauma Therapy Ch 1 & 2 Treating Complex PTSD Ch 1	History of Trauma Diagnosis What is Trauma? The effects of trauma DSM trauma diagnoses Complex PTSD	Self-Care Plan
3	Sept 16 <i>(Yom Kippur)</i>	Trauma Counseling Ch 4, 8, 9, & 27	Assessment of PTSD and associated symptoms The neurobiology of trauma reactions Effects of trauma on development	DP
4	Sept 23	Cultural Competence in Trauma Therapy Ch 1 – 3 Trauma Counseling Ch 17 & 18	Cultural context and cultural competency in trauma treatment Racial and ethnic intolerance Sexual and gender prejudice	DP
5	Sept 30	Principles of Trauma Therapy Ch 11 Trauma Counseling Ch 22 & 26	Acute Trauma Treatment Psychological First Aid Terrorism, Disaster Suicide Assessment/High Risk Clients	DP <i>(Consider turning in C.C. Part 1)</i>
6	Oct 7	Trauma Counseling Ch 7 & 25	Sexual trauma War	DP
7	Oct 14	The Evil Hours Ch 6	Discussion of Chapter 6	Mid Term
8	Oct 21	Principles of Trauma Therapy Ch 4, 5, 6	Building and maintaining the therapeutic relationship Challenges Safe trauma therapy	DP
9	Oct 28	Principles of Trauma Therapy Ch 7, 8, 9	Cognitive Interventions Emotional Processing Increasing Identity and Relational Functioning	DP
10	Nov 4	Treating Complex PTSD Ch 18 & 25;	Affect Regulation Mindfulness	DP

		Principles of Trauma Therapy Ch 10		
11	Nov 11	Treating Complex PTSD Ch 9, 10, 17	Prolonged Exposure Therapy Cognitive Therapy	DP
12	Nov 18	Cognitive Behavioral Therapies Ch 6 & 7	Dialectical Behavioral Therapy Acceptance and Commitment Therapy	DP
	Nov 25		NO CLASS - Thanksgiving	
13	Dec 2	Treating Complex PTSD Ch 13, 23, 24	EMDR Sensorimotor Experiential	DP
14	Dec 9	Treating Complex PTSD Ch 14, 15, 16	Narrative Exposure Emotion Focused Interpersonal Review of Case Conceptualizations	Case Conceptualization
15	Due before Dec 16		Final Exam	Final Exam & Reflection

The syllabus, scheduled topics, formats for assignments, and readings may be adjusted over the course of the semester.