

APA GUIDELINES on Trauma Competencies for Education and Training

APPROVED BY APA COUNCIL OF REPRESENTATIVES
FEBRUARY 2025



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This policy describes competencies that serve as aspirational goals for psychologists. It is meant to guide training programs' curriculum development and psychologists' self-monitoring. This policy is in no way intended to create an enforceable standard of practice, particularly for psychologists already trained and practicing in the field. Nor is it intended to limit the ability of psychologists to practice within their scope of licensure under state law, or to limit coverage, reimbursement, or credentialing by third-party payors for psychological services within that scope of licensure.

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Preamble

Exposure to trauma is pervasive worldwide and is associated with wide-reaching costs to society, making it a significant global public health issue (Davis et al., 2022; Magruder et al., 2017). A comprehensive model of trauma-focused empirically informed competencies (knowledge, skills, and attitudes) was developed at a national consensus conference at Yale University in 2013 and was approved by the American Psychological Association (APA) in 2015 as part of APA's education and training policy. This document represents a revision to those competencies for approval and renewal by the APA. The revised competencies put forth here are intended as aspirational goals for education and training for practice in the United States. The competencies and associated essential components and behavioral anchors for trauma psychology articulated here were developed based upon the following guiding assumptions:

- Competencies are defined as knowledge, skills, and attitudes.
- The competencies are recommendations for a psychologist at entry level to practice in the United States.
- All trauma psychologists who seek to practice at the entry level are encouraged to demonstrate acquisition of these core competencies.
- The competencies assume that the general competencies for professional psychology have been attained.
- There are several models for trauma-informed and trauma-focused mental health practice. The proposed competencies and essential components are not specific to any one model, but rather outline competencies for all trauma-related psychology practice regardless of model.

Five broad competencies were articulated, each with a subset of knowledge, attitudes, and skills to achieving proficiency in each area. In addition, 11 cross-cutting competencies were incorporated into the final product. The cross-cutting competencies represented areas of knowledge, skills, and attitudes that may be considered foundational to all other competencies, including issues such as individual and cultural diversity, incorporation of lifespan factors, and practitioner self-awareness and self-care. We first include the cross-cutting competencies below and then present the five broad competency domains.

Guidelines on Trauma Competencies for Education and Training

Recommended Cross-Cutting Competencies

1. Demonstrate the ability to appreciate and understand the impact of trauma on a wide range of health outcomes, problems, and disparities across time. This includes psychological and physical health, as well as social and occupational/school functioning and quality of life. This competency incorporates understanding that integrated and trauma-informed care are critical components of equitable care for people who have experienced trauma.
2. Demonstrate basic understanding of the biology of stress (e.g., the Hypothalamic-Pituitary-Adrenal [HPA] axis, autonomic nervous system, stress hormones) and the social factors that contribute to trauma (e.g., oppression, alienation, etc.).
3. Demonstrate understanding about trauma reactions and tailor trauma treatments and assessments in ways that respect and account for individual, familial, cultural, intergenerational, community, social, organizational, and systemic factors. This includes understanding of how historically marginalized groups are not well represented in the empirical and clinical literatures, including in the areas of assessment and treatment. This competency also includes demonstrating the ability to identify and understand the professionals' and clients' intersecting identities (e.g., gender, gender identity and gender expression, age or developmental stage, sexual orientation and identity, able-ism status, race, culture/ethnicity, neurodiversity, social class/socioeconomic status [SES], military status or other subcultural affiliations, rural/urban location, immigration, refugee, or asylum seeker status, religious/spiritual beliefs, national origin, Indigenous heritage, language, political viewpoints) as related to likelihood of trauma exposure and associated symptom expression. This competency includes striving for cultural humility while articulating and addressing professionals' own biases, assumptions, and problematic reactions emerging from trauma work and their intersectional (e.g., cultural) differences.
4. Demonstrate the ability to consider and apply an equity, diversity, and inclusion (EDI) framework in all aspects of trauma work (e.g., understanding how targeted violence toward the client based on group identity and membership may be traumatizing). This competency includes how treatment delivery may need to be modified according to the client's needs for identity status (including disability), accessibility, cultural congruence, and their (preferred) mode of engagement and differential goals and outcome. Professionals attend to the ways diversity interacts with systems of care and provider communication with and about the client.
5. Demonstrate understanding of how trauma affects an individual, the family system (including children, siblings, parents, grandparents, other caregivers, extended family members), friends, co-workers/colleagues, members of the community, educational institutions, and organizations' sense of safety and trust. Professionals apply a stance of empathy and understanding as part of their professional demeanor and behave in ways that enhance the physical and psychological safety of all. This competency includes respecting autonomy, identities, and culture of those exposed to trauma and protecting these individuals as appropriate.
6. Demonstrate understanding and ability to tailor assessment and interventions to account for developmental lifespan factors at the time(s) and over the course of the trauma and across points of current contact. Demonstrate the ability to understand, assess, and tailor assessment, diagnosis, and treatment approaches that address the complexities of trauma-related exposure, including any immediate/initial, and short- and long-term effects (e.g., psychiatric comorbidities; betrayal, shame, and other negative emotions; functional impairment; housing-related issues; work/school-related or interpersonal difficulties), and person-environment interactions (e.g., running away from home, being assaulted, becoming involved in criminal legal situations).
7. Demonstrate the ability to appreciate, assess, and integrate strengths, resilience, and potential for growth in individuals who have experienced trauma. Facilitate shared decision-making and a collaborative approach between the individual who has experienced trauma and the psychologist. In other words, respect the individuality, self-determination, and agency of the individual who has experienced trauma and work with them toward recovery and increased functionality.
8. Demonstrate the ability to recognize and address individual and external factors that might affect practitioners'

(a) capacity for self-reflection and tolerance for intense affect and content, including hearing trauma accounts and maintaining professional boundaries in a manner that facilitates disclosure and healing; (b) ethical responsibility for self-care; (c) self-awareness of how one's own history, values, and vulnerabilities impact trauma treatment delivery; and (d) ability and willingness to seek supervision and consultation, peer support, or continuing education and training as needed. Promote provider self-care and resilience.

9. Demonstrate the ability to appreciate the diversity of approaches to understanding and defining trauma and related definitions and terms (e.g., national and international diagnostic systems). Understand the importance of staying current with new developments in the field of traumatic stress studies, trauma treatment and trauma policy. Demonstrate the ability to critically evaluate and apply up-to-date available science on research-supported assessment strategies and treatments for trauma-related disorders/difficulties. Providers should critically evaluate methods/therapeutic practices in light of current scientific evidence and advocate for empirical study.
10. Demonstrate the ability to understand the value and purpose of the various professional, paraprofessional, and lay responders in trauma work and demonstrate the ability to work collaboratively within and across systems to enhance positive outcomes.
11. Demonstrate the ability to communicate scientific knowledge about trauma effectively and accurately to a broad range of audiences and stakeholders, including those individuals, communities, and organizations affected by trauma. Scientific knowledge includes current guidelines and evidence of current and emerging treatments.

Recommended Broad Core Competencies

RECOMMENDED SCIENTIFIC KNOWLEDGE

1. Demonstrate understanding of the epidemiology of traumatic exposure and outcomes, specifically:
 - a. Prevalence and incidence of trauma types, risk and resilience factors, and trauma response trajectories.
 - b. Specific considerations related to subpopulations (e.g., children, adolescents, young and middle-aged adults, older adults; gender diverse/non-binary individuals; veterans; civilians; racial and religious marginalized individuals and communities; immigrants, refugees, and asylum seekers; individuals with disabilities; first responders;

journalists) and settings (e.g., acute care, primary care, community-based or specialized mental health, military or veteran, forensic, criminal legal, refugee camps).

2. Demonstrate basic knowledge of trauma-related terminology, as well as research findings related to mechanisms, models, and interactions among social, psychological, and neurobiological factors (e.g., relational, developmental, cognitive, affective, economic, genetic/epigenetic, health and health behaviors). This includes current research on dissociation as well as the impact of trauma exposure on memory processes, discontinuous memory, or delayed recall of trauma memories.
3. Demonstrate understanding of the social, historical, and cultural context in which traumatic events and trauma-related distress are experienced, researched, assessed, and treated. This includes basic understanding of how the field of trauma psychology was founded and developed.
4. Demonstrate the ability to critically review the methodology, conclusions, and applicability of the published literature on trauma and posttraumatic stress disorder (PTSD) by employing general knowledge (e.g., statistics, research design, critical thinking) as well as trauma-specific knowledge (e.g., terminology, theory, epidemiology, biology).
5. Demonstrate understanding of the study of other emerging modalities (e.g., wearable technology, novel medications, telehealth, developing artificial intelligence tools).

RECOMMENDED PSYCHOLOGICAL ASSESSMENT

1. Demonstrate a willingness and skill to ask about trauma exposure and reactions with all clients, including those with both trauma and non-trauma focused presentations (neither avoiding nor engaging in suggestive/leading questioning about trauma experiences) to accurately diagnose PTSD and other trauma-related conditions.
2. Be familiar with and utilize evidence-based and validated measures. Demonstrate the ability to conduct a thorough assessment of distinct types of trauma exposure and trauma impact based on the most current available evidence base, including validated measures. The measures should be reliable and valid, demonstrating strong psychometric properties for the characteristics of the individual or population (e.g., age/developmental level; language; culture; SES; need for assessment and/or accommodations).
3. Demonstrate awareness of and capacity to modify procedures, processes, and interpretations related to the unique impacts of trauma (e.g., dissociation, avoidance,

trauma reminders, hyperarousal, potential mistrust of providers and medical systems) as they affect assessment.

4. Demonstrate the ability to understand the course and trajectory of trauma responses and tailor assessment accordingly. Demonstrate knowledge that functional impairments (e.g., work, caregiving, school, social/leisure activities) are critical in trauma-informed and related assessments, and that these are not discovered by standardized testing; comprehensive interviews are needed for this aspect of the assessment.
5. Demonstrate the ability to assess strengths, resilience, and growth and integrate those into conceptualizing the client, clinical care, and treatment goals where appropriate.
6. Demonstrate awareness of test interpretation issues frequently encountered in trauma-exposed populations (e.g., whether the test was normed in those who experienced trauma, item sensitivity and specificity, appropriate use of validity scales, response styles, motivation, environmental contexts, the use of behaviorally anchored trauma measures).
7. Demonstrate the ability to assess the extent to which cultural beliefs and practices influence the expression of, reactions to, and coping with trauma exposure, including barriers to accessing and engaging with treatment.
8. Demonstrate knowledge about the practical consequences of trauma-related assessment and diagnosis in different contexts (e.g., social services, military, forensic, education, tribal or refugee healthcare settings).
9. Demonstrate the ability to tailor the trauma assessment, self-report measures, interview questions, and other assessment tasks to client characteristics (e.g., abilities, culture, subculture, age, SES/social class/financial resources, family, or systems), trauma experience (e.g., timing, duration, type, intensity) and the practice setting.
10. Demonstrate knowledge appropriate to scope of practice regarding major trauma-relevant and generic questionnaires/interviews; this can include the questionnaires' psychometrics, strengths, limitations, and appropriateness for specific groups of those who have experienced trauma.

RECOMMENDED PSYCHOLOGICAL INTERVENTION

1. Demonstrate knowledge of the strengths and limitations of the current evidence (or lack thereof) concerning research-supported treatments (psychosocial, pharmacological, neurological, and physical) for trauma-related disorders/difficulties.
2. Demonstrate the ability to tailor, modify, and personalize treatment (e.g., dosage, pacing, delivery modality)

in accord with clients' individual and sociodemographic characteristics, trauma type, clinical presentation, comorbidities, preferences, vulnerabilities, cultural values, and ability status. This will help to prioritize accessible and responsive psychotherapies.

3. Demonstrate the ability to identify and implement evidence-based treatments and best practices and continually monitor their effects on the client. Namely, demonstrate the ability to apply trauma-focused phased treatment and the capacity to continually assess clients' needs and match treatments to evolving needs, including potential symptom exacerbation or elevated risk of self-harm.
4. Demonstrate understanding of the components and purported biopsychosocial mechanisms of change. These should include not only common and specific psychotherapy mechanisms but also evidence-based biological and social concomitants of trauma recovery.
5. Demonstrate the ability to address trauma-related material non-judgmentally and non-punitively with empathy, respect, dignity, and a belief in recovery and resilience (in contrast to pity, horror, indifference, condescension, and resignation). Demonstrate capacity to engage with trauma-related content while guarding against compassion fatigue or vicarious traumatization, by practicing self-care or seeking support, supervision, or consultation.
6. Demonstrate the capacity to help those who have experienced trauma to engage with trauma-focused treatments and persist with them (rather than avoid them or prematurely depart from them) to the extent that it is safe and clinically indicated to do so.
7. Demonstrate knowledge of ways to prevent trauma, minimize its deleterious effects once trauma occurs, and promote recovery and growth after trauma. This includes the ability to select and deliver treatments and promote recovery that are specific to the timing of trauma (e.g., primary prevention prior, secondary prevention during and immediately after, tertiary prevention once symptoms are present and affect functioning).
8. Demonstrate basic familiarity with the intended effects and side effects of common medications that are prescribed to those who have experienced trauma.
9. Recognize that specific psychotherapies are usually the first-choice interventions for PTSD, with medications having a supporting or adjunctive role. Demonstrate understanding of when to refer for pharmacotherapy consultation for individuals with comorbid or complex symptom presentations. Demonstrate the ability to engage, collaborate, and consult with families, social networks, communities, and other important care systems both during treatment and afterward to promote their knowledge and understanding of trauma and posttraumatic

conditions, and to promote recovery and optimize the treatment response (e.g., enhancing social support).

10. Recognize that trauma is often associated with violations of trust and difficulty being vulnerable in close relationships. Demonstrate the ability and patience to cultivate and maintain a therapeutic relationship with trauma-impacted individuals and their families that fosters a sense of safety, trust, and openness to addressing trauma-focused material.
11. Demonstrate skill in emerging technologies designed to implement trauma-specific treatments more effectively or efficiently, especially to overcome barriers to treatment (e.g., telehealth, digital resources, language interpretation services).
12. Develop a capacity to consider the relevance of social and historical factors that may be contributing to trauma symptoms and to consider intervention that might target social and systemic contributors (e.g., advocacy). This would open the door to a consideration of factors such as systemic racism, poverty, and other forms of oppression in trauma treatment planning.

RECOMMENDED PROFESSIONALISM

1. Demonstrate the ability to interface sensitively with forensic, legal, and other external systems in ways that safeguard those who have experienced trauma and enhance outcomes (e.g., comply with child and elder abuse protection services requirements; create and share records that do not create iatrogenic harm when introduced into the system).

NOTE: APA (2007) has record-keeping guidelines that address these issues and practice should not change according to specific diagnoses or settings.

NOTE: It is important that psychologists working with those who have experienced trauma remain cognizant of the context (e.g., legal setting, insurance disputes).

2. Demonstrate enhanced attention to legal (e.g., reporting laws, involuntary hospitalization) and ethical issues in trauma work (e.g., boundary maintenance, role overlap, reporting requirements and consideration, informed consent, confidentiality).

NOTE: APA (2017) has ethical guidelines that cover this area and should be maintained.

3. Demonstrate the skills to work with those who have experienced trauma that minimizes the risk of iatrogenic harm.
4. Demonstrate an understanding of how public policy issues affect trauma work within organizations and with individuals.

5. Demonstrate the ability to engage with other professionals and agencies around trauma issues, including relevant leaders, and to promote systemic, societal, political, economic, and policy changes of benefit to individuals who have been exposed to trauma.

RECOMMENDED RELATIONAL AND SYSTEMS COMPETENCIES

1. Demonstrate knowledge of how trauma can have very disorganizing effects on individuals and groups, including organizations and entire communities. Psychologists seek to respond in ways that reverse these deleterious effects.
2. Demonstrate basic knowledge about skills in offering teaching, supervision, or consultation on trauma-informed systems and models of care.
3. Demonstrate the ability to engage in collaboration with other professionals across disciplines regarding the needs of trauma-exposed individuals, their families, and their communities (e.g., child and elder protective services, state central registries/hotlines, legal aid, child advocacy centers, criminal legal settings).
4. Demonstrate understanding that institutions and systems can contribute to primary and secondary (or vicarious) trauma and offer strategies to reduce these barriers as appropriate. This includes understanding and acknowledging historical experiences (e.g., systemic racism) within healthcare settings and the resulting distrust individuals from those communities may have.
5. Demonstrate an understanding of the importance of using corrective relational experiences within the treatment context (e.g., trustworthiness, safety, and empowerment of client) and the capacity to use the relationship effectively, while remaining sensitive to the vulnerability of those who have experienced trauma and never violating their physical or emotional safety.
6. Demonstrate knowledge about the role of organizations in building cultures of safety, prevention, and preparedness (universal precautions).
7. Demonstrate the ability to consistently recognize how cultural, historical, and intergenerational transmission of trauma influences the perception of trauma itself, the symptoms or consequences/impact of trauma and the perception of providers/helpers.

Implementation and Maintenance of Proposed Competencies

Plan for Promulgating Proposed Competencies

The original competencies were published in APA's Division 56 journal, *Psychological Trauma: Theory, Research, Practice and Policy* (Cook et al., 2014). The Division 56 website provides access to the competencies, including a few resources for their application at varying levels of psychology training and practice.

In addition, there have been numerous endeavors to translate the content and outcome of the original competency conference, as well as trauma psychology more broadly, for psychology practitioners, administrators, training directors, and students. Dr. Joan Cook and Dr. Elana Newman, who spearheaded the conference, presented the proceedings through presentations offered at the APA and the International Society for Traumatic Stress Studies (ISTSS) annual conventions; they also published in peer-reviewed journals and book chapters (Cook & Newman, 2017; Cook et al., 2019). In addition, Henning et al. (2022) provide an excellent recent summary on the development, implementation, and evaluation of high-quality graduate training and professional certification programs in trauma treatment for clinical practitioners, which includes promotion of the competencies.

Two volumes of the APA Handbook of Trauma Psychology have been published (Gold, 2017a, 2017b). These include comprehensive summaries of the empirical knowledge and practical applications in the field of trauma psychology and may be used to instruct students as an advanced undergraduate or graduate-level textbook. The APA Division of Trauma Psychology has also led a monograph series, *Concise Guides on Trauma Care*, to serve as guides for psychologists and other professionals working with those exposed to trauma. For example, one book in that series (Kisiel et al., 2021) offers a comprehensive approach to trauma-informed assessment and treatment in working with children and adolescents. Additionally, the TeachTrauma.com website, developed by a previous chair of the Division 56 Education and Training Committee, provides a wealth of trauma psychology resources for administrators, professors, and students.

Because trauma is such a pervasive and widely recognized antagonist to health and well-being, and because bachelor's-level professionals in many professional settings will routinely work with individuals with significant trauma histories, there have been calls for trauma-informed interdisciplinary educational practice in undergraduate curricula (Elmhurst et al., 2019; Hepscher, 2020). Bachelor's and master's level professionals with degrees in psychology, as

well as doctoral-level psychologists, may be employed by U.S. Department of Veterans Affairs (VA) Medical Centers, hospitals, inpatient psychiatric facilities, primary care clinics, community mental health agencies, K-12 schools, colleges, universities, substance abuse treatment facilities, correctional and prison aftercare systems, and other similar settings (Dublin et al., 2022; Kim et al., 2021; Popescu et al., 2017; Walkley & Cox, 2013). Indeed, there has been a large increase over the past decade in training both healthcare professionals and students in various disciplines about the prevalence, impact, and interventions for those affected by trauma. In fact, Steen et al. (2022) published a qualitative synthesis of 51 training curricula for healthcare professionals and students on child adversity and trauma-informed care.

While the competencies outlined here are intended for graduate students in psychology and doctoral-level psychologists, there is an understanding that education and training in trauma psychology is needed outside of the discipline and earlier in the career cycle.

Plan for Maintaining Currency of Competencies

The *Guidelines on Trauma Competencies for Education and Training* are a living document. As such, they are to be reviewed and revised to include the most current developments in trauma psychology education, training, and practice at least every 10 years, in accordance with APA Association Rule (30-8.3). This revision is submitted as part of that renewal process.

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Background

Terminology Used and Rationale for Proposed Competencies

(a) Use of terms.

The definition of psychological *trauma* has been widely debated (Dalenberg et al., 2017; Marx et al., 2024). When the American Psychiatric Association (1980) first introduced Posttraumatic Stress Disorder (PTSD) into its official diagnostic nomenclature (the Diagnostic and Statistical Manual, 3rd ed.; DSM-3), Criterion A (exposure to a potentially traumatic event) was defined as “a recognizable stressor that would evoke significant symptoms of distress in almost anyone” and was thought to exist “generally outside the range of human experience.” Since its inception, the definition of Criterion A has gone through numerous revisions (Marx et al., 2024). Specifically, due to the varying magnitude, complexity, intensity, frequency, and duration of stressors, experts have struggled to create an all-encompassing definition of trauma.

In the first revision to the DSM-3, the criterion was expanded to include a definition of traumatic exposure as a phenomenon “usually experienced with intense fear, horror, and helplessness” (American Psychiatric Association, 1987) as the original definition was criticized for being too brief and vague (Marx et al., 2024). Taking into account the epidemiological research that had demonstrated traumatic exposure was actually quite common, the DSM-4 (American Psychiatric Association, 1994) revision to Criterion A resembled that of DSM-3-R (American Psychiatric Association, 1987) but increased the number of potentially traumatic stressors to include: being diagnosed with a life threatening illness, child sexual abuse, learning about the death of a loved one, or learning that one’s child has a serious illness. Currently, the DSM-5 (American Psychiatric Association, 2013, 2022) criteria for a traumatic event (Criterion A) are as follows: exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s), (e.g., first responders collecting human remains; police officers repeatedly

exposed to details of child abuse). Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

While the tightening of the traumatic event criterion in DSM-5 is more fully discussed in Friedman et al. (2011), some examples of events that meet diagnostic criteria include childhood physical and sexual abuse, interpersonal or domestic violence, combat/captivity, terrorism, and natural or human-caused disasters. However, we recognize that while we are anchoring our definition of trauma to the official diagnostic nomenclature, we are not excluding broader terms such as betrayal trauma (Freyd, 1996), intergenerational trauma, historical trauma (Kirmayer et al., 2014), oppression-based trauma (Fortuna et al., 2022), or medical trauma (McBain et al., 2023). Intergenerational trauma occurs when exposure to a traumatic event by an earlier cohort continues to affect subsequent generations (Chou & Buchanan, 2021). Oppression-based trauma includes intimidation and violence directed at minority groups that have been marginalized or stigmatized by the dominant culture because of their inability or unwillingness to assimilate. This type of experience may be extremely stressful, with associated negative mental health consequences (e.g., Adames et al., 2023; Kirkinis et al., 2021). Further, racial trauma has been defined as the “events of danger related to real or perceived experience of racial discrimination, threats of harm and injury, and humiliating and shaming events, in addition to witnessing harm to other ethnoracial individuals because of real or perceived racism” (Smith, 2010). Race-based trauma involves ongoing individual and collective injuries due to exposure and re-exposure to microaggressions, threats of harm and injury, humiliating and shaming events, and witnessing racial discrimination toward other people of color or Indigenous peoples (Comas-Díaz et al., 2019). Indeed, attention to racial and cultural context is seminal in understanding the vulnerability to, experience of, and recovery from trauma (Bryant-Davis, 2019, 2023; Comas-Díaz, 2016; Opatow et al., 2013). Medical trauma includes potentially traumatic events related to life-altering or life-threatening medical events, such as pain, cancer, injury, serious illness or pregnancy-related issues, medical procedures, or other frightening treatment experiences (Edmondson, 2014; Price et al., 2016).

Competence has been defined in the medical field as “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served” (Epstein & Hundert, 2002, p.

227). Kaslow (2004) suggested this definition may also be applied to the field of psychology. Further, Kaslow et al. (2004) used Stratford's (1994) understanding of competencies to define competencies as elements of competence that are "observable, measurable, containable, practical, derived by experts, and flexible" (Kaslow et al., p. 775).

Trauma-related competency is defined here as knowledge, skills, and attitudes a psychologist working with populations exposed to trauma ought to possess. Unlike other competencies that were developed to apply to a generalized audience or those that are orientation specific (e.g., cognitive-behavioral), these competencies are designed to apply across trauma-exposed groups, disciplines, and theoretical stances.

The competencies may serve a broad range of professionals including but not limited to practicing organizational and consulting psychologists, healthcare administrators, and graduate school faculty and training directors. For example, these competencies may be used as recommendations for the development of undergraduate, graduate, post-doctoral, and continuing education courses, and as suggested benchmarks for measuring and achieving proficiency (APA, 2004).

Scope of Application and Need for Proposed Competencies

(a) Scope of application for proposed competencies. Many factors converged to suggest the critical need for a focus on trauma psychology training. Trauma and its consequences have been recognized as a high-priority public health risk of major proportion by several federal agencies (e.g., Substance Abuse and Mental Health Services Administration, 2014). Events including the terrorist attacks of September 11, 2001, the wars in Iraq and Afghanistan, and devastating natural disasters such as Hurricane Katrina have moved recognition of trauma and its mental health concomitants to the forefront of the national agenda. This improved awareness is expected to increase the number and proportion of individuals who have experienced trauma, acknowledge trauma effects, and seek services. In addition, the COVID-19 pandemic, police shootings of people from racial and ethnic minorities, and the rise of U.S. mass shootings have further elevated trauma in the national consciousness (Bryant-Davis et al., 2017; Horesh & Brown, 2020; Lowe & Galea, 2017). Thus, more psychologists will likely deliver services to these vulnerable populations, but some lack the evidence-based knowledge, assessment, and skills needed to do so.

Although the scientific literature on trauma psychology is large and growing, most psychologists have only a cursory knowledge of the basic science of trauma psychology. Indeed, a survey conducted by the APA Practice Organization assessed the number of hours per month that practicing psychologists estimated they spent treating those who have experienced

trauma and their interest in additional clinical training on trauma-related issues and topics (Cook et al., 2011). Psychologists reported a mean 14.3 hours spent working with those who have experienced trauma over the past month. Among the 76% who treated any trauma patients, the mean was 16.9 hours. Although trauma psychology is not currently an integral component of the standard curricula in graduate level education (Courtois & Gold, 2009; DePrince & Newman, 2011), generalist psychology practitioners are in fact treating trauma-related concerns in their clinical practices.

Relatedly, a national survey was conducted of all North American doctoral programs in psychology to ascertain the current status of training in trauma (Cook et al., 2017). Training directors were sent email invitations and asked to complete a web-based survey; 151 of 398 responded with adequate information and were included in the analyses. Only one in five offered a trauma psychology course as well as a practicum specifically working with traumatized populations. The most common barriers to addressing trauma were limited capacity for elective courses and little instructor time and program resources. This is consistent with findings from a study by Foltz and colleagues (2023) that found only 8% of doctoral students graduating from APA-accredited programs are required to take a course related to trauma-informed care.

Similarly, directors from psychology internship programs across the United States were asked to participate in a survey regarding their sites' provision of services to traumatized populations and didactic and supervisory training offered to interns (Simiola et al., 2018). Altogether, 259 training directors completed the survey. Using a point system, an impact score of training saturation was determined based on the content and frequency of training offered in didactic, supervision, or combined formats. Of these, all reported at least one trauma training opportunity in either didactic or supervision format. More than half indicated that they offered at least 1 to 3 hours of didactics on trauma per week (62.2%) and slightly fewer offered supervision-specific training opportunities (54.5%). However, only 30.8% identified training opportunities in trauma/PTSD that reached a high level of saturation in training, meaning they offered training activities above the median impact score. The most common barrier to offering trauma training was related to time constraints associated with the need to meet other specialty or program requirements. While it is true that there is a general lack of trauma training in community practice and mental health graduate programs, including psychology, there is also a developing literature on what makes for effective training in evidence-based psychotherapies for PTSD (e.g., consultation, tape review, etc.; Helseth et al., 2020; Rosen et al., 2016).

In addition, psychology textbooks often lack comprehensive and accurate information on trauma, PTSD, and dissociation (Brand et al., 2019; Dalenberg et al. 2012; Kisseel et al., 2014; Wilgus et al., 2016). Explicit and implicit messages about these topics in textbooks and courses may negatively affect understandings of and responses to trauma (Nester

et al., 2022). This likely contributes to psychologists and other mental health providers incorrectly believing that dissociative disorders are rare (International Society for the Study of Trauma and Dissociation, 2011), skepticism about dissociative disorders (Dorahy et al., 2017; Loewenstein & Brand, 2023; Perniciaro, 2014), or erroneously viewing dissociation as iatrogenic rather than trauma-based (Brand, 2016). Relatedly, most psychologists do not apply evidence-based psychological treatments for PTSD consistently, if at all (Rosen et al., 2017).

While not all psychologists who work with traumatized children and adults may be expected to have specialized trauma training, as the complexity of comorbid conditions increases (e.g., dissociation, self-injurious behaviors, chronic suicidality, brain injury), there is an increased need for competency in trauma psychology (Calati et al., 2017; Nester et al., 2022). For example, working with those who have experienced severe and prolonged trauma can be complex and intense and may have negative impacts on the clinician, such as burn-out, compassion fatigue, vicarious traumatization, or issues of countertransference (Figley, 1995; Sprang et al., 2019). More specifically, those with significant trauma histories may have multiple intra- and interpersonal issues that necessitate an arduous and lengthy course of psychotherapy that requires a sophisticated understanding of interventions to achieve resolution (Courtois & Ford, 2013).

In an effort to prevent this type of compassion fatigue, there is a need for increased training, education, supervision, and consultation related to severe and prolonged trauma and complicated presentations, as well as the importance of self-care strategies (Butler et al., 2017; Courtois, 2018; Deblinger et al., 2024; Miller & Sprang, 2017; Shannon et al., 2014). Thus, the application of trauma-informed principles to clinical supervision involves taking the responsibility to enhance supervisees' skills as trauma-informed practitioners as well as *helping them manage the impact their work has on them*. Indeed, a special issue of the journal *The Clinical Supervisor* (Knight, 2018) was devoted to the topic of trauma-informed supervision and assembled papers on a variety of topics written by those with requisite experience and expertise; a new book by the issue's authors expands on these concepts (Knight & Borders, 2020). Knight (2018) described a model that directly incorporates the elements of trauma-informed practice (e.g., safety, trust, collaboration, choice, and empowerment) into supervision that paralleled coursework descriptions in trauma training articles (e.g., Henning et al., 2022; Newman, 2011).

Although an evidence-based core competency model for working with those who have experienced trauma includes understanding and using evidence-based assessments and psychological treatments for PTSD, competent practice in trauma also requires other unique knowledge, skills, and attitudes. For example, the extreme circumstances in which some traumas occur and the attendant psychological consequences may also create conditions that increase the risk for

violation of appropriate practitioner/client boundaries. A way to avoid the possibility of such a violation is to obtain specialized training (Turkus, 2013).

Additionally, it is widely known that there are health disparities—gaps in the quality of health and healthcare—reflective of differences in socioeconomic status, racial/ethnic background, and education level that must be addressed in trauma psychology (McLaughlin et al., 2019; World Health Organization, 2014). For example, exposure to trauma may be higher among people marginalized on the basis of social identity or those who live with psychopathology, including serious mental illness (Evans et al., 2016). Many factors contribute to these discrepancies, including access to and quality of healthcare; increased risk of disease; occupational hazards; or underlying genetic, ethnic, or familial factors. These discrepancies may exacerbate the effects of trauma and require the practitioner to be sensitive and responsive to gender, race, societal, political, and cross-cultural issues. Age, race/ethnicity, disability status, gender, gender diversity and identity, military/veteran status, sexual orientation, and SES are also critical influences to integrate into core competencies of trauma psychology practice (e.g., Garza et al., 2019a, 2019b; Mattar, 2011; Salomaa et al., 2023). Similarly, the conditions of trauma may create characteristics and circumstances in many who have experienced trauma that make it difficult to participate effectively in the treatment process, such as difficulties with trust and problems of emotion regulation. Psychologists working with such clients should be trained to recognize and address such characteristics and circumstances, and also be trained in the development of those practitioner characteristics that have been empirically demonstrated to enhance the likelihood of success with these clients (Ellis et al., 2018). Thus, a competency model will help psychologists to improve their practice with complex, vulnerable traumatized populations.

In April 2013, the Advancing the Science of Education, Training and Practice in Trauma national consensus conference on trauma competencies (the *Guidelines on Trauma Competencies for Education and Training*, also known as the *New Haven Trauma Competencies*) was held at the Yale School of Medicine in New Haven, Connecticut. Sixty experts in the field of traumatic stress were brought together with the overarching goal of identifying empirically-informed knowledge, skills, and attitudes that psychologists must have from a competency perspective when working with traumatized children, adults, families, and communities.

The conference was modeled on previous national consensus conferences such as the Hilton Head conference in child clinical psychology (Johnson & Tuma, 1986), the Houston conference in neuropsychology (Hannay, 1998), the Arden House conference in health psychology (Stone, 1983), and the Pikes Peak conference in geropsychology (Knight et al., 2004). The impact of these previous competency conferences is ongoing and includes specific recommendations for

using scientific understanding in practice as well as training at individual and programmatic levels.

The *Guidelines on Trauma Competencies for Education and Training* include foundational (e.g., scientific knowledge, individual and cultural diversity, ethical and legal issues) and functional competencies (e.g., assessment, intervention; Kaslow et al., 2007; Nash & Larkin, 2012; Rodolfa et al., 2005) specific to trauma psychology. The trauma competencies are like those of most psychology specialties, which share the same foundational and functional competencies but are differentiated by their parameters of practice (e.g., population served; Rodolfa et al., 2005). Like other specialty competencies, these trauma competencies were designed to be developmentally informed and progressively more challenging and refined as one moves through the stages of professional development from student to independent practitioner (Kaslow, 2004; Kaslow et al., 2004; Kaslow et al., 2007). Finally, it was envisioned that assessment of formative and summative competence in trauma, like other competencies, would be multi-trait, multimethod, and multi-informant (Roberts et al., 2005). Such assessments may include methods of evaluation such as multiple-choice exams, problem-based learning, written essays, review of records or recordings, vignettes, performance-based exams to assess specific skills, and client simulations (APA, 2006; Kaslow, 2004; Kaslow et al., 2007).

Benchmarks have been developed to indicate readiness to advance in education and training or readiness for practice (Hatcher et al., 2013). Benchmarks should likewise be modified to reflect different levels of experience at assessment (e.g., beginner, intermediate, expert; Kaslow et al., 2007). For the trauma competencies, a future goal will be to have benchmarks across the various stages of professional development in psychology as well as assessment measures for each of the trauma goals.

The *Guidelines on Trauma Competencies for Education and Training* for practice are not intended as prescriptive or exhaustive but rather as aspirational. These competencies are advisory and do not supersede clinical judgment or the judgment of individuals or institutions with given authority and responsibility for education and training.

(b) Need for proposed competencies. Although the scientific literature on traumatic stress is large and growing, most psychologists have only a cursory knowledge of the basic science of trauma psychology, and do not have formal training in and do not apply evidence-based psychosocial treatments for PTSD consistently, if at all (Cook et al., 2011;). Cutting-edge biological and psychosocial research with clinical applications in the field of trauma is plentiful. Thus, there exists a clear need for the dissemination and implementation of a comprehensive model of empirically informed core competencies in trauma psychology.

More specifically, a core competency model in trauma psychology could serve as a valuable resource for a wide

variety of psychologists. For example, practicing psychologists who want to develop competencies to work with traumatized children and adults may find these trauma competencies helpful in planning their own professional development. Organizational and consulting psychologists may find these trauma competencies helpful in addressing trauma-related issues in the workplace ranging from disaster preparation to policies about sexual harassment and workplace bullying. Similarly, healthcare administrators, graduate school faculty, and training directors planning to review or develop trauma psychology training programs will find these evidence-based core competencies a useful resource in designing or revamping programs.

The implications of not having core competencies in trauma psychology are multifold. Exposure to potentially traumatic events is not rare. A history of exposure to traumatic events is prevalent in the general population. Indeed, general population surveys in 24 countries across six continents found that more than 70% of adults are exposed to a potentially traumatic event at some point in their lives (Benjet et al., 2016). Similarly, large epidemiological studies indicate many children and youth experience exposure to a broad range of one or more traumatic events (for review see Gunaratnam & Alisic, 2017) including assaults by peers and siblings, non-sexual assaults to genitals, dating violence, hate crimes, and property thefts.

A history of exposure to trauma is appreciably more prevalent in clinical samples than in the general population. Although most individuals who experience a single potentially traumatic event do not have long-term negative consequences, a substantial minority develop significant health difficulties (Galatzer-Levy et al., 2018; Goldstein et al., 2016). Exposure to traumatic incidents has been implicated as a risk factor for several trauma-related disorders (i.e., partial- and full-threshold PTSD, Acute Stress Disorder, Complex PTSD) commonly encountered in clinical settings (Brewin et al., 2017; Cloitre et al., 2020; Cloitre et al., 2019; Hughes et al., 2021; Klein et al., 2024; Koenen et al., 2017). Beyond explicitly trauma-related disorders, there are numerous other psychological disorders and symptoms that have been found to be related to a history of trauma (e.g., dissociation, depression, anxiety, substance abuse, eating disorders, personality disorders; Calati et al., 2017; Stein et al., 2013).

A history of exposure to trauma is not only related to impaired psychological functioning but also to serious health risks (Bellis et al., 2019; Hughes et al., 2021). Trauma is also associated with physical health problems (e.g., ischemic heart, chronic lung and liver diseases, reproductive health) and negative health behaviors (e.g., smoking, severe obesity; for review, see Coughlin, 2012; Dalvie & Daskalakis, 2021). For example, traumatic events associated with violence (e.g., childhood sexual abuse, gendered or sexual harassment, rape, or sexual assault of a child or adult) and PTSD may negatively affect reproductive health such as infertility and miscarriage, as well as an unplanned, problem, or forced pregnancy

(Yonkers et al., 2014). Additionally, traumatic exposure and its negative mental health concomitants have been linked to poor social and occupational functioning and overall decreased quality of life in both men and women (Bellis et al., 2019; Hughes et al., 2021; Koenen et al., 2017).

Many clients who seek psychotherapy services have significant trauma histories. Knowledge of and skills in applying assessment measures developed, normed, validated, and determined to be psychometrically suitable for use with those who have been exposed to trauma exist and need more widespread dissemination and implementation. It is important for psychologists to screen comprehensively for potentially traumatic event exposure because many individuals will have experienced more than one type of event or more than one event of the same type. If psychologists do not ask their clients about the occurrence of traumatic events in their lives, clients may not spontaneously report their prevalence as they may not recognize or may minimize the effects of such events. It is advised that psychologists be particularly aware of the trauma risks associated with social determinants, including power, privilege, poverty, low SES status, racism, and oppression when screening for trauma, because people with low economic status are at risk for increased violence (APA Task Force on Socioeconomic Status, 2007; Smith & Chambers, 2015; Woods-Jaeger et al., 2024) starting with sexual assault and severe violence in childhood (Browne & Bassuk, 1997) and continuing in adulthood (APA, 2003). They have higher trauma hospitalization and mortality rates (de Munter et al., 2017). They also often experience the physiological toll of greater exposure to acute and chronic stress due to the environments in which they live (Chen & Matthews, 2003).

Traumas involving interpersonal violence, particularly those that occur during childhood, are important because they can interfere with forming trusting relationships, which in turn can generate, intensify, or change the post-trauma environment and trauma reactions. For example, the trauma of persistent bullying and harassment in childhood and adolescence affects the sense of self and relationship with others of many people in sexual and gender minorities (House et al., 2011). Additionally, it is widely acknowledged that the interaction among gender, political structure, religious beliefs, and attitudes toward violence contribute to the vulnerability and safety of battered women, children exposed to domestic violence, and abusive partners (DePrince, 2022). Thus, trauma-informed psychotherapy should help those who have experienced trauma regain psychosocial equilibrium and become less fearful following trauma by reinforcing the message that they are safe and can trust in others to aid in their protection.

In addition, recognition of the importance of trauma in informing an initial treatment psychotherapy plan or recommendations is sorely needed. Inappropriate diagnosis or underdetection of symptoms can lead to inadequate treatment plans or administration of poorly focused or inappropriate treatment. Effective treatments for PTSD and other trauma-re-

lated conditions exist. In 2012, the APA appointed a multidisciplinary panel to analyze a systematic review of the scientific evidence on interventions for the treatment of PTSD in adults. The panel reviewed the benefits and harms of interventions, considered what is known about patient values and preferences, and considered the applicability of the evidence across demographic groups and settings. In 2017, APA published the Clinical Practice Guideline for the Treatment of PTSD (APA Guideline Development Panel for the Treatment of PTSD in Adults, 2017). A casebook was published subsequently on how the recommended treatments are used in practice (Bufka et al., 2020). In 2021, the APA Board of Directors appointed another multidisciplinary panel to update the 2017 Clinical Practice Guideline for the Treatment of PTSD in Adults.

In brief, several research-supported treatments for PTSD listed in numerous guidelines developed across three continents (i.e., North America, Europe, and Australia; Forbes et al., 2010) support the use of trauma-focused approaches, meaning they involve the processing of traumatic material. In addition, it is important for psychologists to know that focusing only on the index trauma that brings individuals to treatment may miss clinically relevant issues associated with exposure to other traumas and can complicate treatment. In addition, there is a need to be cognizant of the study of other emerging modalities (e.g., psychedelics; Modlin et al., 2024). Psychologists should not ignore adjuvant therapies or have their engagement prohibited in settings where psychology may be viewed as the adjunct therapy. This is particularly important to note as the treatment landscape is evolving.

Although a primary emphasis of the *New Haven Trauma Competencies* was individualized, there are, of course, multiple levels for which competencies might be relevant, including not only on the individual level, but also on the broader parental, family, and community levels. For example, working with traumatized children requires interaction with and participation by parents or other caregivers (who may or may not have also been exposed to trauma).

Process of Developing Competencies

(a) Participants and process. Two fellows of the APA's Division of Trauma Psychology, Dr. Joan M. Cook and Dr. Elana Newman, led the *Guidelines on Trauma Competencies for Education and Training* development process.

Delegates were nominated for attendance at the consensus conference by Drs. Cook and Newman as well as by leaders in the field of traumatic stress. The 60 psychologists, psychiatrists, and social workers represented a broad range of clinical and research experience with trauma-exposed children and adults in civilian and military populations. Delegates came from private practice, federal government, and academic institutions; they represented a diverse array of professional organizations (e.g., APA, ISTSS, National Child Traumatic

Stress Network, International Society for the Study of Trauma and Dissociation). The Appendix presents a list of consensus conference participants' affiliations and areas of expertise.

Based on discussions and review of the current conceptualization of competency benchmarks, five broad core competencies were predetermined by Drs. Cook and Newman before the conference. The five broad core competencies work groups were as follows:

I. Scientific Knowledge About Trauma: Understanding of, familiarity with, and respect for the empirical foundation of the traumatic stress field; research methodology, techniques of data collection and analysis; biological bases of trauma-related behavior; cognitive-affective bases of trauma-related behavior; and development across the lifespan.

(e.g., theory about trauma models; definition of potentially traumatic events; demographics and base rates of potentially traumatic events and related psychiatric disorders in the general population and in clinical populations; biological, neurological, psychological, and social effects of trauma; risk and protective factors for traumatic exposure, PTSD, and trauma-spectrum disorders; influence of health disparities on traumatic exposure, including on trauma causes, treatment, and access to treatment; resilience and recovery)

Knowledge: Understand, be familiar with, and have respect for foundations of current scientific knowledge on trauma and its impact.

Skills: Able to: (1) evaluate empirical research critically and appropriately in trauma; (2) apply scientific findings to clinical situations; (3) apply scientific understanding of trauma community resources and adequate support in various settings and locations including rural and remote regions.

Attitudes: Aware of and willing to: (1) address how one's assumptions affect critical thinking about the current strengths and weaknesses of trauma knowledge; (2) approach interventions with scientific evidence and professional ethical standards.

II. Psychosocial Assessment: Understanding of and familiarity with assessment and diagnosis of trauma-related problems, capabilities, and contextual factors (e.g., structural and policy influences) associated with traumatic events and their impact on those who have had such experiences.

(e.g., knowledge of and skills in applying assessment measures developed, normed, validated, and determined to be psychometrically suitable for use with those who have experienced trauma; utilization of a biopsychosocial approach to case conceptualization to inform initial treatment plan or recommendations)

Knowledge: Understand and have respect for: (1) unique

foundations of theoretical, empirical and contextual basis of psychosocial assessment (test construction and interviewing) with trauma-exposed individuals; (2) existing standards and tools for measurement as well as existing needs for assessment for individuals who have experienced trauma; (3) principles of trauma-focused clinical interviewing that are founded in science and may vary developmentally; and (4) contextual factors that may influence assessment such as an individual's development and environment (e.g., parenting, caregivers, family, community). Such contextual factors may be particularly important when doing assessments with children, adolescents, or cognitively impaired older adults.

Skills: Able to: (1) apply techniques to assess the cognitive, affective, behavioral, and personality dimensions of trauma-exposed individuals; and (2) use assessment tools (e.g., standardized tests, structured interviews, clinical interviews) in a variety of settings (e.g., research, outpatient, inpatient, online, telehealth) and populations (e.g., substance-abusing clients, eating-disordered clients).

Attitudes: Aware of and willing to challenge one's trauma-related biases and look for counterevidence.

The Standards for Educational and Psychological Testing (American Educational Research Association, APA, & National Council on Measurement in Education, 2014) are important for assessing competencies in any area of psychology, including trauma. Psychologists who work with people who have experienced trauma are encouraged to acquire these competencies. In particular, psychologists should evaluate the reliability and validity of the assessment procedures and determine if they are sufficient for the intended use. Further, in assessments of those who have experienced trauma and who speak a different language, psychologists should understand and adhere to the Standards with attention to implications of assessing people who are either non-English speaking or for whom English is not their primary language.

III. Psychosocial Intervention: Understanding of and familiarity with all aspects of the psychosocial intervention process designed to alleviate suffering and to promote health and well-being of trauma-exposed individuals, groups, and communities.

4. (e.g., knowledge of and skill development in evidence-based interventions for trauma-related problems; progress evaluation; modifications of techniques to address problems such as emotion dysregulation, aggression, past treatment nonresponse, and comorbidities such as substance use disorders in those who have experienced trauma; the role of nonspecific factors; potential applications of neuroscience findings to psy-

chosocial practice in those who have experienced trauma)

5. **Knowledge:** Understand and be familiar with: (1) existing science on evidence-based practices for PTSD and other trauma-related difficulties; (2) theoretical and practical common factors in the existing evidence-based interventions for trauma-spectrum disorders; (3) purported mechanisms of change in the evidence-based treatments for trauma-related psychopathology; and (4) foundations of intervention planning, implementation, evaluation, and practice management with those who have experienced trauma.
6. **Skills:** Able to: (1) engage appropriately in case formulation and selection of appropriate intervention strategies for those who have experienced trauma; (2) establish treatment objectives, execute treatment plan and assess treatment progress with those who have experienced trauma; (3) implement evidence-based interventions for those who have experienced trauma, including adapting manualized treatments to meet their needs and to apply them effectively in multiple treatment settings; (4) implement appropriate termination skills with those who have experienced trauma; (5) work collaboratively with and within various care systems as well as with families, parents, or caregivers when clients are children, adolescents, or cognitively impaired older adults; and (6) recognize and overcome barriers to care for those who have experienced trauma.
7. **Attitudes:** Aware of and willing to: (1) question and analyze one's clinical interventions in the best interest of the client; and (2) examine how one's trauma-related values, affect, and history impact delivery of clinical interventions.

IV. Professionalism: Awareness of and ability to be guided by professional values and ethics as evidenced in behavior and comportment that reflect the values and ethics, integrity, and responsibility required to effectively work with individuals who have experienced trauma, as well as other professionals and organizations. When working with those who have been exposed to trauma, practice ought to be conducted with personal and professional self-awareness and reflection, with awareness of competencies, and with appropriate self-care. Understand trauma-informed care and how it differs from trauma-focused interventions. Understand professional standards in forensic trauma practice. **Individual and cultural diversity** – Awareness, sensitivity, and skills in working professionally with individuals, groups and communities exposed to trauma who represent diverse cultural and personal background and characteristics (e.g., age, gender, gender identity and diversity, race/ethnicity, culture, national origin, religion, sexual orientation, disability, language, SES).

(e.g., application of ethical, legal, and professional standards and guidelines when working with those who have

experienced trauma; awareness and application of ethical decision-making when working with those who have experienced trauma, such as limits of confidentiality and laws and policies covering current abuse; forensic trauma practice, individual and cultural diversity, scientific mindedness and self-reflection; advocacy with trauma issues and clients; self-care, particularly to mitigate the potential effects of vicarious traumatization)

Knowledge: Understand and be familiar with: (1) professional ethics codes; (2) how to maintain the principle of non-maleficence; (3) how relevant legal, cultural, and policy issues impact trauma work; (4) short- and long-term difficulties in working as a trauma psychologist; and (5) how to engage in self-care and appropriate use of supervision and consultation.

Skills: Able to: (1) recognize and reconcile ethical and legal issues with trauma-exposed individuals; (2) engage in appropriate professional practice with those who have experienced trauma from diverse groups, including racial/ethnic minorities, persons with disabilities, and other traditionally underrepresented groups; (3) adapt and adopt one's own ethical decision-making model and apply it with contextual sensitivity; (4) know when to seek out information on ethical, legal, diversity, and policy issues; (5) recognize one's role in developing trauma policy and promoting institutional, community, or societal change, including how to engage with relevant leaders around issues to promote systemic and societal change; (6) participate in effective self-care; and (7) conduct routine performance appraisals.

Attitudes: Aware of and willing to: (1) learn, question, and appreciate the ways in which cultural context changes (or does not change) in different cultural and community contexts; and (2) respect the client's capacity to engage in decision-making in ways that are empowering.

V. Relational and Systems: Understand and be familiar with: (1) key trauma-related interpersonal and systems issues; (2) principles of interdisciplinary collaboration when working with people who have been exposed to trauma. The ability to conscientiously and effectively interact with trauma-exposed individuals, couples, families, groups, and/or communities; (3) availability and dynamics of interdisciplinary collaboration opportunities as they may vary across settings and locations (e.g., opportunities may be limited in rural and remote areas); and (4) contexts within which individuals (especially children, adolescents and cognitively impaired older adults) operate, such as parents, caregivers and families.

(e.g., form and maintain effective working alliance with individuals who have experienced trauma and, when appropriate, their family system; form and engage in productive and respectful relationships with peers/

colleagues, supervisors, lay providers, and professionals from other disciplines, organizations, and communities; effectively negotiate conflictual, difficult, and complex relationships)

Knowledge: Understand and be familiar with: (1) interpersonal and systems dynamics such as conflict resolution when interacting with trauma-exposed individuals, groups, and/or communities; (2) empirically supported relationship variables (e.g., alliance, cohesion, empathy, goal consensus and collaboration, positive regard, congruence or genuineness, feedback, repairing ruptures in alliance, self-disclosure, relational management, expectations and preferences, attachment style) with trauma-exposed individuals, couples, families, groups, and communities; and (3) counter-transference issues in trauma-focused treatment.

Skills: Able to: (1) listen to and be empathetic with those who have experienced trauma; (2) accept, evaluate, and implement feedback; (3) tolerate and understand interpersonal conflict in therapeutic relationships and make appropriate disclosures regarding problematic interpersonal situations; (4) tolerate ambiguity and uncertainty in clinical practice; (5) support effective interdisciplinary team functioning, such as communicating without jargon, dealing effectively with disagreements about diagnosis or treatment goals, and supporting and respecting the perspectives of other team members; and (6) work with other professionals in interdisciplinary clinical settings to incorporate trauma information into overall team planning and implementation.

Attitudes: Aware of and willing to: (1) understand and accept client and group cultural beliefs and practices and intervene in ways that facilitate healthy adaptation; and (2) honor interdisciplinary contributions to trauma psychology practice.

Over the three-day national consensus conference, participants rotated among the five working groups. All work group meetings were audiotaped for professional transcription. In addition, each work group had a Yale psychologist who assisted the group, primarily through extensive notetaking. These individuals were able to find Drs. Cook and Newman when the work group leaders needed immediate assistance as participants moved through the process of explicating their core competency area.

All work groups used a technique called the Nominal Group (Delbecq & VandeVen, 1971), an established method for gaining consensus among stakeholders. This approach differs from others that have previously been used in the trauma field and generated an appreciably different document than those that then existed in trauma.

The three steps in the Nominal Group process were:

1. Generating ideas: Work group co-leaders directed every-

one in their group to write down on index cards what they considered to be components of the competency in brief phrases or statements, working silently and independently.

2. Recording ideas: Group members engaged in a round-robin feedback session to concisely record each component (knowledge, skill, or attitude item for day 1 and/or how and when to obtain these competencies for day 2, without debate at that point in the process). One co-leader wrote each idea from a group member on a flip chart visible to the entire group, and then asked for another idea from the next group member. This continued until all group ideas were documented.
3. Discussing Ideas: Each recorded idea was then discussed to determine clarity and importance. For each idea, one of the work group co-leaders asked, "Are there any questions or comments group members would like to make about the item?" Other questions asked were, "Is this specific to trauma training or practice?," "Is this a knowledge, skill, or attitude item?," and "Is this item best worded to be applicable across theories and trauma populations?."

More specifically, conference participants were asked to define the knowledge, skills, and attitudes that were applicable to trauma-exposed children and adults within one of the five broad core competencies. Further, participants were encouraged to define the fewest number of essential competencies that focus on commonalities in the field rather than differences.

Participants were tasked with the goal of establishing competencies based on the following questions: (a) What are the knowledge, skill, and attitude competencies needed for mental health providers working with those who had experienced trauma? (b) Are there distinctive training values, conditions, methods, or experiences that constitute trauma mental health training in this domain, in addition to generally good clinical/counseling training in mental health? (c) When and how might these knowledge, skill, and attitude competencies be acquired over one's training career?; and (d) Do you have any additional commentary and suggestions for those who provide training, such as addressing the institutional resources, mentoring, and supervision needed for trauma training?

At the end of each day, each working group presented to the entire conference their findings. All conference participants voted on the final competencies to be adopted on the final morning of the conference. On the last day of the conference, the lists of competencies were written on large white notepads that hung on the conference room walls. Every participant was given 50 stickers (five colors matched to each of the five competency groups). Participants were instructed to vote for what each of them considered to be the top competencies in their assigned area. Votes were then

tallied to identify those highest-rated competencies by the conference participants.

In addition, we collected all the working groups' white notepads for further review, and also surveyed expert members of APA's Division 56 and the ISTSS and asked them open-ended questions about the competencies within the five broad domains.

In early 2023, each original conference participant was sent an email asking for input on potential revisions to the competencies. The responses were gathered, compared, and reviewed by Drs. Cook and Newman. Subsequently, the membership lists of APA Division 56 and ISTSS were reviewed for potential additional reviewers to cover content areas.

(b) Policy documents relevant to proposed competencies.

A 2003 report by the Institute of Medicine (IOM) called for the establishment of basic clinician competency requirements, across all disciplines, to improve quality of care and patient safety (IOM, 2003). Within psychology, the competency movement is in its third decade (APA, 2006), beginning with the National Council of Schools and Programs of Professional Psychology (Bourg et al., 1987). In 2006, the APA Task Force on the Assessment of Competency in Professional Psychology published its final report calling for a paradigm shift to competency-based education and assessment in psychology (APA, 2006; Kaslow et al., 2004). The final report included 15 principles and nine recommendations on domains of competence and levels of assessment in professional psychology (Kaslow et al., 2007). Numerous other specialties of psychology have moved to a competency-based model, including clinical health psychology (France et al., 2008), clinical child and adolescent psychology (Jackson et al., 2012), and professional geropsychology (Knight et al., 2004).

The development of the *Guidelines on Trauma Competencies for Education and Training* was informed by prior work on core competencies in psychology and other fields (e.g., Danieli & Krystal, 1989; Hobfoll et al., 2007; National Child Traumatic Stress Network Core Curriculum on Childhood Trauma Task Force, 2012; Walsh et al., 2012). The five working groups at the 2013 Advancing the Science of Education, Training and Practice in Trauma conference overlapped with foundational and functional competencies used at the APA 2002 Competencies Conference for Professional Psychology (Kaslow et al., 2004) and in the Cube Model of Competency Development (Rodolfa et al., 2005). Other prominent national organizations, such as the National Child Traumatic Stress Network (Layne et al., 2011), have identified a need for trauma-informed training among health professionals and thus have developed a core curriculum on childhood trauma for social workers (Strand et al., 2014). The *Guidelines on Trauma Competencies for Education and Training* add to these efforts by identifying trauma-specific subcomponents for each of the core competencies (e.g., professionalism, scientific knowledge) across the entire lifespan.

Additionally, the trauma competencies can work in tandem with prior competency efforts to identify core competencies and competency benchmarks across the career span. For instance, the APA Assessment of Competency Benchmarks Work Group (Fouad et al., 2009) identified competency benchmarks for three domains of career development: readiness for practicum, internship, and practice. Similarly, other generic documents have been designed for training in professional psychology, including those aimed at undergraduate (APA Board of Educational Affairs Task Force and Council of Chairs of Training Councils, 2007) graduate, post-doctoral and licensing stages (Fouad et al., 2009; Kaslow et al., 2009).

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Appendices

New Haven Trauma Competency Delegate Affiliation and Area(s) of Expertise

(In Alphabetical Order)

Name	Affiliation	Area(s) of Expertise
Lisa Amaya-Jackson, MD, MPH	Duke University; National Child Traumatic Stress Center; Center for Child and Family Health	Child trauma; evidence-based approaches to treatment; community-based practices
Lucy Berliner, MSW*	Harborview Center for Sexual Assault and Traumatic Stress; University of Washington School of Social Work	Child and adult trauma; crime
S. Megan Berthold, PhD, LCSW*	University of Connecticut School of Social Work	Individuals who have experienced torture, war trauma, human trafficking, female mutilation; refugee and asylum seekers
Sandra L. Bloom, MD*	Drexel University	Complex trauma; the sanctuary model
Brian E. Bride, PhD, LCSW	The University of Georgia	Co-occurring disorders, namely substance abuse and mental health; secondary traumatic stress
John Briere, PhD, Group II Co-leader	University of Southern California; National Child Traumatic Stress Network	Psychological assessment; child abuse; complex trauma; interpersonal violence; gender issues
Ernestine Briggs-King, PhD	Duke University; National Child Traumatic Stress Center	Child and family trauma; racial/ethnic minority issues in relation to assessment and treatment of PTSD
Laura Brown, PhD, Group IV Co-leader	Freemont Community Therapy Project, Seattle	Cultural competence; forensic issues; feminist theory; ethics and standards of practice; LGBT mental health issues
Diane Castillo, PhD	University of New Mexico; New Mexico Veterans Affairs Health Care System	Assessment of PTSD among women and Hispanic veterans; cross-cultural counseling; anger in PTSD
Marylene Cloitre, PhD	National Center for PTSD, Dissemination and Training Division	Evidence-based treatments of PTSD, namely Skills Training in Affective and Interpersonal Regulation
Joan M. Cook, PhD, Conference Chair*	Yale School of Medicine; National Center for PTSD	Aging issues; dissemination and implementation of evidence-based practices; combat/captivity
Christine Courtois, PhD, Group V Co-leader*	Independent Practice, Washington DC	Sexual assault; treatment of complex traumatic stress; childhood abuse
Stephen J. Cozza, MD	Uniformed Services University	Clinical and community response to trauma; military trauma; military family trauma

Constance Dalenberg, PhD	Alliant International University San Diego	Consequences of trauma; trauma symptoms and treatment; forensic evaluations; trauma disclosure
Lori L. Davis, MD	University of Alabama Health System; Tuscaloosa Veterans Affairs Medical Center	Neurobiology; pharmacology; vocational rehabilitation of PTSD
Michael de Arellano, PhD	Medical University of South Carolina	Children who have experienced trauma; racial/ethnic minority issues; psychological sequelae of trauma
Jason Deviva, PhD	Veterans Affairs Connecticut Health Care System; Yale University	Treatment of trauma-related sleep problems; treatment of combat-related PTSD
Diane Elmore Borbon, PhD, MPH, Group IV Co-leader	Duke University; National Child Traumatic Stress Center	Legislative and public policy issues; intergenerational issues; emergency preparedness and response; aging issues
John Fairbank, PhD, Group I Co-leader	Duke University; National Child Traumatic Stress Center	Child trauma; veterans; working with trauma-exposed families; assessment of traumatic stress
Kathleen J. Farkas, PhD, LISW	Case Western Reserve University	Assessment and diagnoses of mental health and substance use disorders
Vincent J. Felitti, MD	Kaiser Permanente San Diego; University of California	Infectious diseases; obesity and trauma; adverse childhood experiences
Jennifer J. Freyd, PhD	University of Oregon	Betrayal trauma; interpersonal trauma; dissociation; gender differences in mental health
Matthew Friedman, MD, PhD	National Center for PTSD, Executive Division; Dartmouth School of Medicine	Pharmacotherapy; neuroscience; stress and PTSD; biological psychiatry
Steven Gold, PhD, Group III Co-leader	Nova Southeastern University	Dissociation; addictions/compulsivity; hypnosis
Bonnie L. Green, PhD	Georgetown University Medical School	Uninsured and low-income populations; consequences of traumatic events
Catherine L. Grus, PhD*	American Psychological Association	Education and training; policy and practice; competency assessment
Jessica Hamblen, PhD*	National Center for PTSD; Dartmouth University	Evidence-based treatments for PTSD; co-occurring trauma and substance use disorders
Vincent Kane, MSW	National Center on Homelessness among Veterans	Homelessness; housing and urban development
Nancy Kassam-Adams, PhD, Group II Co-leader	Children's Hospital of Philadelphia	Pediatric traumatic stress; medical injury; assessment and screening of traumatic stress;
Kathleen Kendall-Tackett, PhD	Independent Practice; Texas Tech University School of Medicine	Trauma-related health disorders; health psychology; crimes against children
Dean Kilpatrick, PhD, Group I Co-leader	Medical University of South Carolina	Epidemiology of trauma and related disorders; gene-environment interactions

Karestan Chase Koenen, PhD	Columbia University's Mailman School of Public Health	Psychological trauma; PTSD; epidemiology; epigenetics of traumatic exposure and PTSD
Roberto Lewis-Fernandez, MD	Columbia University; New York State Center of Excellence for Cultural Competence	Racial/ethnic minority issues: dissociation; anxiety disorders; cultural psychiatry
Steven Marans, PhD, MSW	Yale School of Medicine	Child trauma; trauma consultation and treatment
Elissa McCarthy, PhD*	Veterans Affairs Connecticut Health Care System	Evidence-based psychotherapy; substance abuse
Thomas A. Mellman, MD	Howard University College of Medicine	Trauma-related sleep issues; anxiety disorders
Charlotte Mullican, MPH	Agency for Healthcare Research and Quality	Mental health; substance abuse
Elana Newman, PhD, Conference Vice-Chair*	The University of Tulsa	Evidence-based approaches to treatment; substance abuse and trauma; assessment
John C. Norcross, PhD, ABPP*	University of Scranton; Independent Practice	Empirically supported relationships; evidence-based treatments
Robert H. Pietrzak, PhD	Yale School of Medicine; National Center for PTSD, Clinical Neuroscience Division	Geriatric mental health; resilience; epidemiology of trauma related disorders; neuropsychological assessment
Robert Pynoos, MD, MPH	University of California, Los Angeles; National Center for Child Traumatic Stress	Child trauma; neurobiology of childhood trauma; psychological first aid; disaster interventions
Patricia Resick, PhD	National Center for PTSD, Women's Division; Boston University	Evidence-based treatments for PTSD, namely Cognitive Processing Therapy
David S. Riggs, PhD	Center for Deployment Psychology	Domestic violence; effects of trauma on couples and family; prolonged exposure
Beth N. Rom-Rymer, PhD	Independent Practice	Forensic geriatrics; interpersonal violence; aging and trauma issues; law enforcement; working with impaired professionals
Barbara Rothbaum, PhD, Group III Co-leader*	Emory University	Evidence-based treatments for PTSD, namely Prolonged Exposure and virtual reality therapy
Josef Ruzek, PhD, Group V Co-leader*	National Center for PTSD, Dissemination and Training Division	Early intervention and prevention of PTSD; disaster mental health; Comorbid PTSD-substance use disorders
Paula Schnurr, PhD	National Center for PTSD, Executive Division; Dartmouth School of Medicine	Risk and protective factors in development of PTSD; relationship between trauma, PTSD, and physical health; aging issues
Bruce Shapiro	Dart Center for Journalism and Trauma	Reporting on the aftermath of violence, conflict, and tragedy
Vanessa Simiola, PsyD*	Yale School of Medicine	Interpersonal violence; dissemination and implementation of evidence-based psychotherapies

Carla Smith Stover, PhD	Yale School of Medicine	Families impacted by domestic violence; Evidence-based treatments, namely Trauma-Focused Cognitive Behavior Therapy
Steve Southwick, MD	National Center for PTSD, Clinical Neurosciences Division Yale School of Medicine	Neuroscience; resilience; psychopharmacology
Ginny Sprang, PhD	University of Kentucky	Child and adult trauma; maltreatment; victimization
Virginia Strand, DSW	Fordham University	Implementation of evidence-based treatments; child trauma; family intervention
Amy Street, PhD	Boston University School of Medicine; National Center for PTSD, Women's Division	Interpersonal violence in veteran populations; military sexual assault
Joan Turkus, MD	The CENTER	Dissociation; education and consultation; treatment of traumatic stress
Dolores Vojvoda, MD	Yale School of Medicine; Veterans Affairs Connecticut Healthcare System	Combat trauma; anxiety disorders
Patricia Watson, PhD*	National Center for PTSD, Executive Division; Dartmouth School of Medicine	Development of education manuals; early intervention and prevention of PTSD; resilience
Alison S. Went, LCSW	Veterans Affairs Connecticut Healthcare System	Relational/milieu therapy; trauma-focused treatment
Charles Wilson, MSW	Rady Children's Hospital San Diego	Child and family services; prevention; intervention

Note: * Indicates participants who provided feedback on potential revisions.

Additional Trauma Psychology Experts Surveyed, Affiliation, and Area(s) of Expertise

(In Alphabetical Order)

Name	Affiliation	Area(s) of Expertise
J. Gayle Beck, PhD	University of Memphis	Treatment development and experimental psychopathology of adult anxiety disorders and PTSD
Bethany Brand, PhD	Towson State	Assessment and treatment of PTSD and dissociative disorders
Elissa Brown, PhD	St. John's University	Psychotherapy for child trauma, particularly interpersonal violence; child bereavement
Ateka Contractor, PhD	University of North Texas	Mechanisms of PTSD comorbidity with depression, impulse-based symptoms, and substance use disorders; role of cultural and personality influences in PTSD symptomatology
Maria Crouch, PhD	Yale University	Intersection of trauma-informed care, evidence-based practices, and practice-based evidence (Indigenous approaches) to address alcohol and drug misuse, trauma, and related health impacts of social determinants among American Indian and Alaska Native communities
Bitu Ghafoori, PhD	California State University Long Beach	Psychological reactions to trauma; disaster mental health with specific emphasis on reactions to trauma, epidemiology, and impact of traumatic stress; attachment bonds and traumatic stress; cross-cultural differences in resiliency and pathology after trauma
Damion Grasso, PhD	University of Connecticut	Biobehavioral mechanisms involved in trauma- and stress-related disorders in children; strategies for assessing and treating trauma-related impairment
Robin Gurwitch, PhD	Duke University	Understanding and supporting children in the aftermath of trauma and disasters.
Janna Henning, PhD	Adler University	PTSD; dissociation; death, dying, bereavement; loss, chronic or life-threatening illness
Chris Layne, PhD	Nova Southeastern University	Assessment and treatment of traumatic stress, PTSD, bereavement and grief in children and adolescents; clinical training and education
Sylvia Marotta-Walters, PhD	George Washington University	Complex PTSD disorders; measurement of stress and resilience.
Barbara Niles, PhD	Boston University; National Center for PTSD, Behavioral Science Division	Complementary and integrative health approaches in the treatment of PTSD; Health and lifestyle behaviors in individuals with PTSD and stress-related problems; Telehealth delivery of behavioral treatments

Nnamdi Pole, PhD	Smith College	Psychophysiology and psychotherapy of psychological trauma; ethnic minority mental health.
Christine Valdez, PhD	California State University – Monterey Bay	Treatment barriers and access to trauma mental health for marginalized communities; posttraumatic rumination, cognition, and compassion
Anka Vujanovic, PhD	University of Houston	Psychological and behavioral processes related to PTSD and substance use disorders; suicide risk
Frank Weathers, PhD	National Center for PTSD; Boston University	Assessment of PTSD
Gerald Young, PhD	York University	Intersection of trauma/PTSD and law; forensic assessment



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