

Guidelines on Trauma Competencies for Education and Training¹

Approved by APA Council of Representatives, 2015

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Preamble

The competencies put forth here are intended as guidelines for education and training for practice in the United States. They are based on the work conducted at a national consensus conference on trauma (Cook, Newman, & the New Haven Trauma Competency Group, 2014). 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.
- The competencies articulate **minimal** expectations. All trauma psychologists who seek to practice at the entry-level to practice are encouraged to demonstrate acquisition of these core competencies.
- The competencies assume that the general competencies for professional psychology have been attained.
- There are a number of 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 a given area. In addition, nine cross-cutting competencies were

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voted into the final product. The cross-cutting competencies represented areas of knowledge, attitudes, or skills 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 specific competency domains.

Guidelines on Trauma Competencies for Education and Training

Cross-Cutting Competencies

1. Demonstrate the ability to appreciate and understand the impact of trauma on health outcomes, the contribution of trauma to increasing health disparities, and the impact of integrated and trauma-informed care as a critical component of care for people who are survivors of trauma.
2. Demonstrate understanding about trauma reactions and tailor trauma interventions and assessments in ways that honor and account for individual, cultural, community, and organizational diversity. This competency includes demonstrating the ability to identify and understand the professionals' and clients' intersecting identities (e.g., gender, age, sexual orientation, disability status, racial/ethnicity, SES, military status, rural/urban, immigration status, religion, national origin, indigenous heritage, gender identification) as related to trauma and articulate the professionals' own biases, assumptions, and problematic reactions emerging from trauma work and cultural differences.

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3. Demonstrate understanding of how trauma impacts a survivor, the family system (including parents and caregivers), community, and organizations' sense of safety and trust, and apply the professional demeanor, attitude, and behavior to enhance the survivors' and organizations' sense of physical and psychological safety. This competency includes respecting autonomy of those exposed to trauma and also protecting survivors as appropriate.
4. Demonstrate understanding and ability to tailor assessment and interventions to account for developmental lifespan factors at the time(s) and duration of trauma and at the point of current psychotherapeutic contact.
5. Demonstrate the ability to understand, assess, and tailor interventions and assessments that address the complexities of trauma-related exposure including any resultant long- and short-term effects (e.g., comorbidities, housing related issues), and person-environment interactions (e.g., running away from home and being assaulted).
6. Demonstrate the ability to appropriately appreciate, assess, and incorporate trauma survivors' strengths, resilience, and potential for growth. Facilitate shared decision-making between the trauma survivor and psychologist whenever appropriate.
7. Demonstrate the ability to recognize practitioners': (1) Capacity for self-reflection and tolerance for intense affect and content; (2) Ethical responsibility for self-care;

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and (3) Self-awareness of how one's own history, values, and vulnerabilities impact trauma treatment delivery.

8. Demonstrate the ability to critically evaluate and apply up-to-date available science on research-supported therapies and assessment strategies for trauma-related disorders/difficulties.
9. Demonstrate the ability to understand the value and purpose of the various professional, paraprofessional and lay responders in trauma work and work collaboratively and across systems to enhance positive outcomes.

Scientific Knowledge

1. Demonstrate the ability to recognize the epidemiology of traumatic exposure and outcomes, specifically:
 - a. Prevalence, incidence, risk and resilience factors, and trajectories.
 - b. Subpopulations (e.g., children, adolescents, young and middle-aged adults, older adults; men, women; veterans, civilians) and settings (e.g., primary care, general or specialized mental health, forensic, juvenile justice).
2. Demonstrate basic knowledge of findings, mechanisms, models, and interactions among social, psychological, neurobiological factors (e.g., relational, developmental, cognitive and affective, economic, genetic/epigenetic, health and health behaviors).
3. Demonstrate understanding of the social, historical, and cultural context in which trauma is experienced and researched.

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4. Demonstrate the ability to critically review published literature on trauma and PTSD by employing general knowledge as well as trauma-specific knowledge.
5. Demonstrate the ability to effectively and accurately communicate scientific knowledge about trauma to a broad range of audiences.

Psychological Assessment

1. Demonstrate a willingness to ask about trauma exposure and reactions with all clients, in both trauma and non-trauma focused client presentations.
2. Demonstrate the ability to conduct comprehensive assessment of trauma exposure and trauma impact based on the most current available evidence base.
3. Demonstrate the ability to conduct comprehensive assessment of trauma exposure and trauma impact, such as comprehensive trauma screening measures for domestic violence and intimate partner violence, based on the most current available evidence-base.
4. Demonstrate awareness of and capacity to appropriately adjust procedures, processes, and interpretations related to the unique impacts of trauma (e.g., dissociation, avoidance, triggers) as they affect assessment.
5. Demonstrate the ability to understand the course and trajectory of trauma responses and tailor assessment accordingly.
6. Demonstrate the ability to assess strengths, resilience, and growth both pre-existing and post-trauma.

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7. Demonstrate awareness of test interpretation issues frequently encountered in trauma-exposed populations (e.g., appropriate use of validity scales, response styles, motivation).
8. Demonstrate the ability to assess the extent to which cultural beliefs and practices influence the expression and coping with trauma exposure including barriers to assessing treatment.
9. Demonstrate knowledge about the practical consequences of trauma-related assessment and diagnosis in different contexts (e.g., social services, military, forensic, health care settings).
10. Demonstrate the ability to tailor the trauma assessment, battery, and interview questions to client characteristics (e.g., culture, subculture, age, SES, family or systems), trauma experience (e.g., timing, duration, type) and the practice setting.
11. 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 trauma survivors.

Psychological Intervention

1. Demonstrate knowledge of the current science on research-supported interventions (psychosocial, pharmacological, and somatic) for trauma-related disorders/difficulties.
2. Demonstrate the ability to employ critical thinking collaboratively to tailor and personalize treatment and its pacing with survivors in order to be responsive to trauma

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survivors' trauma type and comorbidities, as well as personality, culture, values, strengths, resources, preferences, parents/caregivers/families, and communities within the context of the recovery environment.

3. Demonstrate the ability to use the right treatment and monitor the effects. Namely demonstrate the ability to apply trauma-focused phased treatment and match treatments to evolving needs. Effective trauma treatment is inherently complex; Psychologists should demonstrate the ability to continually assess the interaction of the client and the changing environment for indicators of improvement or worsening.
4. Demonstrate understanding of the components and mechanisms of change, both common and unique, underlying various therapies for trauma-related disorders.
5. Demonstrate the ability to attend to trauma-related material non-judgmentally and non-punitively with empathy, respect, and dignity and a belief in recovery and resilience (in contrast to pity, condescension, and resignation).
6. Demonstrate the ability to implement non-avoidant strategies in engagement, retention, and delivery of trauma-focused treatment (i.e., avoid avoidance).
7. Demonstrate the ability to identify opportunities to reduce the deleterious effects of trauma and promote recovery and growth before, during, and following trauma exposure (i.e., prevention and mitigation).
8. Demonstrate understanding about how a comprehensive pharmacological treatment plan can be part of a biopsychosocial approach to trauma response, when warranted.

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9. Demonstrate an understanding about the pharmacology of each medication as it relates to therapeutic and adverse effects and how drug actions might be modified by genetics, gender, age, and health behaviors (e.g., diet, smoking, alcohol use) as well as their interactions (e.g., race-based medication interactions).
10. Demonstrate the ability to collaborate with trauma clients' families, social networks, and care systems to promote non-avoidance and positive trauma-related responses.
11. Demonstrate the ability 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.

Professionalism

1. Demonstrate the ability to sensitively interface with legal and other external systems in ways that safeguard trauma survivors and enhance outcomes (e.g., 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 trauma survivors remain cognizant of the context (e.g., legal setting, insurance disputes).
2. Demonstrate enhanced attention to ethical issues that are relevant to trauma survivors and appropriate boundaries in trauma work (e.g., boundary maintenance, role overlap, informed consent, confidentiality).

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NOTE: APA (2010) has ethical guidelines that cover this area and those should not be overshadowed.

3. Demonstrate skills to hear and work with clients' trauma material and associated distress 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 relevant leaders around trauma issues and promoting systemic, social, and policy changes.

Relational and Systems

1. Demonstrate knowledge of the disorganizing effects of trauma. Given that trauma results in changes at the individual and systems levels, psychologists demonstrate the ability to respond to these deleterious effects appropriately.
2. Demonstrate knowledge about and skills in offering consultation on trauma-informed systems of care and models of care.
3. Demonstrate the ability to engage in interdisciplinary collaboration regarding traumatized individuals, their families and communities.
4. Demonstrate the ability to educate and communicate trauma-specific knowledge effectively to multiple audiences, including those communities and organizations that are acutely impacted by trauma.

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5. Demonstrate understanding that institutions and systems can contribute to primary and secondary (or vicarious) trauma and offer strategies to reduce these barriers as appropriate.
6. Demonstrate an understanding of the importance of using relational healing for relational injury (e.g., trustworthiness) and the capacity to use the relationship effectively.
7. Demonstrate knowledge about the role of organizations in building resilience, prevention, and preparedness (universal precautions).
8. Demonstrate the ability to consistently recognize how cultural, historical, and intergenerational transmission of trauma influences the perception of helpers.

Implementation and Maintenance of Proposed Competencies

1. Plan for Promulgating Proposed Competencies

The competencies were published in APA's Division 56 journal, *Psychological Trauma: Theory, Research Practice and Policy* (Cook, Newman, & the New Haven Trauma Competency Group, 2014). A website may also be established to provide access to the competencies including resources for their application at varying levels of psychology training and practice.

In addition, we are engaged in a number of endeavors to translate the content and outcome of the conference for psychology practitioners, administrators, and training directors. Outlets

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include other peer reviewed journals, and professional organization magazines and newsletters (e.g., ISTSS StressPoints). Indeed, APA's Monitor published a piece on the trauma consensus conference (Wilson, 2013). In addition, Drs. Cook and Newman have presented the proceedings through presentations offered at the APA and the ISTSS annual conventions.

2. Plan for Maintaining Currency of Competencies

The *Guideline 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).

Commentary may be addressed to:

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Background

1. Terminology Used and Rationale for Proposed Competencies

(a) Use of terms.

The definition of psychological *trauma* has been widely debated (Weathers & Keane, 2007). When the American Psychiatric Association (1980) first introduced Posttraumatic Stress Disorder (PTSD) into its official diagnostic nomenclature (the Diagnostic and Statistical Manual, Third Edition; DSM-III), 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 (Weathers & Keane, 2007). 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-III, the criterion was expanded to include a definition of traumatic exposure as a phenomena “usually experienced with intense fear, horror and helplessness” (American Psychiatric Association, 1987) as the original definition was criticized for being too brief and vague (Weathers & Keane, 2007). Taking into account the epidemiological research that had demonstrated traumatic exposure was actually quite common, the DSM-IV (American Psychiatric Association, 1994) revision to Criterion A resembled that of

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DSM-III-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.

Presently, the DSM-5 (American Psychiatric Association, 2013) 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, Resick, Bryant, and Brewin (2011), some examples of events that meet diagnostic criteria include childhood physical and sexual abuse, interpersonal or domestic violence, combat/captivity, terrorism, natural or man-made disasters.

However we recognize that while we are anchoring our definition of trauma to the official 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 a 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.

diagnostic nomenclature, we are not excluding broader terms such as intergenerational trauma, historical trauma or oppression-based trauma. Intergenerational trauma occurs when exposure to a traumatic event by an earlier cohort continues to affect subsequent generations (Danieli, 1998). 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 willingness to assimilate. This type of experience(s) can be very extremely stressful with associated negative mental health consequences (e.g., Helms, Nicolas, & Green, 2010; Spanierman & Poteat, 2005).

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 can 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 the minimal knowledge, attitudes and skills a psychologist working with populations exposed to trauma ought to possess. Unlike other competencies which 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.

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The competencies can serve a broad range of professionals including but not limited to practicing organizational and consulting psychologists, health-care 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).

2. Scope of Application and Need for Proposed Competencies

(a) Scope of application for proposed competencies. Many factors converge to suggest the critical need for a focus on trauma psychology training at this time. Trauma and its consequences have been recognized as high priority public health risk of major proportion by several federal agencies (e.g., U.S. Department of Health and Human Services, 2003; U. S. Surgeon General, 1999). Events including the terrorist attacks of September 11th, the wars in Iraq and Afghanistan, and devastating natural disasters such as Hurricane Katrina have broadened recognition of trauma and its mental health concomitants to the forefront of the national agenda. This improved awareness is expected to facilitate an increase in the number and proportion of trauma survivors acknowledging trauma effects and seeking services. Thus more psychologists will likely deliver services to these vulnerable populations, but some lack evidence-based knowledge, assessment and psychotherapy skills needed to do so.

Extensive coverage of trauma is not an integral component of the standard curricula in graduate level education for psychologists (Courtois & Gold, 2009; DePrince & Newman, 2011).

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Further, although the scientific literature on traumatic stress is large and growing, most psychologists have only a cursory knowledge of trauma science and do not apply evidence-based psychosocial treatments for PTSD consistently, if at all (Gray, Elhai, & Schmidt, 2007; Pignotti & Thyer, 2009; Sprang, Craig, & Clark, 2008). While not all psychologists who work with traumatized children and adults can 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 (Chu, 1998; Salston & Figley, 2003). For example, working with survivors with severe and prolonged trauma can be both complex and intense and may have negative impacts on the clinician such as burn-out, compassion fatigue, or issues of countertransference (Figley, 1995; Salston & Figley, 2003). More specifically, trauma survivors may have multiple intra- and interpersonal issues that necessitate an arduous and lengthy course of psychotherapy that requires a sophisticated understanding of interventions in order to achieve resolution (Chu, 1992). In an effort to prevent this type of compassion fatigue, Salston and Figley (2003) emphasize the need for increased training, education, supervision and consultation related to trauma. Indeed, Adams and Riggs (2008) found that graduate level clinicians with trauma-specific training are less likely to report vicarious traumatization.

Although an evidence-based core competency model for working with trauma survivors includes understanding and utilizing evidence-based assessments and psychosocial interventions for PTSD, competent practice in trauma also requires other unique knowledge, attitudes and skills. For example, the extreme circumstances in which some traumas occur and the attendant

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psychological consequences can 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 health care that are reflective of differences in socioeconomic status, racial/ethnic background, and education level, that must be addressed in trauma psychology. These discrepancies exist due to many factors including access to health care, increased risk of disease, occupational hazards, or underlying genetic, ethnic or familial factors. These discrepancies can exacerbate the effects of trauma and require the practitioner to be sensitive and responsive to gender, race, social, political and cross-cultural issues. Attention to age, race/ethnicity, disability status, gender, gender diversity and identity, military/veteran status, sexual orientation and socioeconomic status (SES) are also critical influences to integrate into core competencies of trauma psychology practice (e.g., Brown & Pantalone, 2011). Similarly, the conditions of trauma can create characteristics in many survivors that have been empirically shown to make it difficult for people 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 client characteristics, 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. Thus, a competency model will help psychologists to improve their practice with complex, vulnerable traumatized populations.

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In April of 2013 the “Advancing the Science of Education, Training and Practice in Trauma” national consensus conference on trauma competencies (deemed there the *New Haven Trauma Competencies*) was held at the Yale School of Medicine in New Haven, Connecticut. Sixty leading 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 both 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, Karel, Hinrichsen, Qualls, & Duffy, 2004). The impact of these previous competency conferences are ongoing and include 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, also known as the *New Haven Trauma Competencies*, include both 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 similar to most psychology specialties which share the same foundational and functional competencies but are differentiated by their

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parameters of practice (e.g., population served; Rodolfa et al., 2005). Similar to 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). Finally, it was envisioned that assessment of formative and summative competence in trauma, like other competencies, would be multi-trait, multi-method, and multi-informant (Roberts, Borden, Christiansen, & Lopez, 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 in nature. 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.

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(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, Dinnen, Rehman, Bufka, & Courtois, 2011; Gray et al., 2007; Pignotti & Thyer, 2009; Sprang et al., 2008). Cutting-edge biological and psychosocial research with clinical applications in the field of trauma is plentiful and in need of dissemination. Thus, there exists a clear need for the dissemination 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, health-care 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 multi-fold. Exposure to potentially traumatic events is not a rare event. A history of exposure to traumatic

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events is prevalent in the general population. Indeed, many individuals in the United States are exposed to trauma at some point in their lives. In fact, conservative estimates indicate that up to 60% of adults have experienced at least one event that would be considered traumatic, such as child maltreatment, interpersonal violence, natural disaster, war or serious accident, in their lifetime (Kessler et al., 2005). More specifically, in a large epidemiological study, the most commonly reported traumatic exposures leading to partial or full PTSD were unexpected death of a loved one, serious illness or injury to someone close, and sexual assault (Pietrzak, Goldstein, Southwick, & Grant, 2011).

Similarly, large epidemiological studies indicate a plurality of children and youth experience exposure to a broad range of one or more traumatic events in their lifetimes (for brief review see Fairbank, 2008) including assaults by peers and siblings, nonsexual assaults to genitals, dating violence, hate crimes, and property thefts. Indeed in a nationally representative sample of children and adolescents ages 2 to 17 years, up to 71% had been exposed to one or more victimization incidents in the past year (Finkelhor, Ormrod, Turner, & Hamby, 2005).

A history of exposure to trauma is appreciably more prevalent in clinical samples than in the general population. Although the majority of individuals who experience a single potentially traumatic event do not have long-term negative consequences, a substantial minority develop significant health difficulties (Kessler, 2000). Exposure to traumatic incidents has been implicated as a risk factor for a number of trauma-related disorders (i.e., PTSD, Acute Stress Disorder, Complex PTSD) commonly encountered in clinical settings (Kessler, 2000). Beyond

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the explicitly trauma-related disorders, there are many other psychological disorders and symptoms that have been found to be related to a history of trauma (e.g., dissociation, depression, anxiety, substance abuse, personality disorders; for brief review, see Gold, 2004).

A history of exposure to trauma not only is related to impaired psychological functioning but to serious health risks as well (Kessler, 2000). 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; Nightingale, R., Sher, Mattson, Thilges, & Hansen, 2011). For example, traumatic events associated with violence (e.g., child sexual abuse, gendered or sexual harassment, rape, or sexual assault of a child or adult) and PTSD may negatively impact 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 (Kessler, 2000).

Many clients who seek psychotherapy services have significant trauma histories (Gold, 2004). Knowledge of and skills in applying assessment measures developed, normed, validated and determined to be psychometrically suitable for use with trauma survivors exist and are in need of more widespread dissemination. 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 and/or more than one event of the same type. If

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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 poverty and low SES status when screening for trauma because people with low economic status are at risk for increased violence (APA, 2003; APA, 2007) 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 (Marcin, Schembri, He, & Romano, 2003) as well as 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 that affects many Lesbian Gay Bisexual Transgender Queer Questioning Intersex Ally people's sense of self and relationship with others (House, Van Horn, Coppeans, & Stepleman, 2011). Additionally it is widely acknowledged that the interaction among gender, political structure, religious beliefs, attitudes toward violence contribute to the vulnerability and safety of battered women, children exposed to domestic violence, and abusive partners (Walker, 1999). Thus trauma-informed psychotherapy should contribute to a trauma survivors regaining of psychosocial equilibrium and

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a decrease in fearfulness following trauma by reinforcing the message that one is safe and can trust in others to aid in their protection.

In addition, the importance of trauma in informing an initial treatment psychotherapy plan or recommendations is sorely needed. Inappropriate diagnosis or under-detection of symptoms can lead to inadequate treatment plans or administration of poorly focused or inappropriate treatment (e.g., Hegel et al., 2005). Effective treatments for PTSD and other trauma-related treatments exist. In brief, several psychotherapies, namely Prolonged Exposure (Foa, Hembree, & Rothbaum, 2007), Cognitive Processing Therapy (Resick & Schnicke, 1993) and Eye Movement Desensitization Reprocessing (Shapiro, 2001), are research-supported treatments for PTSD listed in numerous guidelines developed across three continents (i.e., North America, Europe and Australia; Forbes et al., 2010). All of these treatments are trauma-focused 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.

Although a primary emphasis of the New Haven Trauma Competency Model was individualized, there are, of course, multiple levels for which competencies might be relevant, including not only on the individual, but also on the broader parental and family unit, and the community, to mention a few. 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).

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3. Process of Developing Competencies

(a) Participants and Process.

The Guidelines on Trauma Competencies for Education and Training development process was led by two fellows of the APA's Division of Trauma Psychology, Drs. Joan M. Cook and Elana Newman.

Delegates were nominated for attendance to the consensus conference by Drs. Cook and Newman as well as 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, academic institutions, as well as representing a diverse array of professional organizations (e.g., APA, ISTSS, National Child Traumatic Stress Network, International Society for the Study of Trauma and Dissociation). A list of consensus conference participants' affiliation and area(s) of expertise can be found in the Appendix.

Based on discussions and review of the current conceptualization of competency benchmarks, five broad core competencies were pre-determined by Drs. Cook and Newman prior to the beginning of the conference. The five broad core competencies work groups were as follows:

1. Scientific Knowledge about Trauma – Understanding of, familiarity, and respect for the empirical foundation of the traumatic stress field; research methodology, techniques of data

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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 and 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: (1) Understand, be familiar with and have respect for foundations of current scientific knowledge on trauma and its impact.

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

Attitudes: (1) Aware and willing to 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.

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II. Psychosocial Assessment – Understanding of and familiarity with assessment and diagnosis of trauma-related problems, capabilities, contextual factors (e.g., structural and policy influences) associated with traumatic events and their impact on survivors.

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

Knowledge: Understand and respect for the: (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 trauma survivors; and (3) Principles of trauma-focused clinical interviewing that are founded in science and may vary developmentally; (4) Contextual factors that may influence assessment such as an individual’s development and environment (e.g., parenting, caregivers, family, community). This may be particularly important when doing assessments with children, adolescent 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) Utilize assessment tools (e.g., standardized tests, structured interviews, clinical interviews) in a variety of settings

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(e.g., research, outpatient, inpatient) and populations (e.g., substance abusing clients; eating disordered clients).

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

The Standards for Educational and Psychological Testing (American Educational Research Association, American Psychological Association, & National Council on Measurement in Education, 2014) are important to 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, these 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 particular 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 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.

(e.g., knowledge of and skill development in evidence-based interventions for trauma-related problems; progress evaluation; modifications of techniques to address problems

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such as emotion dysregulation, aggression, past treatment non-response, and co-morbidities such as substance use disorders in trauma survivors; the role of non-specific factors; potential applications of neuroscience findings to psychosocial practice in trauma survivors)

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 trauma survivors.

Skills: Able to: (1) Engage appropriately in case formulation and selection of appropriate intervention strategies for trauma survivors; (2) Establish treatment objectives, execute treatment plan and assessing treatment progress with trauma survivors; (3) Implement evidence-based interventions for trauma survivors including adapting manualized treatments to meet trauma clients' needs and to be effectively applied in multiple treatment setting; (4) Implement appropriate termination skills with trauma survivors; (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 trauma survivors.

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Attitudes: Be aware 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 comportsment that reflects the values and ethics, integrity, and responsibility required to effectively work with trauma survivors, other professionals, and organizations. When working with trauma survivors, 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 trauma survivors; awareness and application of ethical decision-making when working with trauma survivors 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)

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Knowledge: Understand and be familiar with: (1) Professional ethic 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 trauma survivors 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 social change; (6) Participate in effective self-care; and (7) Conduct routine performance appraisal.

Attitudes: Be aware 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.

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V. Relational and Systems. Understand and be familiar with the: (1) Key trauma-related interpersonal and systems issues; (2) Principles of interdisciplinary collaboration when working with trauma survivors. 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); (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 trauma survivors 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

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individuals, couples, families, groups and communities; and (3) Counter-transference issues in trauma-focused treatment.

Skills: Able to: (1) Listen and be empathic with trauma survivors; (2) Accept, evaluate and implement feedback; (3) Tolerate and understand interpersonal conflict in therapeutic relationship and make appropriate disclosures regarding problematic interpersonal situations; (4) Tolerate ambiguity and uncertainty in clinic practice; (5) Support effective interdisciplinary team functioning, such as communicating without jargon, dealing effectively with disagreements about diagnosis or treatment goals, supporting and respecting the perspectives of other team members; and (6) Work in interdisciplinary clinical settings in working with other professionals to incorporate trauma information into overall team planning and implementation.

Attitudes: Willing to: (1) Understand and accept the clients and groups 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 audio-taped for professional transcription. In addition, each work group had a Yale psychologist who assisted the group, primarily through extensive note-taking. These individuals were also 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.

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All work groups utilized a technique called the Nominal Group (Delbecq & VandeVen, 1971), a tried and true 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 currently exist in trauma.

The three steps in the Nominal Group process followed were:

1. Generating Ideas:

Work group co-leaders directed everyone in their group to write down what they considered to be components of the particular competency in brief phrases or statements on index cards, 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 new 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

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members would like to make about the item?” Other questions were asked were, “Is this specific to trauma training or practice?,” “Is this a knowledge, attitude, or skill 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, attitudes, and skills 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, attitude and skill competencies needed for mental health providers working with trauma survivors? (b) Are there distinctive training values, conditions, methods, or experiences that comprise 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, attitude and skill 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 conference at large their findings and all conference participants voted on the final competencies to be adopted on the final morning of the conference. More specifically, on the last day of the conference, the lists of competencies were written on large white notepads that hung on the conference room walls.

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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 its assigned area. Votes were then tallied to identify those highest rated competencies by the conference participants as a whole.

In addition we collected all of the working groups white notepads for further review as well as 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.

(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). Various other fields within the sciences including medicine (Accreditation Council for Graduate Medical Education, 2007; Epstein & Hundert, 2002), dentistry (American Association of Dental Schools, 1997) and nursing (National Organization of Nurse Practitioner Faculties, 2012) have successfully implemented competency-based assessment during training, credentialing and through continuing education. 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 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 a 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.

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; NCTSN Core Curriculum on Childhood Trauma Task Force, 2012; Walsh et al., 2012). The five working groups utilized at the “Advancing the Science of Education, Training and Practice in Trauma” 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 have identified a need for trauma-informed training among health professionals, such as the National Child Traumatic Stress Network (Layne et al., 2011) and have developed a core curriculum on childhood trauma for social workers (Strand, Abramovitz, Layne, Robinson, & Way, 2014). The *Guidelines on Trauma Competencies for Education and Training* adds to these efforts by identifying trauma-specific sub-components 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

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APA Assessment of Competency Benchmarks Work Group (Fouad et al., 2009) identified competency benchmarks for each of 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, 2006) graduate, post-doctoral and licensing stages (Fouad et al., 2009; Kaslow et al., 2009).

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Section E: Appendices

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1. Delegate Affiliation and Area(s) of Expertise
(In Alphabetical Order)

	Affiliation	Area(s) of Expertise
Lisa Amaya-Jackson, M.D., MPH	Duke University; National Child Traumatic Stress Center; Center for Child and Family Health	Child trauma; Evidenced-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; Victims of crime
S. Megan Berthold, Ph.D., LCSW	University of Connecticut School of Social Work	Victims of torture, war trauma, human trafficking and female mutilation; Refugee and asylum victims of trauma
Sandra L. Bloom, M.D.	Drexel University	Complex trauma; The Sanctuary Model
Brian E. Bride, Ph.D., LCSW	The University of Georgia	Co-occurring disorders, namely substance abuse and mental health; Secondary traumatic stress
John Briere, Ph.D., Group II Co-leader	University of Southern California; National Child Traumatic Stress Network	Psychological assessment; Child abuse; Complex trauma; Interpersonal violence; Gender issues

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Ernestine Briggs-King, Ph.D.	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, Ph.D., 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, Ph.D.	University of New Mexico; New Mexico Veterans Affairs Health Care System	Assessment of PTSD amongst women and Hispanic veterans; Cross-cultural counseling; Anger in PTSD
Marylene Cloitre, Ph.D.	National Center for PTSD, Dissemination and Training Division	Evidence-based treatments of PTSD, namely Skills Training in Affect and Interpersonal Regulation
Joan M. Cook, Ph.D., Conference Chair	Yale School of Medicine; National Center for PTSD	Aging issues; Dissemination and implementation of evidence-based practices; Combat/Captivity
Christine Courtois, Ph.D., Group V Co-leader	Independent Practice, Washington DC	Sexual assault; Treatment of complex traumatic stress; Childhood abuse
Stephen J. Cozza, M.D.	Uniformed Services University	Clinical and community response to trauma; Military trauma; Military family trauma

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Constance Dalenberg, Ph.D.	Alliant International University San Diego	Consequences of trauma; Trauma symptoms and treatment; Forensic evaluations; Trauma disclosure
Lori L. Davis, M.D.	University of Alabama Health System; Tuscaloosa Veterans Affairs Medical Center	Neurobiology; pharmacology; Vocational rehabilitation of PTSD
Michael de Arellano, Ph.D.	Medical University of South Carolina	Child victims of trauma; Racial/ethnic minority issues; Psychological sequelae of trauma
Jason Deviva, Ph.D.	Veterans Affairs Connecticut Health Care System; Yale University	Treatment of trauma-related sleep problems; treatment of combat-related PTSD
Diane Elmore, Ph.D., M.P.H., 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, Ph.D., 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, Ph.D., LISW	Case Western Reserve University	Assessment and diagnoses of mental health and substance use disorders

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Vincent J. Felitti, M.D.	Kaiser Permanente San Diego; University of California	Infectious diseases; Obesity and trauma; Adverse childhood experiences
Jennifer J. Freyd, Ph.D.	University of Oregon	Betrayal trauma; Interpersonal trauma; Dissociation; Gender differences in mental health
Matthew Friedman, M.D., Ph.D.	National Center for PTSD, Executive Division; Dartmouth School of Medicine	Pharmacotherapy; Neuroscience; Stress and PTSD; Biological psychiatry
Steven Gold, Ph.D., Group III Co-leader	Nova Southeastern University	Dissociation; Addictions/compulsivity; Hypnosis
Bonnie L. Green, Ph.D.	Georgetown University Medical School	Uninsured and low income populations; Consequences of traumatic events
Catherine L. Grus, Ph.D.	American Psychological Association	Education and training; Policy and practice; Competency assessment
Jessica Hamblen, Ph.D.	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

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Nancy Kassam-Adams, Ph.D., Group II Co-leader	Children's Hospital of Philadelphia	Pediatric traumatic stress; Medical injury; Assessment and screening of traumatic stress;
Kathleen Kendall-Tackett, Ph.D.	Independent Practice; Texas Tech University School of Medicine	Trauma-related health disorders; Health psychology; Crimes against children
Dean Kilpatrick, Ph.D., Group I Co-leader	Medical University of South Carolina	Epidemiology of trauma and related disorders; Gene-environment interactions
Karestan Chase Koenen, Ph.D.	Columbia University's Mailman School of Public Health	Psychological trauma; PTSD; Epidemiology; Epigenetics of traumatic exposure and PTSD
Roberto Lewis-Fernandez, M.D.	Columbia University; New York State Center of Excellence for Cultural Competence	Racial/ethnic minority issues: Dissociation; Anxiety disorders; Cultural psychiatry
Steven Marans, Ph.D., MSW	Yale University School of Medicine	Child trauma; Trauma consultation and treatment
Elissa McCarthy, Ph.D.	Veterans Affairs Connecticut Health Care System	Evidence-based psychotherapy; Substance abuse
Thomas A. Mellman, M.D.	Howard University College of Medicine	Trauma-related sleep issues; Anxiety disorders
Charlotte Mullican, MPH	Agency for Healthcare Research and Quality	Mental health; Substance abuse

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Elana Newman, Ph.D., Conference Vice-Chair	The University of Tulsa	Evidence-based approaches to treatment; Substance abuse and trauma; Assessment
John C. Norcross, Ph.D., ABPP	University of Scranton; Independent Practice	Empirically-supported relationships; Evidence-based treatments
Robert H. Pietrzak, Ph.D.	Yale University School of Medicine; National Center for PTSD, Clinical Neuroscience Division	Geriatric mental health; Resilience; Epidemiology of trauma related disorders; Neuropsychological assessment
Robert Pynoos, M.D., 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, Ph.D.	National Center for PTSD, Women's Division; Boston University	Evidence-based treatments for PTSD, namely Cognitive Processing Therapy
David S. Riggs, Ph.D.	Center for Deployment Psychology	Domestic Violence; Effects of trauma on couples and family; Prolonged Exposure
Beth N. Rom-Rymer, Ph.D.	Independent Practice	Forensic geriatrics; Interpersonal violence; Aging and trauma issues; Law enforcement; Working with impaired professionals

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Barbara Rothbaum, Ph.D., Group III Co-leader	Emory University	Evidence-based treatments for PTSD, namely Prolonged Exposure and virtual reality therapy
Josef Ruzek, Ph.D., 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, Ph.D.	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, M.A.	Yale School of Medicine	Interpersonal violence; Dissemination and implementation of evidence-based psychotherapies
Ginny Sprang, Ph.D.	University of Kentucky	Child and adult trauma; Maltreatment; Victimization
Carla Smith Stover, Ph.D.	Yale University School of Medicine	Families impacted by domestic violence; Evidence-based treatments, namely Trauma-Focused Cognitive Behavior Therapy

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Virginia Strand, DSW	Fordham University	Implementation of evidence-based treatments; Child trauma; Family intervention
Amy Street, Ph.D.	Boston University School of Medicine; National Center for PTSD, Women's Division	Interpersonal violence in veteran populations; Military sexual assault
Steve Southwick, M.D.	National Center for PTSD, Clinical Neurosciences Division Yale School of Medicine	Neuroscience; Resilience; Psychopharmacology
Joan Turkus, M.D.	The CENTER	Dissociation; Education and consultation; Treatment of traumatic stress
Dolores Vojvoda, M.D.	Yale School of Medicine; Veterans Affairs Connecticut Healthcare System	Combat trauma; Anxiety disorders
Patricia Watson, Ph.D.	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

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