

Examining the Relationship between Traumatic Experiences and Posttraumatic Growth among Counselors-in-Training

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Abstract

The present study explored the relationship between experience of trauma and posttraumatic growth (PTG) among 86 graduate level counselors-in-training (CIT). Results indicated that the most frequent trauma endorsed was witnessed or learned about violence to a loved one and the higher the rating of the most severe trauma experienced related to a higher reported level of personal growth. Overall, 67% of the CIT received support for their trauma by participating in personal counseling. Implications for counselor educators includes an understanding of the potential for trauma impacting students as well as different responses to trauma based on gender and the number of traumatic experiences.

Keywords: trauma, posttraumatic growth, counselor education, counseling, counselors-in-training

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Traumatic experiences are common in the general population, effecting people of all ages genders, educational levels, cultures and socioeconomic backgrounds (APA, 2000; Donah-Burke, 2009; Ho, Chan, & Ho, 2004; Levers, 2012; Michalopoulos & Aparicio, 2012; Shigemoto & Poyrazli, 2013; Tedeschi & Calhoun, 1996). Exposure rates to at least one common traumatic event among the general population ranged from 36% to 81% (Levers, 2012). In addition, Levers (2012) reported that about 25% of the general population reported experiencing two or more traumatic episodes. The Diagnostic Inventory Schedule, used in part to assess the type and severity of traumatic experiences, includes many common traumas such as being in an accident, seeing someone become hurt, physical victimization, experiencing sexual abuse, and loss of a loved one (Dillman, 2000; Levers, 2012). Smith, Summers, Dillon, and Cogle (2016) reported that the three most endorsed types of worst-event traumas were related to sexual trauma, physical violence, and unexpected death of a loved one.

These stressful life events can be very challenging for some individuals depending on the type of trauma, the number of traumas experienced, the severity of those experiences, and the support they receive. Common reactions to traumatic events include re-experiencing or reliving the traumatic memories, avoidance tendencies and psychic numbing, and psychobiological

changes and physiological reactivity (Lukaschek et al., 2013). If these core symptoms are prolonged, persistent and interfere with a person's ability to carry out life activities, a diagnosis of post-traumatic stress disorder (PTSD) may be warranted (Lukaschek, et al., 2013). Unlike the high rates of exposure to traumatic events, the prevalence rates among the general population for PTSD are much lower ranging from 7% to 10% (Levers, 2012). In general, women were consistently more likely to meet criteria for PTSD and experience more severe symptoms than men who experienced the same posttraumatic event (PTE) (Vishnevsky, Cann, Calhoun, Tedeschi, & Demakis, 2010). Tolin and Foa (2006) suggested that women experience trauma in different ways than men due to the differences in cognitive or affective processing of the event itself. Such differences were associated with women experiencing more acute psychological and biological responses to traumatic events. Interestingly, it was also noted that when both men and women experience the same PTE, women were more likely to meet the criteria for PTSD (Tolin & Foa, 2006).

Trauma among Counselors-in-Training

Students enrolled in graduate counseling programs are not immune to experiencing trauma or immune to experiencing symptoms related to traumatic experiences (Stewart-Spencer, 2010). In fact, many individuals enter the field of counseling because of personal struggles or traumas that led them to the helping fields thereby contributing to their empathy to help others (Stewart-Spencer, 2010). Unfortunately, clear and cohesive data related to the types of trauma experienced and the frequency at which trauma occurs among counselors-in-training (CIT) is lacking. Overall, little is known about how the trauma and the severity of those traumas among those entering the counseling field impacts their effectiveness at being a counselor. This is important because vicarious trauma can have adverse effects on work performance as well as the therapeutic relationship (Ledoux, 2015).

Evans (1997) reported that 93% of 205 CIT reported having experienced at least one trauma in their lives. In addition, Evans (1997) found that the most common trauma was intentional harm caused to them (18.6%), followed by loss of a loved one (17.2%) and threat to life and limb (14.9%). The study noted that among the 205 CIT who reported traumatic experiences, 197 also reported personal growth from experiencing the trauma. Evans (1997) concluded that counselor educators should consider the traumatic histories of CIT. If personal trauma is not addressed, counselors can encounter indirect trauma from their clients leaving them vulnerable to compassion fatigue (Stewart-Spencer, 2010).

If these symptoms persist, a counselor's ability to be an effective counselor may diminish and become impaired (American Counseling Association, 2010). According to the American Counseling Association Taskforce (ACAT) trauma can have a significant negative impact on a counselor's professional functioning which compromises client care or poses the potential for harm to clients (ACA, 2010). In a grounded theory study, Capps (2008) found that faculty in counselor education programs reported impairment issues with some CIT including but not limited to addiction, and prior significant life stressful event histories. Stewart-Spencer (2010) found that 543 CIT had limited knowledge of indirect trauma resulting from re-experiencing of stressful life events due to contact with clients.

Similarly, Curry (2007) reported some of the challenges faced by counseling practitioners include high stress, burnout, compassion fatigue, vicarious trauma, and counselor impairment all of which lead to emotional depletion due to work related responsibilities potentially hindering the counselor's ability to empathize with clients. While burnout impacts one's physical and emotional state depleting prior motivation and meaning-making, compassion fatigue occurs in context during the therapeutic relationship hindering the effective processing of highly stressful therapeutic content (Deighton, Gurriss, & Traue, 2007; Ledoux, 2015). According to Ledoux (2015), compassion fatigue itself has been used as an umbrella term often variously characterized as vicarious trauma and or a variant of burnout. For example, therapists not working through their past histories of trauma have high symptomatology presentation resulting in compassion fatigue and burnout (Deighton, et al., 2007). Curry (2007) echoed the ACA's Code of Ethics (2014) mandate for professional counselors to be knowledgeable and aware of impairment issues while working with clients. Furthermore, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) new standards mention the need for counselor resiliency development in training programs such as provision of information to students regarding personal counseling services provided by professional counselors (CACREP, 2016, I.H). Although more work is needed in this area, accrediting bodies such as CACREP are noting the need for graduate counseling programs to ensure the health of graduating counselors as noted in the standards.

Relationship between Experiencing Trauma and Positive Growth

Beyond the well documented negative effects of trauma and trauma symptoms, there is common belief that people, including those in training, may actually experience positive growth from trauma (Cann et al., 2010; Evans, 1997; Hobfoll, et al., 2007; Tedeschi & Calhoun, 1996). Originally coined from positive psychology, post-traumatic growth (PTG) has been theoretically and empirically examined (Baker et al., 2008; Cann, et al., 2010; Hagedaars & van Minnen, 2010; Kashdan & Kane, 2011; Tedeschi & Calhoun, 1996). According to Calhoun and Tedeschi (2004), when someone experiences a traumatic event, the stress challenges their worldview and existing core beliefs/schemas giving them the opportunity to change their cognitive processing and assumptions about the world.

Tedeschi and Calhoun (1996) empirically documented and categorized PTG into five areas of growth: new possibilities, personal strength, relating to others, spiritual change, and appreciation of life. This distress can lead to positive changes and growth in an individual's self-perception, relationships with others, and life philosophy. For example, Sim, Lee, Kim, and Kim (2015) surveyed patients who had a higher stage of cancer or who underwent total gastrectomy and found more than half of the patients reported moderate to high levels of PTG. Similarly, Taylor, Lichtman and Wood (1984) found that 60% of women who were diagnosed with cancer changed their philosophy of life (changes in life priorities).

Tedeschi and Calhoun (1996) sampled 186 college students who had experienced traumatic events and 60% reported mild to significant growth. In general, studies have reported that the higher the severity of a trauma, the more likely a person would report personal growth (Cann et al., 2010; Shigemoto & Poyrazli, 2013; Sim, Lee, Kim, & Kim, 2015; Tedeschi & Calhoun, 1996). In addition, there is evidence that suggests the more traumas a person experiences the higher their PTG (Anderson & Lopez-Baez, 2012; Donah Burke, 2009; Evans,

1997; Hooper, Marotta, & Depuy, 2009; Tedeschi & Calhoun, 1996). In a sample of U.S. and Japanese college students, Shigemoto and Poyrazli (2013) found that the number of traumas reported in both samples were significantly and positively related to PTG. As espoused in research and literature, counselors are not immune to the debilitating experiences of trauma.

Competencies in Trauma Counseling

There is dearth in training about trauma-informed counseling in graduate counselor education programs (Courtois & Gold, 2009; Layne et al., 2014; Litz & Salters-Pedneault, 2008; Lonergan, O'Halloran, & Crane, 2004; Paige, 2015). The rationale for training about trauma-informed counseling is to ensure counselors entering the field are adequately equipped with knowledge and skills of trauma-informed care (Layne et al., 2014; Paige, 2015). Furthermore, various researchers (Layne et al, 2014; Mattar, 2011; Paige, 2015; Turkus, 2013) have echoed the need for trauma training counseling competencies for mental health counselor programs. Specifically, Turkus (2013) noted criteria encompassing education, clinical practice, research, and self-reflection as important elements for inclusion in the training of competent trauma mental health practitioners. To further espouse the rationale for trauma training, Michalopoulos and Aparicio (2012) found higher social support and experience level as significant components mitigating the vicarious trauma.

Unfortunately, there is a dearth of research related to the experiences of trauma and personal growth among CIT, including the impact of gender, type, severity, and the number of traumas experienced. The purpose of this study was to further the work of earlier research (Evans, 1997; Stewart-Spencer, 2010) and to provide more information related to trauma and trauma growth among CIT. The study was guided by the following research questions:

1. What are the most frequent types of traumas reported by CIT?
2. How severe is the rating of the most impactful trauma reported by CIT?
3. How much personal growth do CIT report experiencing from their trauma?
4. What are the most frequent types of supports CIT receive when they experience traumas?
5. Are there differences between male and female CIT in the number of traumas reported and in their personal growth?

Method

Participants

The sample of Masters level CIT were recruited from a large private university with CACREP-accredited programs in five different locations in the Midwest, Northeast, and Southern United States. It is estimated that a total of 925 individuals received the email from their respective chairperson. A total of 98 CIT attempted to complete the anonymous survey they received. Twelve participants were excluded from the study due to incomplete responses to questions resulting in a total of 86 respondents. The study resulted in a response rate of 10% over a period of five months. Participants were 18-years old and above.

The sample majority was female (83.5%). Regarding age, 13.1% were between the ages of 18-25, 32.1% were between the ages of 26-33; 14.3% were between the ages of 34-41, and 28.6% were between the ages of 42-49. The majority of students (55.8%) were African

Americans; 30.2% were Caucasians; and 8.1% were Hispanic/Latinos. Concerning religious affiliation, 40.7% were Protestants; 30.2% were Catholics; and 22.1% selected “other.” The largest group of students (46.5%) was married; 37.2% were single; 14% were divorced; and 2.3% were separated. The vast majority (96.5%) were enrolled in a community counseling program. Relative to status in program, 36.5% completed 22-48 credits, 30.6% completed 1-21 credits, and 32.9% completed 48+ credits.

Procedures

Permission was previously obtained from the institutional review board (IRB) of the university under study. Cover letters and consent forms were sent to program chairs of five counseling programs and requested to forward a link of the study survey to students. The chairpersons from the five CACREP programs sent emails to their CIT. Participants were asked to click a link leading to a website designed for counseling research. The consent form for participation was embedded in the survey link. When participants completed reviewing the consent they were asked whether or not they wanted to continue with the study with a yes or no question. Because this was a trauma study, participants were encouraged to discontinue completing the survey if they were uncomfortable. Counseling resources were also provided including a list of counseling resources in the locations of university sites studied and a nationwide phone number, a confidential and voluntary counseling referral service provided free of charge, to call for referral if any emotional concerns arise due to the study. Two reminders were sent to program chairs to ensure follow-up.

Measures

Beyond demographic questions, the survey included questions about types of trauma experienced, the severity of the trauma(s), types of counseling received, and personal growth questions related to the experience. The two questionnaires included are described below.

Trauma Experience Questionnaire (TEQ)

The TEQ consists of 13 questions constructed by Evans (1997) to measure subjective traumatic experiences. The first nine questions consist of answering “yes” or “no” to whether or not the respondent experienced a specific type of trauma. The nine types were: experienced a threat to life, experienced severe physical harm, intentionally harmed someone, witnessed someone being harmed, experienced violent sudden loss of someone, learned about the loss of someone close, exposed to a noxious agent, caused severe harm to someone, and lastly the category “other” was available to list any other trauma that was not asked. The four additional questions included asking the participant to identify the most traumatic event experienced out of all of the traumas they reported, rate the severity of that event, rate the length of time the trauma was experienced, and finally what kinds of support were received to treat the trauma.

Regarding the content validity of the nine (9) TEQ trauma type questions, it was designed based on eight (8) types of traumas delineated in the literature by Green (1993). Evans (1997) conducted a pilot study and restructured the instrument to include a ninth trauma to capture the subjective experiences of any other trauma not listed among the eight. Regarding the construct validity of the TEQ, 13 items were also constructed for infusion into the previous 8 trauma types. After the pilot study (Evans, 1997), two raters were given the original article of Green (1993) from which the TEQ was constructed and the 13 items. The two raters were in agreement with 12

of the 13 items. Seven out of the 12 items were infused into the 8 traumas while 5 were combined to form the ninth subjective trauma of “other”. Prior to this study, the TEQ was further reviewed by two content experts and determined acceptable as a basic instrument that captures a general picture of various traumas. Feedback necessitated the addition of a statement at the beginning of the instrument noting potential for re-experiencing traumatic experiences. The total reliability score of the TEQ for all 9 types of trauma was a Cronbach’s alpha of .564.

Posttraumatic Growth Inventory (PTGI)

The PTGI is a 21-item questionnaire developed by Tedeschi and Calhoun (1996) that asks questions about changes that occurred in a person’s life as a result of experiencing trauma. The instrument has five general areas: relating to others, new possibilities, personal strength, spiritual change, and appreciation of life. PTGI has been found to be reliable in measuring the extent of PTG after a traumatic experience (Tedeschi & Calhoun, 1996). Internal consistency for the entire measure (.90), and internal consistencies for the 5 subscales: new possibilities (.84), relating to others (.85), personal strength (.72), spiritual change (.85), and appreciation of life (.67) are acceptable. Test-retest reliability for the entire measure over two months was $r = .71$ while test-retest reliabilities for the factors ranged from $r = .37$ to $r = .74$. The instrument has also been reported to have high reliability in several other studies (Shakespeare-Finch, Smith, Gow, Embleton, & Baird, 2003; Tedeschi & Calhoun, 1996).

Results

Simple descriptive statistics were completed on the demographic variables and the TEQ. The most frequent trauma experienced by CIT was “witnessed or learned about violence to a loved one” (62%). Both “intentionally harmed or injured someone” and “had experienced a threat to life and/or limb” were the second most reported trauma (56%). In addition, most respondents received support for their trauma including counseling (34%), family (23%) and spiritual assistance (17%). The nine traumas and their frequencies are represented in Table 1.

Table 1
Traumatic Experiences Endorsed by CIT

Type of Trauma	Frequency	Valid %
Witnessed or learned about violence to a loved one	53	61.6
Intentionally harmed or injured	48	55.8
Experienced a threat to life and/or limb	48	55.8
Experienced a violent or sudden loss of a loved one	42	48.8
Witnessed /been exposed to an event that was horrifying or grotesque	40	47.6
Severe physical harm or injury	30	36.1
Caused death or severe harm to another	25	29.1
Other	22	25.6
Exposed to a noxious agent	12	14.0

Participants were then asked to choose which one of the traumas they experienced was the most severe. The most severe traumas chosen and the associated mean on the PTGI are presented in Table 2. The highest mean growth reported was among the CIT who chose the “other” category ($n=10, M=93.60$). The other category included emotional and psychological abuse, sexual assault, domestic violence, mental abuse, childhood abandonment, vicarious trauma of client experiences such as rape, incest and torture, and severe neglect as a child. Even though “intentionally harmed or injured” was selected as the most common severe type of trauma ($n=15, SD = 29.4$), it had one of the lowest PTGI means (65.07). This relationship might be due to the common occurrence of this type of trauma. In addition, a Pearson correlation between the rating of the most severe trauma experienced (scale 1 to 5) and the total score on the PTGI indicate a significant correlation ($r=.203, p=.031$). Those who rated their trauma severe were more likely to have higher scores on their total growth score.

Table 2
Total Posttraumatic Growth by Most Severe Traumatic Experience

Total Posttraumatic Growth Most Traumatic Experience	Mean Growth	n	Std. Deviation
Other	93.60	10	16.1
Exposed to a noxious agent	87.67	3	37.3
Witnessed/been exposed to an event that was horrifying or grotesque	77.29	7	14.3
Caused death or severe harm to another	74.75	8	30.7
Experienced a violent or sudden loss of a loved one	72.69	13	28.3
Witnessed or learned about violence to a loved one	69.43	7	30.8
Intentionally harmed or injured	65.07	15	29.4
Experienced a threat to life and/or limb	63.77	13	30.3
Severe physical harm or injury	63.60	5	27.3
Total	72.74	81	27.8

The number of traumas reported and its relationship to growth was examined. Total traumas were tallied and then the mean on the PTGI was calculated and reported in Table 3. Mean PTGI scores increased significantly if a person reported more than one trauma. However, a correlation between the total number of traumas and the total score on the PTGI was not significant ($r=.143, p=.191$).

Table 3
Mean Growths Associated with Number of Traumas

Variable	n	Mean Growth
One trauma	9	49.1
Two traumas	14	73.5
Three traumas	10	88.0
Four traumas	17	68.6
Five traumas	16	71.2
Six traumas	9	89.0
Seven traumas	5	73.2
Eight traumas	2	76.5

An independent *t*-test between men and women and the total number of traumas reported was done. Men reported experiencing significantly ($p=.011$) more traumas than women. On average men reported almost 5 lifetime traumas (4.93) whereas women report almost 3.5 (3.46). Finally, an independent *t*-test between men and women on their PTGI total score found statistically significant differences ($p=.044$) between men and women with women reporting more growth (74.3) than men (69.0).

Discussion

Findings from this study highlight the traumas, severity, frequency, and personal growth from traumas experienced among 86 CIT. Important findings include the relationship between the number of traumas experienced and personal growth, the relationship between trauma and gender, and the relationship between type of trauma and personal growth.

Regarding the relationship between the number of traumas experienced and personal growth, the results seem to support that despite the overwhelming potential for negative physical and psychological consequences of trauma, there are significant levels of growth if a respondent reported more than one trauma. The relationship between trauma and gender supports, even though men reported more traumas, women reported more growth. Finally, those who endorsed the “other” trauma had the highest mean growth. Most of those who reported the “other” category wrote in their answer as being sexual abuse or sexual assault.

Number of Total Traumas

Ninety-five percent of the sample reported one to eight traumas. Similarly, Evans (1997) found 93% of a sample of CIT reported having experienced at least one trauma. In a community sample, Breslau et al., (1998) reported approximately 90% lifetime exposure, and that men reported 5.3 traumatic events compared to women with 4.3. Kessler, Sonnega, Bromet, Hughes, and Nelson (1995), found 61% of men and 51% of women reported at least one trauma. Gender differences were also supported in this study with men reporting almost five traumas while women reported 3.5 traumas. Research supports that men on average experience more traumas than women (Tolin & Foa, 2006). Men are more likely to experience non-sexual assaults,

accidents, illness, injury and witnessing death or injury while women on the other hand are more likely to report various forms of sexual traumas, and psychological distress (Tolin & Foa, 2006). The findings of this study seem to support men having the likelihood of reporting more traumas based on the nature of traumas experienced. Although more men reported traumas, gender roles and emotional presentation of symptoms could be different in men than women. For example, women are more likely to meet criteria for PTSD, men are more likely to meet criteria for potentially traumatic events (PTEs; Tolin & Foa, 2006).

As the number of traumas increased, so does the participants who reported such numbers. For example, there was a moderate increase in number of traumas from $n = 9$ CIT (1 trauma, 11%) to $n = 17$ CIT (4 traumas, 20.70%). There was also a substantial increase in the number of CIT who reported one trauma versus two traumas. For example, there was a 6% increase between the number of CIT who reported one trauma ($n = 9$ CIT, 11%) and two traumas ($n = 14$ CIT, 17.10%). Also, there was an 8.5% increase in number of traumas between three traumas ($n = 10$ CIT, 12.20%) and four traumas ($n = 17$ CIT, 20.70%). The most significant increase ($n = 50$ CIT, 61%) was between one trauma ($n = 9$ CIT, 11%) to four traumas ($n = 17$ CIT, 20.70%) indicating the highest number of CIT exposure to traumatic experiences. The findings support that CIT report similar numbers of traumas experienced as does the general population.

Types and Frequencies of Specific Traumas

Overall, this study confirmed 62% of CIT “witnessed or learned about violence to a loved one”, while 56% “experienced intentional harm or injury” and “experienced a threat to life and or limb” respectively. In the general population, over one’s lifetime 69% experienced at least one type of traumatic event (Briere, Agee, & Dietrich, 2016). The one type of trauma often reported is death of a loved one because dying is a normal part of life and people are most familiar with it. In this study, almost half of CIT reported “death of a loved one”. Furthermore, in the general population, commonly reported types and frequencies of traumas include emotional abuse, physical abuse, sexual abuse and assault, community violence, institutional violence, and witnessed violence (Breslau et al., 1998; Kessler, et al., 1995). Previous studies have confirmed types and frequencies of specific traumas in specified populations such as students. For example, Stewart-Spencer (2010) and Evans (1997) found multiple traumas similar to this study in a sample of CIT while Michalopoulos and Aparicio (2012) found personal trauma histories in a sample of social workers. Similar to the results of this current study, Vrana and Lauterbach (1994) reported multiple traumas in their study of a nonclinical sample of college students.

Severity of Most Traumatic Experience

The majority of CIT in the current study reported “intentionally harmed or injured” ($n = 15$, 19%, $SD = 29.4$) as the most severe traumatic experience. A total of 26 CIT (32%) reported severe traumas common to the general population (“experienced a violent or sudden loss of a loved one” $n = 13$, 16%, $SD = 28.3$, and “experienced a threat to life and or limb”, $n = 13$, 16%, $SD = 30.3$). The “other” category of traumas also was highly endorsed ($n=10$, $SD = 16.1$). This category contained written responses with several mentions of sexual traumas. These were also among the common types of traumas experienced in the general population and often co-exist with other traumas such as domestic violence, mental abuse, child abandonment, and sexual assault. In general, there were overlaps in severity of traumas reported supporting that just

because a particular trauma was endorsed as most traumatic does not necessarily translate to that trauma having the most psychological effect.

Trauma and PTG

Despite the disproportionate representation in the sample, men reported more traumas than women, while women reported significantly higher growth compared to men. A study by Olf, Langeland, Draijer, and Gersons (2007) noted that women are more likely than men to experience acute psychological and biological responses to trauma including intense fear, avoidance, intrusive thoughts, horror, helplessness, panic and anxiety. According to posttraumatic growth theoretical assumptions, such higher perceived threat may lead to greater turmoil of an individual's assumptive world, thereby setting the stage for greater reports of growth (Calhoun & Tedeschi, 2004). Also, women engage in negative rumination that potentially increases awareness of personal strengths or an understanding of the importance of social connections leading to greater PTG (Calhoun & Tedeschi, 2004). This perhaps portrays a sense of perseverance on the part of women to cope more as a result of willingness to ask for support or help. Overall, individuals who have faced trauma develop positive change in perception of the self, improved relationship with others, and changes in life's priorities (Calhoun & Tedeschi, 2004; Tedeschi & Calhoun, 1996).

In the current study, as the number of traumas increased, so did posttraumatic growth. For example, there was a significant difference in growth between one trauma and three traumas. The low growth of one trauma may be attributed to their own intrinsic motivation to cope during the first occurrence (eg., Calhoun & Tedeschi, 2004). As more traumatic events occur, CIT may have had more resiliency to cope, possibly due to being in a counseling program and prior counseling experiences, or social support could have contributed to their growth. The results also seem to support as the number of traumas increased, the growth initially drastically increased, then slightly plateaued between four and five traumas and then increased again at six and then plateaued again at seven and eight. This seemingly supports growth itself being a continuous process with challenges along the way. Regarding growth in terms of severity, the number of students who endorsed a particular type of trauma does not necessarily mean higher growth. Rather, the results seem to indicate students' growth was inversely related to higher number who identified a particular trauma as most traumatic. According to Calhoun and Tedeschi (2004), higher levels of PTG seem to occur based on the severity of the crisis or trauma, rather than on number of people who endorsed a particular trauma as being traumatic.

Implications for Theory and Practice

Given the frequency and severity of trauma found in this study, it is suggested that counselor educators be aware of the potential of educating students who have experienced many traumas in their lifetime with knowledge that some students have experienced what they would consider a "severe" trauma. As enrollment in counselor education programs has consistently shown that most students have a history of some type of trauma or mental health issue and they choose this profession to help others because they understand. In addition, men reported more traumas than women, which was unexpected and a factor that counselor educators may want to consider in their teaching and supervision curricula. In terms of curriculum and program implications, faculty are vested with responsibility to support students engaged in training practices essential for growth and development. According to 2016 CACREP Standards, Section

4 on Evaluation in the Program, assessment of student's knowledge, skills, and personal dispositions are vital (CACREP, 2016). Personal dispositions may include commitment, traits, values, beliefs, interpersonal functioning, and behaviors that influence a counselor's professional growth and interactions with clients and colleagues (CACREP, 2016).

Monitoring gatekeeping for CIT including supervision and receiving help from support systems has implications for appropriate client service provision in the future. Trauma can lead to debilitating life consequences when untreated. When such impairment issues arise, there is potential for counselors to harm their clients. In the event that impairment issues are not evident during admissions, then there needs to be a system in place to address remediation, retention and in some cases removal of impaired counselors-in-training. Therefore, counselor educators and supervisors should emphasize appropriate ethical codes related to impairment issues for counselors to take necessary professional responsibility to monitor and address their own impairment issues (ACA 2014, C.2.g).

Untreated trauma has implications for PTSD and substance-related disorders. The CACREP standards outlined the need for counselor education programs to incorporate crisis and trauma training in various counseling curricula (CACREP, 2016) a mandate also recommended in previous studies (Adams & Riggs, 2008; Black 2006; Evans, 1997; Stewart-Spencer, 2010). Finally, during supervision, Barrett and Barber (2005) suggested that supervisors should try to incorporate a framework of selected interventions and strategies focused on encouraging, rather than discouraging trainees based on their cognitive and emotional development.

Future Research Opportunities

Future research is needed to examine the differences in frequency and effects of trauma between men and women. The counseling field is typically female oriented with fewer men entering the field. However, those men in this study reported many more traumas than females. This issue needs to be examined further. Furthermore, different types of traumas experienced by CIT should be examined to increase understanding of potential impact of vicarious trauma symptoms. Further research should also explore the extent of sexual abuse of counselors-in-training. Further research should focus on measuring a specific traumatic event in relation to severity of such event. Comparison of a CIT group and non-CIT group to examine relationships regarding trauma and posttraumatic growth should be considered by future researchers. Replication of the current study with larger groups of students at various points of their graduate programs may help to explain the nature of trauma and social support during counselor training. Further research can examine how different kinds of trauma contribute to various growth factors of the PTGI but being more specific in having participants focus on a particular type of trauma. Additional research is needed to determine whether the inclusion of a trauma training course contributes to increased posttraumatic growth.

Limitations

Perhaps the most significant limitation of this study was that the study lacked questions that specifically asked about experiencing sexually related traumas. This type of trauma is obvious, because it was a common response that was written in when a respondent chose the "other" category. Future research in this area should include traumas related to sexual assault and sexual abuse. In addition, the descriptive nature of the study, the sample size and the response

rate limit the generalizations of the results. It was a study based on self-reports of traumatic experiences and posttraumatic growth and subjectivity has implications for research. Finally, there was also a disproportionate number of women and men, hence our conclusions of this study's results should be generalized with caution. Rather conclusions of this study are a baseline for future studies.

Conclusion

The main aim of the study was to examine the relationship between traumatic experiences and posttraumatic growth among CIT. Results support that CIT experience similar traumas to the general population with similar degrees of severity and growth. In addition, the study found variation in growth among men and women with women reporting more growth than men. This represents differences in coping styles among genders. Positive growth resulting from traumatic events further aligns with change in perceptions of self, others, and life priorities. The study presents implications for expansion of trauma research in student populations and the need for trauma curriculum development taking into account gender differences because men and women respond differently to traumatic experiences. Because types of traumas are unique to gender, it is therefore important to view and understand trauma using a gender lens to ensure treatment is individualized based on types and numbers of traumas reported. Future curriculum development should also focus on integrating classroom assignments based on individual student needs.

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