A Consensus Statement on Trauma Mental Health: The New Haven Competency Conference Process and Major Findings

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Although the scientific literature on traumatic stress is large and growing, most psychologists have only a cursory knowledge of this science and have no formal training in, nor apply evidence-based psychosocial treatments for, trauma-related disorders. Thus, there exists a clear need for the development and dissemination of a comprehensive model of trauma-focused, empirically informed competencies (knowledge, skills, and attitudes). Therefore, the New Haven Competencies consensus conference was assembled. Sixty experts participated in a nominal group process delineating 5 broad foundational and functional competencies in the areas of trauma-focused and trauma-informed scientific knowledge, psychosocial assessment, psychosocial interventions, professionalism, and relational and systems. In addition, 8 cross-cutting competencies were voted into the final product. These trauma competencies can provide the basis for the future training of a trauma-informed mental health workforce.

Keywords: stress disorders, competencies, evidence-based practice, professional competence, professional training

Many factors converge to suggest the critical need for specific trauma training at this time. Trauma and its consequences have been recognized as a high-priority public health risk (e.g., U.S. Department of Health & Human Services, 2003). Events including the terrorist attacks of September 11, 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 practitioners will likely deliver services to these vulnerable populations, but lack evidence-based knowledge, assessment, and psychotherapy skills needed to do so. In this context, trauma-related evidence-based practice was defined as the "the integration of the best available research" about trauma "with clinical expertise in the content of patient characteristics, culture, and preferences" (American Psychological Association [APA], 2006, p. 273).

Extensive coverage of trauma is not an integral component of the standard curricula in graduate-level education (Courtois & Gold, 2009; DePrince & Newman, 2011). Further, although the scientific literature on traumatic stress is large and growing, most clinicians have only a cursory knowledge of trauma science and do not apply evidence-based psychosocial treatments and assessments for posttraumatic stress disorder (PTSD) consistently, if at all (e.g., Cook, Dinnen, Rehman, Bufka, & Courtois, 2011; Gray, Elhai, & Schmidt, 2007). Although not all clinicians 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 traumatic stress mental health.

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 psychological consequences, can also create conditions that increase the risk for violation of appropriate practitioner–client boundaries. For example, a therapist may inadvertently create a problematic therapeutic alliance by ignoring or restructuring the relationship to

respond to a clients' dependent or mistrusting presentation in ways that could be disempowering or reminiscent of the abusers' dynamics. Competent practice in trauma requires specialized training to avoid such violations. In addition, the conditions that promote and exacerbate the effects of trauma require the practitioner to be sensitive and responsive to social, political, and cross-cultural issues. For example, some trauma survivors may have significant concerns about revealing trauma details because they fear persecution, prosecution, retaliation, and/ or alienation by others. Similarly, the conditions of trauma can create characteristics in many survivors that make it difficult for people to participate effectively in the treatment process, such as difficulties with trust and problems of emotion regulation. Clinicians working with such clients should be trained to recognize and address such client characteristics, and should also be trained in the development of those therapist behaviors that have been demonstrated to enhance the likelihood of success with these clients. Such abilities might include therapists' self-care plans to stay healthy and effective in the face of demanding trauma-related work and specific alliance-building skills such as collaborative agenda setting. Thus, a competency model will help practitioners to improve their practice with complex, vulnerable trauma-exposed populations.

In April 2013, the Advancing the Science of Education, Training and Practice in Trauma national consensus conference on trauma competencies (the New Haven 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 clinicians must have from a "competency" perspective when working with both traumatized children and adults.

The New Haven 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 practice. The trauma competencies are similar to most psychology specialties, which share the same foundational and functional competencies but are differentiated by their parameters of practice (e.g., population served; Rodolfa et al., 2005). Similar to other specialty competencies, these trauma competencies were designed to be developmentally informed, criterion based, and progressively more challenging and refined as one moves through the stages of professional development from student to independent practitioner (Kaslow et al., 2004). Finally, it was envisioned that assessment of formative and summative competence in trauma, like other competencies, would be multitrait (e.g., knowledge and skills across multiple domains: diagnosis, intervention, professionalism), multimethod (e.g., self-report, observation), and multi-informant (e.g., feedback from multiple sources: supervisor, peers, clients; Roberts, Borden, Christiansen, & Lopez, 2005). Such assessments may include methods of evaluation, such as multiple-choice exams, problem-based learning, written essays, record reviews, vignettes, performance-based exams to assess specific skills, and client simulations (APA, 2006; Kaslow et al., 2004, 2007).

The New Haven Competencies for trauma training and practice are not intended as prescriptive or exhaustive standards, but rather as aspirational guidelines. 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.

Process of Developing Competencies

Background and Foundation

A 2003 report by the Institute of Medicine called for the establishment of basic clinician competency requirements, across all disciplines, to improve quality of care and client safety (Institute of Medicine, 2003). Various other fields within the sciences, including medicine (Accreditation Council for Graduate Medical Education, 2007), 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 from curriculum-based education with course objectives to competency-based education and assessment in psychology (APA, 2006; Kaslow et al., 2004). The final report included 15 principles and nine recommendations on domains of competence and levels of assessment in professional psychology (Kaslow et al., 2007).

The development of the New Haven Competencies 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 current approach differs from others that have been used in the trauma field in the past, as it aims to create minimal standards across a diversity of ages and types of trauma survivors', and across theories. Further, the five working groups utilized at the Advancing the Science of Education, Training and Practice in Trauma conference overlapped with foundational and functional competencies used at the APA 2002 Competencies Conference for Professional Psychology (Kaslow et al., 2004), and in the Cube Model of Competency Development (Rodolfa et al., 2005). Other prominent national organizations 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, in press). The New Haven Competencies adds to these efforts by identifying trauma-specific subcomponents for each of the core competencies (e.g., professionalism, scientific knowledge) across the entire life span.

Additionally, the trauma competencies can work in tandem with prior competency efforts to identify core competencies and competency benchmarks across the career span. For instance, the APA Assessment of Competency Benchmarks Work Group (American Psychological Association Board of Educational Affairs and Council of Chairs of Training Councils, 2007) identified competency benchmarks for each of three domains of career development: readiness for practicum, internship, and practice. Similarly, other documents have been designed for training in professional psychology at the introductory (APA Board of Educational Affairs Task Force, 2007), and graduate,

post-doctoral and postlicensure levels (Fouad et al., 2009; Kaslow et al., 2009).

Participants and Process

Delegates were nominated for attendance at the consensus conference by organizers and the advisory board. A nomination process was used to select 60 psychologists, psychiatrists, and social workers who represented a broad range of clinical and research experience with trauma-exposed children and adults in civilian and military populations. Delegates were selected to represent different professions, professional roles (independent practice, medical settings, public office, and academic affiliation), diverse professional organizations (e.g., APA, International Society for Traumatic Stress, National Child Traumatic Stress Network), and different theoretical and methodological approaches to the trauma field. Given the emphasis on psychology, psychologists made up the greater proportion of delegates.

Based on discussions with Dr. Catherine Grus, the deputy executive director of the APA's Education Directorate, and review of the current conceptualization of competency benchmarks, five broad core competencies were predetermined prior to the beginning of the consensus conference to be consistent with APA's model of defining core competency in professional psychology (Fouad et al., 2009). The five broad core competencies work groups were as follows:

• Scientific knowledge about trauma: understanding of, familiarity, and respect for the empirical foundation of the trauma field (group coleaders: John Fairbank and Dean Kilpatrick).

• Psychosocial trauma-focused assessment: understanding of and familiarity with assessment and diagnosis of trauma-related problems, capabilities and contextual factors associated with traumatic events and their impact on survivors (group coleaders: John Briere and Nancy Kassam-Adams).

• Trauma-focused psychosocial intervention: understanding and familiarity with all aspects of the evidence-based psychosocial intervention process designed to alleviate suffering and to promote the health and well-being of trauma-exposed individuals or groups (group coleaders: Steven Gold and Barbara Rothbaum).

• Trauma-informed professionalism: awareness of, and ability to be guided by, professional values and ethics, as evidenced in behavior and comportment that reflect trauma-specific values and ethics, cultural sensitivity, integrity, and responsibility required to effectively work with trauma survivors, other professionals, and administration in different settings (group coleaders: Laura Brown and Diane Elmore).

• Trauma-informed relational and systems: understanding and familiarity with the (a) key trauma-related interpersonal and systems issues, and (b) principles of interdisciplinary collaboration when working with trauma survivors (group coleaders: Christine Courtois and Josef Ruzek).

Over the 3-day conference, participants rotated among the five working groups. Work group leaders were provided with open-ended responses about competencies from surveyed expert members of APA's Division 56 and the International Society for Traumatic Stress Studies for their reference as well to use within the groups, as needed. All work groups were audiotaped for

professional transcription and a Yale psychologist also took supplementary notes.

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 mental health training? (c) When and how might these knowledge, attitude, and skill competencies be acquired over one's training career? and (d) Provide commentary and suggestions for those who provide training, such as addressing the institutional resources, mentoring, and supervision needed for trauma training.

All work groups utilized the nominal group technique (Delbecq & VandeVen, 1971), a tried-and-true method for gaining consensus among stakeholders. First, in the generating ideas stage, work group coleaders directed everyone in their group to write down what they considered to be components of the particular domain assigned to them in brief phrases or statements on index cards, working silently and independently. Next, in the recording ideas stage, group members engaged in a round-robin feedback session to concisely record each component (knowledge, skill, or attitude item for Day 1, or how and when to obtain these competencies for Day 2, without debate at that point in the process). One coleader 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 ideas were documented. Finally, in the discussing ideas phase, each recorded idea was then discussed to determine clarity and importance. For each idea, the moderator asked, "Are there any questions or comments group members would like to make about the item?" Other questions were asked, such as, "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 disciplines?"

More specifically, conference participants were asked to define the knowledge, attitudes, and skills that were applicable to trauma-exposed adults and children 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.

Each working group presented to the conference at large their groups' findings from the end of the day, and all conference participants voted on the final competencies to be adopted on the final morning of the conference. On the last day of the conference, the lists of competencies were written on large white notepads that hung on the conference room walls. Every participant was given 50 stickers (10 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 rated as the highest competencies by the work group as a whole.

Content of the Proposed Competencies

Preamble to New Haven Competencies

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, skill, and attitudes.

• The competencies are expectations for a psychologist at *entry level* to practice.

• The competencies articulate *minimal* expectations; all trauma psychologists who seek to practice at the entry level should be able to demonstrate acquisition of these core competencies.

• The competencies assume that 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 are not specific to any one model, but rather outline necessary competencies for all trauma-related psychology practice regardless of models.

A total of five broad competencies were articulated, each with a subset of knowledge, attitudes, and skills necessary for achieving proficiency in a given area. In addition, eight cross-cutting competencies were voted into the final product. The cross-cutting competencies represented areas of knowledge, attitude, or skill that were believed to be foundational to all other competencies, including issues such as individual and cultural diversity, incorporation of life-span factors, and therapist self-awareness and self-care. We first include the cross-cutting competencies below and then present the specific competency domains.

Description of the Competencies

Cross-cutting competencies. Although several of the cross-cutting competencies are repeated in more specific forms throughout the other competencies, all delegates agreed that these knowledge, skills, and attitudes were an essential part of trauma practice (see Table 1). The importance of tailoring trauma-focused knowledge and practice to integrate individual differences, cultural identity, and developmental issues is essential, as these concerns interact with trauma responses and recovery. Shared decision making, when possible, was highlighted as a pivotal trauma-focused practice to counteract the helplessness and loss of agency typically present during a traumatic event. Furthermore, facilitat-

ing psychological and physical safety was identified as a critical competency. Examples include providing a therapeutic alliance that fosters trust and interpersonal security, focusing on eliminating any client's potential self-harm behaviors, and helping the client attain physical safety in potentially dangerous interpersonal relationships. Another key competency addresses the practitioner's capacity to effectively tolerate trauma-related affect and content, as well as understand and appropriately manage his or her own values, vulnerabilities, and history in his or her professional role. Similarly, responsible engagement in self-care was identified as a skill and attitude for the ethical and responsible professional conduct among trauma-focused professionals. Finally, the ability to critically evaluate, retain, and apply up-to-date science and appreciate different professionals roles in the trauma response were deemed vital for ethical trauma-focused practice.

Scientific knowledge about trauma. Five overarching scientific trauma-focused attitudes, skills, and knowledge were derived that focused on the ability to recognize, respect, and critically evaluate up-to-date foundational scientific trauma-specific knowledge and apply it appropriately and ethically to clinical situations (see Table 2). In particular, a focus on prevalence, incidence, risk and resilience factors, trajectories, subpopulations, and settings were considered essential knowledge. Additional foundational knowledge identified included understanding trauma-related mechanisms, models, and the interactions of social, psychological, and neurobiological factors in the trauma response. Consistent with the cross-cutting competencies, understanding the social, historical, and cultural context in which trauma is both experienced and researched, as well as the capacity for critical thinking about research, was deemed necessary. Although the competencies were designed to be trauma specific, integrating trauma-specific knowledge with general knowledge was underscored as essential, further highlighting the underlying principle that any trauma specialization must occur in the context of a wider education about clinical science, research, and practice. Finally a commitment to responsibly disseminate and communicate scientific findings about trauma to a broad range of audiences was endorsed.

Table 1
Cross-Cutting Trauma-Focused Competencies

1. 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 includes demonstrating the ability to identify the professionals' and clients' models of intersecting cultural identities (e.g., gender, age, sexual orientation, disability status, race/ethnicity, SES, military status, occupational identity, rural/urban, immigration status, religion, national origin, indigenous heritage, and gender identification) as related to trauma and articulate the professionals' own biases, assumptions, and problematic reactions emerging from trauma work and cultural differences.

2. Demonstrate understanding and ability to tailor assessment and interventions to account for developmental lifespan factors at time(s) and duration of trauma as well as time of contact.

3. 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, etc.), and person–environment interactions (e.g., running away from home and being assaulted).

4. Demonstrate the ability to appropriately appreciate, assess. and incorporate trauma survivors' strengths, resilience. and potential for growth in all domains. Facilitate shared decision making whenever appropriate.

5. Demonstrate understanding of how trauma impacts a survivor's and organization's sense of safety and trust. Apply the professional demeanor, attitude, and behavior necessary to enhance the survivor's and organization's sense of physical and psychological safety. This includes respecting the autonomy of those exposed to trauma but also protecting survivors as appropriate.

6. Demonstrate the ability to recognize the practitioners': (1) capacity for self-reflection and tolerance for intense affect and content, (2) ethical responsibility for self-care, and (3) self-awareness of how one's own history, values, and vulnerabilities impact trauma treatment deliveries.

7. Demonstrate ability to critically evaluate and apply up-to-date existing science on research-supported therapies and assessment strategies for trauma-related disorders/difficulties.

8. Demonstrate the ability to understand and appreciate the value and purpose of the various professional and paraprofessional responders in trauma work and work collaboratively and cross systems to enhance positive outcomes.

Table 2
Scientific Knowledge About Trauma

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 and settings.
2. Demonstrate basic knowledge of findings, mechanisms, models, and interactions among social, psychological, neurobiological factors (e.g., relational, cognitive and affective, economic, genetic/epigenetic findings, health and health behaviors).
3. Demonstrate understanding of the social, historical, and cultural context in which trauma is experienced and researched.
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 and educate scientific knowledge about trauma to a broad range of audiences, including those communities and organizations that are impacted by trauma.

Note. PTSD = posttraumatic stress disorder.

Psychosocial trauma-focused assessment. Ten assessment competencies were determined that focus on the knowledge of, and skills in, applying up-to-date assessment measures developed, normed, validated, and determined to be psychometrically suitable for use with trauma survivors, given any potential unique trauma-specific client presentations (see Table 3). A willingness to ask about trauma exposure was noted as essential because if clinicians do not ask, clients are unlikely to spontaneously report traumas, as they may not recognize the effects of these events on their lives or they minimize the effects. Further, the importance of assessing lifetime trauma exposure was emphasized; focusing only on the index trauma that brings individuals to treatment often misses clinically relevant issues associated with exposure to other traumas. Selecting and adjusting procedures, processes, and interpretations for trauma-exposed clients, with an awareness of the impact of the presentation and trajectory of trauma responses, was recommended. Consistent with the cross-cutting competencies, the importance of considering and applying cultural, developmental, contextual, and scientific knowledge to the specific situation was highlighted.

Trauma-focused psychosocial intervention. Eleven competencies emerged that included knowledge about the extant science on research-supported trauma interventions, including specific evidence about pharmacological treatment and mechanisms of change (see Table 4). Therapists conducting trauma-informed and trauma-focused treatments are expected to attend to trauma-related material nonpunitively, and to implement engagement and therapeutic strategies that do not support client avoidance but foster a sense of safety, trust, and openness to address trauma-focused material. The importance of collaboration especially with clients' families, social networks, and care systems to promote nonavoidance and positive trauma-related responses was emphasized. Similar to the cross-cutting competencies, the importance of tailoring treatment choice and treatment pacing to the specific survivors' trauma presentation, type, comorbidities, personality, values, strengths, and environment was noted as essential.

Trauma-informed professionalism. Five competencies were created that address the values, skills, and attitudes to work ethically on behalf of trauma survivors both within traditional therapeutic situations and within organizations and systems (see Table 5). Because many forms of trauma occurrence, and the immediate and long-term responses to those events, are affected by policy and systems, several competencies address the need for a trauma-focused practitioner to be adept at helping individuals navigate those systems, as well as directly promoting systematic, social, and policy changes that will benefit trauma survivors. Similar to the trauma-focused psychosocial intervention competencies, particular attention to ethical responsibilities to minimize iatrogenic harm and maximize optimal outcomes was highlighted; in particular, these competencies address the clinician's capacity to establish and maintain appropriate clinical boundaries, and to effectively

Table 3
Psychological Trauma-Focused Assessment

1. Demonstrate a willingness to ask about trauma exposure and reactions with all clients, in both trauma- and non-trauma-focused 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 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 processes and responses.
4. Demonstrate the ability to understand the course and trajectory of trauma responses and tailor assessment accordingly.
5. Demonstrate the ability to assess strengths, resilience and growth both preexisting and posttrauma.
6. Demonstrate the awareness of test interpretation issues frequently encountered in trauma-exposed populations (e.g., appropriate use of validity scales, response styles, motivation).
7. Demonstrate the ability to assess the extent to which culture, beliefs, and practices influence the expression and coping with trauma exposure, including barriers to assessing treatment.
8. Demonstrate knowledge about the practical consequences of trauma-related assessment and diagnosis in different contexts (e.g., social services, military, forensic).
9. Demonstrate the ability to tailor the trauma assessment, battery, and interview questions to match characteristics (e.g., culture, age, socioeconomic, family or systems) of client, setting, and trauma experience.
10. Demonstrate knowledge appropriate to scope of practice regarding major trauma-relevant and generic questionnaires/interviews; this can include the psychometrics, strengths, limitations, and appropriateness for specific groups of trauma survivors.

Table 4
Trauma-Focused Psychological Intervention

1. Demonstrate knowledge about the current existing science on research-supported interventions (psychosocial, pharmacological, and somatic) for trauma-related disorders/difficulties.
2. Demonstrate the ability to employ critical thinking and work collaboratively to tailor and personalize any psychosocial and pharmacological treatment and its pacing with survivors. This approach involves being responsive to particular trauma survivors' trauma type and comorbidities, as well as culture, personality, values, strengths, resources, and preferences, within the context of the recovery environment.
3. Demonstrate the ability to apply trauma-focused phased treatment, and match treatments to evolving needs. This approach involves continually assessing the interaction of the client and the changing environment to assess 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 nonjudgmentally and nonpunitively 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 nonavoidant strategies in engagement, retention, and delivery of trauma-focused treatment (i.e., avoid avoidance).
7. Demonstrate the ability to maintain a focus 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.
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).
10. Demonstrate the ability to collaborate with trauma clients' families, social networks, and care systems to promote nonavoidance and positive trauma-related responses.
11. Demonstrate the ability to cultivate and maintain a therapeutic relationship with trauma-impacted individuals that fosters a sense of safety, trust, and openness to addressing trauma-focused material.

bear witness and help clients' with trauma-related emotions, problems, and concerns.

Trauma-informed relational and systems. The seven competencies in this category focus on the ability to effectively and conscientiously interact with trauma-exposed individuals, groups, and/or communities (see Table 6). In particular, these competences focus on recognizing the disorganizing effects of trauma at the individual and systems levels, and utilizing knowledge, relational skills, and consultation skills to effectively address and transcend such barriers in order to foster recovery and resiliency, preparedness, and prevention. This approach underscores the importance of recognizing how individual, intergenerational, cultural, and historical factors can impact the perceptions of general and trauma-focused help providers and generating health care delivery processes to address these barriers. The importance of interdisciplinary collaboration, cross-cutting competencies, was once again emphasized as a key element of trauma-informed relational and systems work.

Future Directions

The proposed competencies are now being reviewed for approval by APA's Board of Educational Affairs. A future goal will be to articulate benchmarks for reaching these competencies across the various stages of professional development, as well as assess-ment measures for each of the competencies (Kaslow et al., 2009). Educators are encouraged to develop training curricula based on the consensus competencies. Training curricula can be designed in numerous ways: technologically based, problem-solving focused (DeRosa, Amaya-Jackson, & Layne, 2013; Layne et al., 2014) or specific to trauma-related content, attitudes, and emotions (Newman, 2011). Funding for these future large-scale efforts will be a barrier that needs to be addressed in future dissemination and implementation plans.

In the meantime, practicing clinicians who want to develop competencies to work with traumatized children and adults may find these trauma competencies helpful in planning their own professional development. Others 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.

Conclusion

In summary, the New Haven trauma competencies are intended to describe the competencies that mental health providers aspire to attain for competent practice when engaging in specialized work with trauma survivors. The New Haven trauma competency conference should be viewed as an initial step in an ongoing process. Although the information provided is viewed as useful for a

Table 5
Trauma-Informed 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).
2. Demonstrate the ability to engage with relevant leaders around trauma issues and promoting systemic, social, and policy change.
3. Demonstrate an understanding of how public policy issues affect trauma work within organizations and with individuals.
4. 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).
5. Demonstrate skills to hear and work with clients' trauma material and associated distress that minimizes the risk of iatrogenic harm.

Table 6
Trauma-Informed Relational and Systems

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1. Demonstrate knowledge of the disorganizing effects of trauma at all levels. Given that trauma results in changes at the individual and systems levels, psychologists must demonstrate the ability to respond to these deleterious effects appropriately.
2. Demonstrate knowledge about and skills of offering consultation on trauma-informed systems of care and models of care.
3. Demonstrate the ability to engage in interdisciplinary collaboration regarding traumatized individuals and communities.
4. Demonstrate understanding that institutions and systems can contribute to primary and secondary trauma and offer strategies to reduce these barriers as appropriate.
5. Demonstrate an understanding of the importance of using relational healing for relational injury (e.g., trustworthiness) and the capacity to use the relationship effectively.
6. Demonstrate knowledge about the role of organizations in building resilience, prevention, and preparedness (universal precautions).
7. Demonstrate the ability to consistently recognize how the cultural, historic, and intergenerational transmission influences perception of helpers.

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variety of different constituencies, and was developed through consensus from diverse trauma experts, it is intended to be a "living" document that may need modification to meet specific individual and program training goals.

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