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# Community-Based Counselors' Preparedness for Providing Trauma-Informed Care

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# Walden University

College of Social and Behavioral Health

This is to certify that the doctoral dissertation by

LaShaunda L. Smith

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2025

Abstract

Community-Based Counselors' Preparedness for Providing Trauma-Informed Care

by

LaShaunda L. Smith

MA, Walden University, 2017

BS, University of Mississippi, 2014

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

November 2025

Abstract

This constructivist grounded theory study examined how community-based mental health counselors perceive their preparedness to provide trauma-informed care. Guided by Charmaz's constructivist grounded theory, semistructured interviews were analyzed through coding and constant comparison to co-construct meaning around counselors' lived experiences. This study explored how counselors define, develop, and sustain preparedness for trauma-informed care. The purpose was to generate an interpretive understanding of how counselors constructed meaning around their preparedness, including how training, supervision, and professional experiences shaped their ability to serve trauma-affected clients. Participants included 12 master's-level licensed and pre-licensed community-based mental health counselors with experience serving trauma-affected clients. Findings revealed that preparedness is a dynamic process influenced by individual, organizational, and systemic factors. Counselors identified trauma-specific training, supervision, and experiential learning as essential supports, while resilience and cultural competence enhanced confidence and effectiveness. Participants also reported insufficient graduate training and limited resources as barriers to sustaining trauma-informed practice. The resulting theory conceptualized preparedness as an ongoing process of continuous learning, reflection, and support. Recommendations include integrating trauma-informed content into counselor education, expanding supervision opportunities, and strengthening agency support systems. The study's implications for positive social change include advancing counselor competence, improving trauma-informed care, and fostering more resilient and equitable communities.

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# Dedication

This dissertation is dedicated to my beloved great-grandmother, Lena Taylor, who passed away in February 2024 at the age of 104. As I began writing this dissertation, I carried the weight of her absence and the warmth of her unwavering spirit. From the earliest days of my childhood, I promised her that I would become a doctor. It was a promise I held close to my heart, and today, I am proud to say that I have kept that promise. Her excitement and pride in my academic journey fueled my determination, especially in the moments when the path seemed uncertain. Lena Taylor was more than a matriarch; she was the foundation of our family, the embodiment of wisdom, grace, and strength. Her life was a testament to resilience, and her belief in me never wavered. I can still hear her words of encouragement and see the sparkle in her eyes when she spoke of the day I would become Dr. Smith. Though she did not get to see this moment in person, I know she is with me in spirit. This achievement is as much hers as it is mine. I love you, I miss you, and I hope I've made you proud, Granny. This is for you.

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To my BWT group and close friends from childhood and University, your support, laughter, and motivation reminded me that I was never alone. This accomplishment reflects the love and support of you all.

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# Chapter 1: Introduction to the Study

## Introduction

According to Section A.4.a of the American Counseling Association (ACA) Code of Ethics (2014), counselors have a duty to "do no harm" when working with clients. A significant challenge in fulfilling this obligation is accurately distinguishing between trauma responses and diagnosable mental health disorders. *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA], 2013) provides a framework for classification and diagnosis; however, misdiagnosis remains common and can lead to harmful treatment outcomes, strained therapeutic relationships, and increased client distress (Foltz et al., 2023). These challenges often result from counselors' limited training in trauma-informed approaches, which can cause diagnostic discrepancies and ineffective treatment planning (Foltz et al., 2023; Remley & Herlihy, 2020). Researchers have highlighted the limited integration of trauma-informed care in counselor education programs, noting the need for stronger preparation in this area (Felter et al., 2022; Foltz et al., 2023).

In this study, I explored how community-based mental health counselors perceived their level of preparedness to provide trauma-informed care. This chapter introduces the study, including the background, problem, and purpose statements, nature of the study, limitations, delimitations, assumptions, and definitions. The chapter ends with a discussion of the study's significance for the counseling profession.

**Background**

The concept of trauma dates back to the ancient Greeks, who used the term to describe a "wound" (Blehm, 2024). In contemporary use, the term trauma refers to emotional and psychological responses to harmful experiences such as accidents, crimes, natural disasters, abuse, neglect, violence, and war (Substance Abuse and Mental Health Services Administration [SAMHSA], 2023). Counselors who work with trauma-affected clients must develop specialized knowledge and skills to respond effectively (Benjamin & Carolissen, 2015). However, researchers continue to identify significant gaps in graduate-level training related to trauma competencies (Felter et al., 2022). Since the COVID-19 pandemic, these gaps have become even more apparent as exposure to adverse childhood experiences (ACEs) has grown, contributing to long-term trauma and adversity (CDC, 2024; Foltz et al., 2023). Foltz et al. (2023) emphasized that when counselors-in-training lack trauma awareness, they are unprepared to address ACEs effectively, which directly affects the services they provide.

Clients who seek services in community-based mental health often come from low-income backgrounds and experience continuous trauma related to community-level stressors and daily exposures (Benjamin & Carolissen, 2015; Eagle & Kaminer, 2013). Counselors in these settings frequently serve individuals with complex trauma, co-occurring mental health and substance use disorders, and socioeconomic challenges such as poverty, housing instability, and limited access to healthcare. These conditions heighten the need for counselors to develop adequate preparation for providing trauma-informed care (SAMHSA, 2014; SAMHSA, 2020; Courtois & Gold, 2009). However,

clinicians in community-based agencies are often novice counselors, recent graduates, or provisionally licensed professionals (Last et al., 2022). Factors such as high caseloads, low pay, and organizational pressures have been linked to elevated turnover rates, with many counselors moving to other mental health sectors. Counselors who remain face increased risk of compassion fatigue, secondary traumatic stress, and burnout due to limited training and insufficient organizational support (Last et al., 2022; Rossi et al., 2012; Sutton et al., 2022). Sutton et al. (2022) emphasized the importance of supervision, peer support, and balanced caseloads for mitigating these risks and sustaining counselor well-being.

Researchers consistently emphasize the need for comprehensive trauma-informed care training within counselor education and supervision (Felter et al., 2022; Foltz et al., 2023; Last et al., 2022; Rossi et al., 2012; Sutton et al., 2022). In this study, I examined how community-based mental health counselors perceived their preparedness to provide trauma-informed care, focusing on how their education, training, and professional experiences shaped their ability to serve trauma-affected clients. Counselors frequently relied on personal experiences, supervision, and workplace learning to guide their practice, but consistently identified gaps in formal training and difficulty distinguishing trauma responses from diagnosable disorders. The analysis of these findings reveals systemic deficiencies in counselor preparation, which form the foundation of the problem addressed in this study: the prevalence of trauma in community-based settings continues to exceed the level of trauma-informed training counselors receive.

## Problem Statement

Community-based mental health counselors frequently serve individuals and groups who have experienced significant trauma, including violence, abuse, and displacement. Addressing the complex needs of these populations requires counselors to adopt trauma-informed approaches that consider the pervasive impact of trauma on clients' mental health and well-being. The degree to which counselors feel adequately prepared to provide such care remains underexplored, particularly in community-based settings where resources may be limited, and exposure to traumatized populations is frequent. Researchers have found that counselor education programs frequently lack formal training in trauma-informed care (Felter et al., 2022; Foltz et al., 2023). Many programs do not require trauma or crisis intervention coursework, leaving new counselors underprepared for the realities of community practice (Moh & Sperandio, 2022). As a result, counselors may face challenges such as misdiagnosis, poor treatment planning, and ineffective interventions (Foltz et al., 2023).

A lack of training also contributes to counselor burnout and secondary traumatic stress. Counselors with limited self-awareness or unresolved ACEs are at greater risk of burnout and vicarious trauma (Felter et al., 2022; Plath & Fickling, 2022; Sutton et al., 2022). Although counselor education curricula emphasize self-care, they often fail to equip counselors with the skills needed to effectively manage the demands of trauma work (Felter et al., 2022; Foltz et al., 2023; Moh & Sperandio, 2022).

The effects of the COVID-19 pandemic have further increased exposure to trauma, intensifying strain on providers (Foltz et al., 2023; Moh & Sperandio, 2022).

Burnout in graduate training often continues into professional careers, contributing to turnover (Warlick et al., 2021). The Bureau of Health Workforce (2023) reported that over half of the U.S. population lives in designated Mental Health Professional Shortage Areas, with shortages expected to grow. These issues raise serious questions about the preparedness of counselors to provide trauma-informed care in community-based settings. Through this study, I addressed this gap by exploring how counselors view their preparedness using a constructivist grounded theory approach to capture their lived experiences and to develop a theoretical explanation of the factors that shape preparedness.

## Purpose of the Study

Although ethical codes require counselors to provide competent services, little is known about how community-based mental health counselors perceive their preparedness to deliver trauma-informed care (American Counseling Association [ACA], 2014). My purpose for this qualitative constructivist grounded theory study was to generate an interpretive understanding of how counselors constructed meaning around their preparedness, including how training, supervision, and professional experiences shaped their ability to serve trauma-affected clients. In this study, I developed a theoretical explanation of how counselors navigated the challenges of providing trauma-informed services in community-based settings.

Research on counselor education and supervision indicates that trauma-informed care is often underemphasized in preparation programs, raising questions about how counselors understand their readiness to work with trauma-affected populations (Felter et

al., 2022; Foltz et al., 2023; Last et al., 2022; Rossi et al., 2012; Sutton et al., 2022). Findings from this study included insights for counselor education programs, supervisors, and mental health organizations to strengthen training, support, and trauma-informed practices. In the results, I identified how counselors perceived barriers to competence when working with clients who had experienced trauma, underscoring systemic shortcomings in counselor preparation (Foltz et al., 2023; Remley & Herlihy, 2020). Ultimately, this research can inform strategies to better prepare counselors-in-training and practicing clinicians, contributing to positive social change by expanding access to competent, sustainable trauma-informed mental health care.

## Research Question

How do community-based mental health counselors view their level of preparedness to work with traumatized populations?

## Conceptual Framework for the Study

Grounded theory is founded on principles of symbolic interactionism in sociology (Starks & Trinidad, 2007). The tenets of grounded theory are that meaning is understood through social processes. Constructivist grounded theory was developed by Kathy Charmaz, a Glaser and Strauss student who founded grounded theory (Charmaz, 2014; Starks & Trinidad, 2007). Charmaz developed a more modernized approach to grounded theory in which she focuses on the basis that the role of a researcher is a co-participant of the study rather than a neutral observer (Charmaz, 2014; Mills et al., 2006). Charmaz (2014) argued that the researcher and participants construct data, research processes, and theories. The tenets of constructivist grounded theory are based on the idea that people

create their own knowledge, and reality is determined by their experiences (Charmaz, 2014; Mills et al., 2006).

In this study, I used a constructivist grounded theory approach following Charmaz's (2014) principles to guide this investigation into perceptions of counselors providing trauma-informed care to clients in community-based settings. I chose constructivist grounded theory because it privileges the co-construction of meaning between researcher and participants. Rather than treating knowledge as something to be discovered, I actively engaged with counselors' narratives and embraced my interpretive role as a co-participant in meaning-making. As a result, new insights into counselors' preparedness emerged from our shared dialogue, shaped by their lived experiences and my reflexive engagement with the data (Patton, 2015; Raskin, 2011; Starks & Trinidad, 2007).

Moreover, in this study, I focus on the level of preparedness of counselors in community-based settings who provide trauma-informed care to traumatized clients. The overall goal of this study is to explore the environments in which social processes occur in order to construct an explanatory theory grounded in counselors' perceptions, perspectives, and individual meanings, making a constructivist grounded theory approach the most appropriate (Charmaz, 2014; Starks & Trinidad, 2007). I selected this constructivist framework to give counselors a voice and to inform counseling practice, supervision, and education, with the goal of promoting meaningful change in counselor preparation and training.

**Theoretical Framework for the Study**

The theoretical foundation of this study is professional identity theory, which explains how individuals internalize the norms, values, and expectations of their profession and develop a self-concept that reflects their professional role (Gibson et al., 2010). Professional identity theory is grounded in psychological and sociological perspectives on identity formation, career development, and professional socialization. How counselors' professional identity influences their perceived preparedness to provide trauma-informed care offers a lens for understanding (Gibson et al., 2010).

Gibson et al. (2010) and Carvalho et al. (2021) discussed how counselors developed their professional identity through training, experiential learning, mentorship, and self-reflection, especially during the early stages of their careers. Their work suggests that preparedness encompasses not only technical knowledge and skills but also counselors' self-perception as competent professionals capable of addressing clients' complex needs. In this study, I examined how counselors' preparedness to work with traumatized populations was shaped by organizational culture, supervision structures, community expectations, and broader societal views. These interconnected factors highlight how professional identity and learning experiences intersect to shape counselors' confidence in serving trauma-affected clients (Carvalho et al., 2021; Gibson et al., 2010).

I used professional identity theory as the conceptual foundation for exploring counselors' perceptions, and constructivist grounded theory for collecting and interpreting their lived experiences. In the next section, I describe the research design and

methodological choices and explain how they align with the study's purpose and research question.

## Nature of the Study

I use a constructivist grounded theory approach in this study to explore the perspectives and experiences of counselors who provide trauma-informed care in community-based mental health settings. Through this approach, I aim to better understand how counselors perceive their competence to deliver effective therapeutic interventions and their level of preparedness to work with traumatized populations (Charmaz, 2014; Patton, 2015). As developed by Charmaz (2006), constructivist grounded theory emphasizes the co-construction of meaning between the researcher and participants, making it an ideal methodology for investigating the subjective experiences and perceptions of counselors' level of preparedness in providing trauma-informed care in community mental health settings.

Data collection involved semistructured interviews with community-based mental health counselors who had experience providing trauma-informed care to clients. In this study, I use purposeful sampling to guide participant selection, ensuring a diverse range of counselors based on years of experience, training backgrounds, and practice settings. Through initial interviews, I focus on participants' perceptions of preparedness, the challenges they encounter, and the supports they identify as helpful when working with traumatized populations. As themes emerge, I apply theoretical sampling to refine and expand data collection, enabling deeper exploration of key areas.

To enhance trustworthiness, I employ multiple strategies, including triangulation of data sources, member checking, debriefing, and prolonged engagement with the data (Charmaz, 2014; Patton, 2015). I engaged in ongoing reflexivity throughout the research process by journaling after each interview and memoing during analysis. At times, my professional background in community mental health influenced how I initially interpreted burnout and resilience. Returning to participants' words and using member checking allowed me to center their meanings while acknowledging how my own perspective informed the analytic process. This reciprocal interplay reflects the constructivist view that data and theory are co-constructed through interactions between the researcher and participants.

In this study, I analyze the data using grounded theory coding methods, open, focused, and theoretical, to identify patterns, develop categories, and construct an interpretive theory that explains the factors shaping counselors' preparedness. (Charmaz, 2014; Patton, 2015). This analysis draws on thematic strategies to organize and interpret data in a manner consistent with grounded theory, allowing for the identification of shared patterns of meaning across participants (Charmaz, 2014; Lincoln & Guba, 1985). Maintaining reflexivity throughout the research process allows me to account for my perspectives and ensures that participants' voices remain central in the development of theory. The findings of this study contribute to the literature on trauma-informed care, counselor education, and professional development by offering practical recommendations to strengthen training, supervision, and organizational support within community mental health settings (Charmaz, 2014).

**Definitions**

*Trauma:* An emotional response to a terrible event like an accident, crime, natural disaster, physical or emotional abuse, neglect, experiencing or witnessing violence, death of a loved one, war, and more. Immediately after the event, shock and denial are typical. Longer-term reactions include unpredictable emotions, flashbacks, strained relationships, and even physical symptoms like headaches or nausea (American Psychological Association, n.d.).

*Traumatic Stress:* A term for reactive anxiety and depression. The experience of traumatic stress includes subtypes of anxiety, depression, and disturbance of conduct, along with combinations of these symptoms (American Psychiatric Association, 2013).

*Trauma-informed care:* a behavioral health service model that considers trauma's impact on an individual's well-being. Trauma-informed care takes a trauma-informed approach to the delivery of behavioral health services that includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. Trauma-informed care approaches trauma through ecological and cultural lenses, recognizing that context significantly influences how individuals perceive and process traumatic experiences, whether acute or chronic. Trauma-informed care involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma. Trauma-informed care emphasizes active consumer participation as a core principle in the development, delivery, and evaluation of services. (SAMHSA, 2014).

*Continuous traumatic stress:* Various levels of trauma occur continuously, such as daily exposure to issues within a community like poverty, homelessness, gang violence, and any other problems that can negatively impact an individual or community (Eagle & Kaminer, 2013).

*Secondary traumatic stress*: a known response to close contact with a traumatized individual (Ivicic & Motta, 2017).

*Adverse Childhood Experiences (ACE): ACEs* are defined as events that can be potentially traumatic and occur during childhood from ages 0-17 (CDC, 2024).

*Burnout*: The end state of long-term chronic stress, and is a syndrome represented by three dimensions: mental fatigue or emotional exhaustion, negative feelings and perceptions about the people one works with or depersonalization, and a decrease in feelings of personal accomplishment (McCormack et al., 2018).

*Clinical Mental Health Counselor*: Clinical mental health (CMH) counselors include psychologists, psychiatrists, mental health technicians, marriage counselors, couples counselors, family counselors, social workers, family therapists, licensed professional counselors, provisionally licensed professional counselors, and master's level counselors (Young & Cashwell, 2017).

## Assumptions

In this constructivist grounded theory study on community-based mental health counselors' views of their preparedness to work with traumatized populations, I am guided by several key assumptions. These assumptions are foundational for interpreting data and ensuring the study's meaningfulness while acknowledging aspects that cannot

be definitively proven but are critical for the inquiry. One identified assumption of the study is that counselors can self-reflect on their experiences during their educational and supervisory training periods. The constructivist grounded theory approach relies heavily on participants’ ability to reflect on their experiences and express their thoughts and feelings (Charmaz, 2014). Without this self-awareness, the richness and depth of the data could be compromised. This assumption is necessary because I seek to explore subjective viewpoints and construct a theory based on these reflections (Charmaz, 2014). While self-awareness cannot be uniformly demonstrated across all participants, it is critical to believe that participants can provide valid and insightful responses about their experiences (Charmaz, 2014).

Another key assumption is that working with traumatized populations requires specific knowledge, skills, and preparation that may differ from general counseling competencies. This belief informs the study’s focus on understanding how counselors perceive their readiness to work within this specialized area. Without this assumption, the research question loses its significance, as there would be no basis for distinguishing trauma work from other forms of mental health counseling. This assumption is not directly verifiable but aligns with existing literature highlighting trauma-informed care's complexity (SAMHSA, 2014b).

Due to the unique environment of community-based mental health work, I also assume that there are impacts on counselors’ perceptions of their preparedness. Factors such as organizational support, access to training, and caseload demands are believed to shape these perceptions. This assumption underscores the importance of situating the

research within community-based settings rather than generalizing findings to all mental health counselors. While the exact influence of context cannot be predetermined, acknowledging it is essential for developing a constructivist grounded theory that accurately reflects participants' experiences (Baird & Kracen, 2006).

A fourth assumption is that participants will answer interview questions honestly and authentically, sharing their genuine perspectives without significant bias or withholding information. This assumption is critical for ensuring the integrity of the data and the credibility of the resulting theory. While researchers cannot fully control or verify participant honesty, creating a safe and trusting interview environment encourages openness and reduces the likelihood of distorted responses (Creswell & Poth, 2018).

A final assumption is that knowledge is co-constructed between the researcher and participants, consistent with the principles of constructivist grounded theory. This epistemological stance guides how I collect, analyze, and interpret data, emphasizing the subjective and relational nature of the research process. The belief in co-construction cannot be empirically validated but is central to the methodology and the study's philosophical underpinnings (Charmaz, 2014). These assumptions are necessary to align the research design with the study's purpose and methodology. These assumptions clarify my position and expectations while acknowledging inherent uncertainties. By explicitly stating them, I provide a transparent framework for interpreting findings and addressing potential limitations. Each assumption is critical to the meaningfulness of the research, as it ensures coherence between the research question, methodology, and data analysis process.

## Scope and Delimitations

This study focuses on the perceptions of master's-level counselors, pre-licensed counselors, and licensed professional counselors who have experience working in community-based mental health settings with traumatized clients. Perceptions of individuals from other mental health professions were not included. The research problem guiding this study is how counselor education, training, and supervision prepare counselors to work effectively with clients who have experienced trauma. Counselors who could reflect on their experience and training working with this population were identified as participants.

Clinicians without experience providing trauma-informed care were excluded to ensure that the data reflected the perspectives of counselors with direct practice knowledge of this population. Client perspectives and experiences were not included, as the study focused solely on the counselor's point of view. Future research could extend this work by examining client perspectives to gain additional insights into how they view counselor competence in trauma-informed care. Such research would allow for comparing counselor and client perspectives, providing a more comprehensive understanding of trauma-informed care competence.

## Limitations

Certain limitations bind every research study, and this constructivist grounded theory study on community-based mental health counselors' perceptions of their preparedness to work with traumatized populations is no exception. These limitations primarily pertain to the study's design, methodology, and the inherent challenges of

qualitative research. I will outline specific areas where limitations were identified, their implications, and the measures to be taken to address them.

One key limitation of this study is its reliance on self-reported data. Participants' reflections on their level of preparedness may be influenced by their subjective experiences, personal biases, or social desirability, potentially leading to over or underestimating their actual preparedness (Creswell & Poth, 2018). While the constructivist grounded theory approach emphasizes participants' perspectives, the inherent subjectivity of qualitative data presents challenges to maintaining dependability and confirmability. Triangulation through additional data sources, such as observational studies or client outcome data, could enhance the study's credibility but was not feasible within the scope of this research.

Another limitation relates to the transferability of findings. This study focuses on a specific population of community-based counselors within a defined geographic region. Consequently, the findings may not fully capture the experiences or perspectives of counselors in different settings, such as private practice or inpatient care, or regions with differing sociocultural dynamics (Lincoln & Guba, 1985). While I provide detailed, contextual descriptions to support transferability, the applicability of findings to other populations remains limited.

My positionality and interpretive role inevitably shaped the findings of this study. Rather than viewing this as a limitation, constructivist grounded theory recognizes the researcher as a co-constructor of meaning. My reflexive journaling and committee debriefings helped surface potential biases, ensuring that my interpretations were

transparent and that participants' voices remained central. This reflexive stance, consistent with Charmaz's (2014) approach, strengthened rather than weakened the analytic process." As qualitative research emphasizes the co-construction of meaning between the researcher and participants, there is a risk that the researcher's interpretations may inadvertently influence the findings (Charmaz, 2014). To mitigate this, reflexivity will be actively practiced throughout the research process. Regular journaling and peer debriefing can be employed to reflect on potential biases and maintain transparency in the data analysis process. Additionally, an audit trail can be maintained to document all decisions and changes made during the study to enhance dependability.

Several measures can be implemented to address and minimize these limitations. To counteract the subjectivity of self-reported data, iterative questioning techniques and member checking can be used during interviews to clarify participants' responses and ensure accuracy (Merriam & Tisdell, 2016). Furthermore, I employed theoretical sampling to seek diverse perspectives and saturate emerging categories, further strengthening this constructivist grounded theory. Detailed contextual information about the research setting, participants, and their professional environments will be included to enhance the study's transferability. This level of detail enables readers to determine the relevance of the findings to their own contexts (Lincoln & Guba, 1985). Additionally, efforts will be made to recruit a demographically diverse sample to encompass a range of experiences and viewpoints.

Although this study has inherent limitations related to design, methodology, and researcher subjectivity, I actively acknowledge and address these challenges throughout

the research process. I engaged in prolonged interaction with the data to enhance credibility, conducted member checking, and incorporated triangulation across interviews, reflexive journaling, and demographic questionnaires (Lincoln & Guba, 1985). Dependability and confirmability were strengthened through maintaining a reflexive journal, documenting analytic decisions, and seeking feedback from my dissertation committee throughout the research process. I supported transferability by providing detailed descriptions of the participants, settings, and contexts to allow readers to assess their applicability to other environments. These strategies enhance the trustworthiness of the findings and strengthen their applicability for understanding how community-based counselors perceive their preparedness to work with traumatized populations.

## Significance

One emerging theme in the literature linked to counselor education and supervision is the lack of trauma-informed care training in counselor education programs (Felter et al., 2022; Foltz et al., 2023). Several studies have found that trauma-informed care is not a required component of counselor education, and courses specifically focused on crisis intervention and trauma are often absent from program curricula (Felter et al., 2022; Foltz et al., 2023; Moh & Sperandio, 2022). As a result, counselor education programs do not fully prepare students to work in highly demanding environments, such as community-based mental health settings, or to serve clients experiencing ongoing and complex trauma (Felter et al., 2022; Foltz et al., 2023; Moh & Sperandio, 2022). Additional emphasis on trauma-informed training is needed to address these gaps,

support supervisory development, and strengthen counselor preparedness (Rossi et al., 2012; Sutton et al., 2022).

This study contributes to social advocacy and promotes positive social change by amplifying the voices of community-based counselors and emphasizing the urgent need for systemic improvements in counselor education. Community-based mental health organizations frequently serve marginalized and underserved populations, including individuals in rural areas with limited access to care and urban communities disproportionately affected by poverty, violence, and systemic inequities (Felter et al., 2022; Sutton et al., 2022; National Institute of Mental Health [NIMH], 2023). By examining counselors' lived experiences providing trauma-informed care in community-based settings, this study expands the trauma-informed care literature and offers actionable insights for counselor training and supervision. The findings may also inform community-based organizations as they develop program evaluations and targeted training initiatives that better address the needs of novice counselors, thereby reducing turnover and promoting more consistent, effective care for vulnerable populations (Foltz et al., 2023; Remley & Herlihy, 2020). Ultimately, this research advances the development of competent counselors and strengthens access to trauma-informed mental health services, thereby promoting equity, resilience, and healing across diverse communities (Carvalho et al., 2021; Gibson et al., 2010).

## Summary

In this chapter, I provided an overview of the background of the study, the purpose and problem statement, the research question, and the conceptual framework. A

review of the relevant terms defined, limitations, delimitations, and bias was also explored. Then, a discussion of the significance of this study to the counseling profession is provided. In the next chapter, I will provide a literature review on extensive research surrounding trauma-informed care practices, education, and training.

# Chapter 2: Literature Review

## Introduction

The purpose of this study was to explore the perceived level of preparedness of counselors who provide trauma-informed care in community-based mental health agencies. Trauma exposure is widespread: approximately 60% of men and 50% of women will experience at least one type of trauma in their lifetimes (U.S. Department of Health and Human Services, 2024). According to the U.S. Centers for Disease Control and Prevention (CDC, 2024), 64% of adults in the United States have experienced at least one adverse childhood experience (ACE) before age 18, and 17.3% have experienced four or more ACEs during childhood or adolescence.

Despite this prevalence, researchers maintain that graduate-level training in mental health disciplines remains insufficient for preparing counselors to work effectively with trauma-exposed clients (Courtois & Gold, 2009; Felter et al., 2022; Layne et al., 2014). Counselors working in highly demanding environments, such as community-based mental health settings, face increased risks of burnout and secondary traumatic stress due to organizational challenges, including high caseloads, limited training, and inadequate support (Bride et al., 2004; Craig & Sprang, 2010; Deblinger et al., 2024; Fukui et al., 2020; Hensel et al., 2015; HRSA, 2023). Clients in these settings often represent the most vulnerable populations, facing intersecting trauma, chronic stress, and systemic barriers to care (Hoge et al., 2016; Morrissey et al., 2019; SAMHSA, 2014). This context underscores the importance of examining how counselors in community-based agencies construct their preparedness to provide trauma-informed care.

The Health Resources and Services Administration (HRSA, 2023) has identified an ongoing mental health crisis, characterized by persistent unmet service needs across the United States and a projected significant decline in the mental health workforce by 2036. Multiple patient-level and provider-level barriers further strain the system (HRSA, 2023). Turnover rates for mental health providers average 25–60% annually (Fukui et al., 2020), and the shortage is especially pronounced in rural communities, where burnout and role strain are common (HRSA, 2023; Watanabe-Galloway et al., 2015). Although scholars emphasize the importance of counselor self-care as a protective factor against burnout and secondary traumatic stress, high turnover and job dissatisfaction remain pervasive (HRSA, 2023).

An extensive review of the literature reveals numerous studies examining counselor burnout, accreditation and training standards in counselor education, workforce trends, and organizational factors that contribute to turnover in community-based mental health settings (Bride et al., 2004; Craig & Sprang, 2010; Deblinger et al., 2024; Felter et al., 2022; Foltz et al., 2023; Fukui et al., 2020; Hensel et al., 2015; HRSA, 2023; Sutton et al., 2022; Warlick et al., 2021; Watanabe-Galloway et al., 2015). However, few studies have focused on counselors’ perspectives on providing trauma-informed care in these demanding environments or their perceptions of preparedness (Carr, 2024; Dixon & Schwarz, 2014; Last et al., 2022).

In this literature review, I focused on topics that shape the perspectives of clinicians working in community-based mental health who provide trauma-informed care. Major sections include the search strategy used, community counselors’ narratives, the

roles of individual and organizational factors in burnout, educational and training deficits, trauma-informed care training, counselor education program curriculum, job-related stress among providers, comparisons between private practice and nonprofit clinicians, behavioral health clinician training, counselor wellness, the impact of continuous trauma exposure on providers, trauma-informed care's effect on clinicians, and workforce trends.

## Literature Search Strategy

Using the Walden University library online, I searched the following databases: APA PsycINFO, SAGE Journals, PROQUEST, PsyArticles, and Academic Search Premier. I also searched the following databases using a web search: Google Scholar, CACREP, and the National Center for Health Workforce Analysis. I limited the search range to the past five years to ensure all research was current. After collecting current literature, I conducted an open search to determine the advancement of research outcomes.

I completed the literature search between February 2019 and September 2024 using various search terms to identify multidisciplinary perspective sources. Search terms used to identify literature included the following: *community-based mental health, community-based counselors, novice counselors, mental health turnovers, trauma, trauma-informed care, secondary trauma, training deficits, counselor education, trauma-informed pedagogy, vicarious trauma, CACREP requirements, clinician perspectives of burnout, training deficits, clinician's perspectives on training deficits,* and *mental health retention rates*.

I found that several dated studies align with this research study and that some recent studies suggest the lack of trauma-informed care training in counselor education programs (Felter et al., 2022; Foltz et al., 2023). The issue that prompted me to search the literature is that clinicians who provide trauma-informed care in community-based settings can be impacted negatively by patient-level barriers and provider-level barriers (Sutton et al., 2022). There is a continued need for additional training and coursework for clinical mental health counselors in trauma-informed therapy and practices (Felter et al., 2022; Foltz et al., 2023; Moh & Sperandio, 2022). If a counselor is not equipped to provide quality care, it can lead to issues in the counseling relationship, misdiagnosis, and adverse treatment outcomes (Foltz et al., 2023). Graduate programs continue to show a lack of emphasis on training students to provide trauma-informed care (Felter et al., 2022; Foltz et al., 2023).

Comparatively, issues that directly impact the counselor as they relate to a lack of training can lead to a lack of self-awareness, leading to problems such as burnout (Plath & Fickling, 2022). In the literature, there are overlapping themes of burnout also seen in the development of secondary traumatic stress in mental health providers. Counselors with a lack of self-awareness and unresolved adverse childhood experiences suffer higher rates of burnout and vicarious trauma (Felter et al., 2022; Sutton et al., 2022). Burnout and self-awareness are discussed throughout counselor education programs with an emphasis on self-care, but there is insufficient training in trauma-informed care to prepare counselors to work in community-based settings (Felter et al., 2022; Foltz et al., 2023; Moh & Sperandio, 2022).

Moh and Sperandio (2022) suggested that since the COVID-19 pandemic, there has been an increase in individuals who experience trauma due to various environmental factors. Foltz et al. (2023) found that as trauma exposure increases, organizational issues directly affect mental health providers, contributing to burnout. Similarly, Warlick et al. (2021) discussed how graduate clinicians develop burnout early in their careers and often continue to struggle with it as professionals, which can contribute to high turnover rates. According to the Bureau of Health Workforce (2023), as of December 2023, more than half of the U.S. population lives in a designated Mental Health Professional Shortage Area. These realities align with the theme of Support and Well-being in this study, as participants described how limited preparation, systemic shortages, and organizational stressors directly shaped both their sense of preparedness and their ability to sustain effective trauma-informed care in community-based settings (Felter et al., 2022; Foltz et al., 2023; Sutton et al., 2022).

There is a substantial shortage of addiction counselors, marriage and family therapists, mental health counselors, psychologists, and psychiatrists, projected to continue to increase deficits due to issues of burnout and a lack of trained professionals (Bureau of Health Workforce, 2023). Furthermore, this leads to a question surrounding clinical mental health clinicians' level of preparedness in providing trauma-informed care to clients due to the lack of trauma-informed training across counselor education programs (Moh & Sperandio, 2022).

## Conceptual Framework

The conceptual framework that I used to guide this study was constructivist grounded theory. Charmaz (2014) defines constructivist grounded theory as a modernized approach incorporating coding, theoretical sampling, and memo writing to understand participants' experiences comprehensively. This approach emphasizes critical reflexivity and the researcher's positionality, ensuring that the researcher's assumptions and processes are continuously questioned and adapted (Charmaz, 2014). By employing a constructivist grounded theory approach, this study captures how community-based mental health counselors perceive their preparedness to work with traumatized populations based on their lived experiences.

Constructivist grounded theory provides a dynamic framework for interpreting individual experiences, allowing exploration beyond technical skill assessment to encompass personal identity and emotional readiness (Charmaz, 2014; Mills et al., 2006). Charmaz (2014) argued that researchers should view participants' narratives as interpretations of their lived experiences, reflecting their actions and what they consider important. This approach allows unexpected themes to emerge during interviews, fostering a co-constructed dialogue that responds to the meanings participants convey, a key principle in Charmaz's framework (Charmaz, 2014). For example, when counselors describe their preparedness, they may not only discuss clinical skills but also highlight aspects such as resilience, self-awareness, and emotional coping strategies as integral to their work with trauma-affected populations.

Trauma-informed care provides a complementary framework that aligns with constructivist grounded theory principles. Trauma-informed care emphasizes trust, safety, empowerment, and collaboration as relational and contextual elements, while constructivist grounded theory highlights meaning-making as a process co-created by the researcher and participant (Charmaz, 2014; Moh & Sperandio, 2022). Together, I have found that these approaches support a relational and reflexive process that honors participant voice and context. In this study, this integration was important because counselors' descriptions of preparedness reflected their individual experiences and the influence of systemic and organizational structures. Rather than viewing preparedness as a fixed trait, constructivist grounded theory allowed exploration of preparedness as a dynamic and evolving process. At the same time, trauma-informed care provided a lens to interpret how participants framed preparedness through themes such as Support and Well-being and Preparedness Through Training and Education. This integration clarified that counselors' professional identities and their capacity to sustain trauma-informed practice emerged through both their personal growth and the systemic contexts in which they worked (Charmaz, 2014; Mills et al., 2006; Moh & Sperandio, 2022; Sutton et al., 2022).

Using a constructivist grounded theory approach, this research generated insights into how counselors made sense of their readiness and the factors that shaped it. The emergent theory illuminated the interplay among personal, organizational, and systemic influences, offering both theoretical insights and practical implications. These co-constructed findings inform practices that enhance counselor education, training, and

supervision while aligning with trauma-informed principles to foster effective and sustainable support systems. This integration of trauma-informed care and constructivist grounded theory provided the methodological foundation for the study, while professional identity theory served as the theoretical lens for examining counselors' perceptions of preparedness, as discussed in the following section.

## Theoretical Foundation

The theoretical foundation for this study is rooted in professional identity theory. This framework guides the exploration of how community-based mental health counselors perceive their level of preparedness to work with traumatized populations. While constructivist grounded theory emphasizes emergent insights rather than the imposition of pre-existing theories, professional identity theory provides a structured lens for understanding the complex factors that shape counselors' sense of readiness.

### Professional Identity Theory

Professional identity theory provides a foundation for examining how counselors develop and refine their professional self-concept. Historically, identity theories, such as Erik Erikson's Psychosocial Development Theory (1950) and James Marcia's Identity Status Theory (1966), underscored the role of career exploration in identity formation. Erikson's identity vs. role confusion stage highlighted the importance of synthesizing various experiences to form a cohesive professional identity (Erikson, 1959). Marcia's (1966) model expanded on Erikson's work by describing identity development across four statuses: diffusion, foreclosure, moratorium, and achievement. These theoretical insights translate to professional identity development, which is influenced by factors

such as supervision, mentorship, and practical experience (Gibson et al., 2010). Understanding how counselors' professional identities evolve when working with traumatized populations is key to assessing their perceived preparedness.

### *Application to Research Question*

I sought to uncover how community-based mental health counselors perceive their level of preparedness to work with traumatized populations by exploring their experiences within the context of professional identity. By examining how these counselors navigate and integrate their training, supervision, and real-world practice, I aim to illuminate the factors that contribute to or hinder their sense of preparedness. Insights from professional identity theory provide a comprehensive understanding of the dynamic and multidimensional nature of counselors' readiness to address the complexities of trauma in community mental health settings. The following section explores key concepts, including trauma, trauma-informed care, burnout, CACREP standards, community mental health, and telehealth, to synthesize existing research and identify gaps in counselors' preparation. These insights provide a conceptual foundation for understanding counselors' perceptions of their readiness to deliver trauma-informed care in community settings.

## Literature Review Related to Key Variables and/or Concepts

Community-based mental health counselors frequently serve clients affected by trauma. Trauma-informed care offers a framework for creating safe, empowering therapeutic environments, but its integration into counselor education remains limited.

Compounding this issue are challenges like burnout, compassion fatigue, and systemic barriers that impact counselors' ability to provide adequate care.

Standards set by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) guide counselor training, yet gaps persist in preparing clinicians for trauma-specific work. Community mental health counselors face unique demands, often addressing the broader social determinants of health alongside mental health needs. The rise of telehealth further underscores the importance of specialized training to deliver trauma-informed, culturally responsive care in both traditional and virtual settings. This section examines key concepts, including trauma, trauma-informed care, burnout, CACREP standards, community mental health, and telehealth. I synthesized existing research to highlight gaps in counselors' preparation and provide a framework for examining their perceived readiness to deliver in community settings.

**Trauma**

The term *trauma* was used historically to describe a wound by the ancient Greeks (Blehm, 2024). British physician John Erichsen is credited in the 1860s with the modernized meaning of the term in his writings on observed behaviors in individuals who suffered from fear of railway accidents that was attributed to shock, distress, or concussion, which he defined as "trauma syndrome" (Blehm, 2024). In later years, Sigmund Freud and J.M. Charcot began using the term trauma to refer to "the wounding of the mind," which caused a sudden and unexpected emotional shock later known as *hysteria* (Blehm, 2024). During World War I, military physicians used the term "shell shock" to describe the condition soldiers experienced, including fatigue, impaired vision

and hearing, tremors, and nightmares after battle (Blehm, 2024). This then led to an adaptation of the term by Herbert Kardiner, who then identified this condition as what became known as chronic traumatic war neurosis, known today as Post Traumatic Stress Disorder (Blehm, 2024).

Trauma can occur on an individualized level and affect groups of people within communities (James & Gilliland, 2013). *Trauma* is a broad term that can also be misconstrued as a *crisis* (James & Gilliland, 2013). The word *crisis* can have many meanings; most people have a general or broad idea of the word. Similarly, the terms *crisis* or *crises* can be linked to various types of *trauma* or *disasters* (James & Gilliland, 2013). Modern researchers continue to debate the concept of *trauma* (Benjamin & Carolissen, 2015; Plath & Fickling, 2022). For example, terms such as compassion fatigue, burnout, and vicarious traumatization are all linked to the concept of trauma and are examples of overlapping themes (Benjamin & Carolissen, 2015; Melaki & Stavrou, 2023; Plath & Fickling, 2022; Pruginin et al., 2017; Sutton et al., 2022). Effects of trauma can be both long-term and short-term, occurring after the initial shock or even developing years later.

Furthermore, researchers indicated that issues such as secondary traumatic stress and vicarious trauma can occur among mental health providers who provide care to traumatized individuals or communities (Baird & Kracen, 2006; Ivicic & Motta, 2017; Pearlman & MacIan, 1995). Baird and Kracen (2006) define secondary traumatic stress and vicarious trauma as emotional and psychological responses that can occur among mental health clinicians who work closely with traumatized individuals. Secondary

traumatic stress is defined by Ivicic and Motta (2017) as a response to being in close contact with a traumatized individual. Additionally, countertransference has remained a prominent issue that has implications for providing adequate therapy services and building therapist relationships. Sigmund Freud once described countertransference as problematic in successfully treating clients (Barros et al., 2020). Secondary traumatic stress is a known response to close contact with a traumatized individual (Ivicic & Motta, 2017).

**Trauma-Informed Care**

Butler et al. (2011) define “trauma-informed” as an approach that recognizes how victimization and violence affect individuals’ lives and mental health, and applies that knowledge to the development of services and systems that address their needs. The overall impact of trauma-informed care on mental health professionals is significant, offering both opportunities for better client outcomes and challenges in maintaining professional well-being (Baird & Kracen, 2006; Green et al.,2014; Melaki & Stavrou, 2023; Sutton et al., 2022). Proper training, support, and self-care are essential to mitigate the challenges of working with traumatized populations. Researchers indicate that trauma work has a negative influence on mental health professionals and their professional identity (Sutton et al., 2022). The experience of working with clients who have experienced trauma has also been known to directly impact mental health providers negatively. Preliminary evidence suggests that mental health providers working in community-based settings face a heightened risk of burnout, challenges with professional

identity, and other forms of occupational stress due to high caseloads and exposure to clients experiencing ongoing trauma (Green et al., 2014).

The experience of working with clients who have trauma has a direct impact on mental health providers. Therefore, counselors must have an awareness of vicarious trauma and secondary traumatic stress (STS) and are encouraged to engage in self-care practices and seek support to reduce issues such as burnout and compassion fatigue (Baird & Kracen, 2006; Bradford & de Amorim Levin, 2020). One of the highest-risk groups for vicarious trauma is mental health providers (Bradford & de Amorim Levin, 2020). Constant exposure to traumatized populations can lead to vicarious trauma because professionals can internalize some of their clients' trauma symptoms. The emotional toll of continually working with trauma survivors can result in compassion fatigue, where professionals feel emotionally drained, detached, or unable to engage empathetically with clients (Bradford & de Amorim Levin, 2020; Green et al.,2014; Sutton et al., 2022). Benjamin and Carolissen (2015) indicated that individuals living in poverty experience trauma continuously as a result of their environment and socioeconomic status. Rossi et al. (2012) noted that counselors providing care in the community mental health sector work regularly with individuals who have complex mental health needs and experience continuous trauma, conditions that contribute to significant stress among providers. Many community-based counselors report limited access to standardized or ongoing professional development in trauma-informed care, an issue consistently documented in the literature (Melaki & Stavrou, 2023; Rossi et al., 2012; Wyche, 2021). Trauma-informed care requires ongoing education and training to

stay updated on trauma research and interventions to aid in the development of counselors' professional identities and increase counselors' confidence (Barros et al., 2020; Green et al.,2014; Sutton et al., 2022).

Current researchers found dissimilarities in data related to a counselor's professional identity, worldview, and beliefs linked to feelings of security and trust when working with individuals with trauma (Barros et al., 2020; Rossi et al., 2012; Sutton et al., 2022). Barros et al. (2020) found a link between vicarious trauma and maladaptive coping strategies in counselors who work with clients who experience stress in a highly demanding environment, such as community-based mental health, and work with clients who experience trauma. In other research that I have explored, I found that individuals who struggle with adverse childhood experiences or are exposed to trauma have a potential risk for issues such as countertransference behaviors with clients.

Connery and Murdock (2019) provide valuable insights into the relationship between countertransference and the triggers therapists experience when working with trauma clients. This study further supports the development of the study's hypothesis and research questions regarding counselors' preparedness to provide trauma-informed care to clients in clinical mental health settings.

Access to high-quality trauma-informed care workshops, supervision, or peer support varies widely across agencies. For trauma-informed care to be effective, organizations must support clinicians with the appropriate policies, resources, and workplace culture (Branson, 2019; Green et al., 2014; Melaki & Stavrou, 2023; Wyche, 2021). Without this, mental health professionals may struggle to implement trauma-

informed care effectively, leading to frustration and burnout (Benjamin & Carolissen, 2015; Branson, 2019; Green et al., 2014; Melaki & Stavrou, 2023; Rossi et al., 2012). Therefore, counselors who implement trauma-informed care are encouraged to reflect on how working with trauma affects their own mental health, promoting emotional awareness and self-regulation, which some providers lack, leading to issues of burnout (Benjamin & Carolissen, 2015; Branson, 2019; Green et al., 2014; Melaki & Stavrou, 2023; Wyche, 2021).

**Burnout**

Burnout can impact an individual professionally, socially, and individually. Results from a work environment with insufficient administrative support, compensation, poor working conditions, low morale, high turnover, and staffing issues can lead to burnout (Benjamin & Carolissen, 2015; Branson, 2019; Green et al., 2014; Melaki & Stavrou, 2023). There are three known effects of trauma care on mental health professionals, known as compassion fatigue, secondary traumatic stress, and vicarious trauma (Sutton et al., 2022). Terms such as compassion fatigue, burnout, and vicarious traumatization are all linked to one underlying concept, which is identified as trauma (Benjamin & Carolissen, 2015; Plath & Fickling, 2022). Counselors working with high caseloads, under-resourced, or in crisis-heavy environments often feel unprepared to maintain trauma-informed practices amid competing priorities (Benjamin & Carolissen, 2015; Melaki & Stavrou, 2023; Plath & Fickling, 2022; Sutton et al., 2022). In fact, these issues can lead to the development of burnout and secondary traumatic stress, further affecting a counselor's confidence in delivering care to traumatized populations (Plath &

Fickling, 2022; Sutton et al., 2022). Employee burnout includes absences, increasing tardiness, reduced job performance and commitment, and turnover, which are ongoing issues in community-based mental health agencies (Green et al., 2014; Salyers et al., 2017). Moreover, issues like burnout or vicarious trauma hinder organizational functioning in community-based settings due to employee burnout, can cause high costs for healthcare systems, and are a critical factor in delivering quality care (Green et al., 2014; Salyers et al., 2017).

**CACREP**

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredits counseling education programs at colleges and universities in the United States. CACREP was developed in 1981 through the ACA to create clearer standards to aid in the development of a unified and clear professional identity for all counselors (Bahen & Miller, 1998; Council for Accreditation of Counseling & Related Educational Programs, 2024; Mascari & Webber, 2013). In 1987, CACREP was recognized by the Council on Post-Secondary Accreditation (COPA), which provided national recognition (Bahen & Miller, 1998; Mascari & Webber, 2013). CACREP standards offer counselor education programs a framework for developing an integrated professional counselor identity. These requirements ensure that students develop a strong professional identity as graduate counselors and have opportunities to specialize in identified areas of practice. Graduates must demonstrate knowledge and skill across the curriculum and professional dispositions to obtain their degree (Bahen & Miller, 1998; CACREP, 2024). CACREP requires counselor education programs to integrate service

and advocacy throughout the core curriculum. Leadership and advocacy are interwoven into master's and doctoral-level curricula in CACREP-accredited programs (Farrell et al., 2020).

Despite the increasing prevalence of trauma and adversity since the COVID-19 pandemic, graduate counseling programs continue to lack sufficient trauma-related training (Foltz et al., 2023). Foltz et al. (2023) found a positive correlation between the integration of trauma-related training in APA-accredited doctoral programs and counselors' increased ability to provide effective care to clients who experience trauma. Yet, researchers argue the need for further research in counselor education and traumatology (Foltz et al., 2023).

**Clinical Mental Health: Origins**

In the late 1800s, progressive social reforms were developed, emphasizing the mental state of an individual. The counseling profession was developed as a vocational guide during the Industrial Revolution. During rapid growth within the United States, cities experienced a higher need for social services (New York Behavioral Health, 2020; St. Bonaventure University, 2023; Watson & Schmit, 2020). In the early 1900s, Frank Parsons, the father of vocational guidance, opened the Bureau of Vocational Guidance in Boston, MA, to aid individuals in finding a career that matched their skills and personal traits. Throughout the 20$^{th}$ century, individuals like E.G. Williamson, C. Gilbert Wrenn, and Clifford Beers aided in the advancement of the mental health movement, separation of mental health counseling independent from the workplace, and things such as a six-

step method used by mental health counselors (New York Behavioral Health, 2020; St. Bonaventure University, 2023; Watson & Schmit, 2020).

In 1942, Carl Rogers's client-centered approach to psychotherapy continued to shift the core beliefs within counseling (New York Behavioral Health, 2020; St. Bonaventure University, 2023; Watson & Schmit, 2020). The Mental Health Act of 1946 aided in the establishment of the National Institute of Mental Health (NIMH), which authorized the Surgeon General to improve the mental health of U.S. citizens through research on the causes, diagnosis, and treatment of psychiatric disorders (Carr, 2024; NIMH, 2023). By the 1950s, various counseling organizations, such as the American Personnel and Guidance Association, now known as the American Counseling Association (ACA), were established in 1952. The passing of the National Defense Education Act of 1958 provided funds for establishing counseling and guidance institutes to train counselors. In 1963, the Community Mental Health Centers Act was passed, leading to the development of community mental health treatment facilities.

In 1976, the American Mental Health Counselors Association (AMHCA) was created with ethical and licensing requirements for clinical mental health counselors. In 1982, the National Board of Certified Counselors (NBCC) and a standardized national exam for state-level counselor certification were established. By 1992, counseling was included as a primary mental health profession by the National Institute of Mental Health and the Center for Mental Health Services (New York Behavioral Health, 2020; St. Bonaventure University, 2023; Watson & Schmit, 2020).

**Community Mental Health**

While clinical mental health focuses on diagnosing and treating individual conditions, community mental health broadens this focus to include the social and environmental factors that shape well-being, such as systemic barriers and access to care. During the 1960s, additional counseling theories emerged, like humanist theories, which began the development of theoretical frameworks to view human existence holistically. As time progressed, more emphasis was placed on mental health asylums and psychopathic hospitals. Due to the continued expansion of evidence-based practices in the 19th century, individuals who had acute and less severe forms of mental illness yielded no better cure or outcomes for patients than those in a different environment (Dixon & Schwarz, 2014; New York Behavioral Health, 2020; St. Bonaventure University, 2023; Watson & Schmit, 2020). As a result, the development of the Community Mental Health Centers Act, passed in 1963, provided federal funding for creating community mental health centers in the United States. In response to the Community Mental Health Act of 1963, the federal government established more than 700 community mental health centers (CMHCs), which now provide services to over half of the U.S. population and contributed to a decline in state hospital populations (Dixon & Schwarz, 2014). Comparatively, the community mental health movement is credited with historically addressing issues such as trauma and violence, social problems, issues of racism, poverty, and other social issues that are of concern and have impacted accessibility to mental health treatment (Carr, 2024). In recent years, the importance of trauma-informed care in community mental health has gained prominence. This approach

emphasizes understanding the impact of trauma on mental health and designing services that foster healing and recovery (Carr, 2024).

There are continuous issues in community mental health, such as unmet social welfare, lack of housing, inadequacies, and uncoordinated mental healthcare, which created a mental health crisis that brought up additional needs for additional reforms to be developed even in today's society (Carr, 2024; Dixon & Schwarz, 2014; New York Behavioral Health, 2020; St. Bonaventure University, 2023; Watson & Schmit, 2020). Counselors working in more rural community mental health areas, such as in the state of Mississippi, face several challenges that impact their ability to provide adequate care (DMH, 2022; Mongelli et al., 2020; U.S. Census Bureau, n.d.). These issues are shaped by factors such as socioeconomic conditions, limited resources, high rates of trauma, and systemic barriers within the mental health infrastructure (Mongelli et al., 2020). For example, in 2019, a federal judge ruled that Mississippi had violated the ADA by having inadequate resources in communities to treat people with mental illnesses (United States of America vs. The State of Mississippi, 2019). Most consumers served by community mental health centers are poor or have low incomes (DMH, 2022).

Mississippi has 11 independent regional Community Mental Health Centers, and over 51% of residents live in rural areas, which makes it the 4th most rural state in the US (DMH, 2022; United States of America vs. The State of Mississippi, 2019; U.S. Census Bureau, n.d.). Mississippi is predominantly rural, and many communities have limited access to mental health services. Mental health facilities and licensed professionals are often concentrated in urban areas, leaving rural populations underserved (DMH, 2022;

U.S. Census Bureau, n.d.). Counselors face the challenge of covering large geographic areas and managing clients who may have difficulty accessing care due to transportation and distance issues (DMH, 2022; U.S. Census Bureau, n.d.). Community mental health centers obtain funding through donations and by applying for state and federal grants. Many community mental health centers operate with limited budgets, making retaining staff, implementing new programs, and providing adequate services to all clients difficult. Seventy percent of the community centers' revenues come from Medicaid, private insurers, and out-of-pocket payments from clients provided by the Mississippi Department of Mental Health (DMH, 2022). Medicaid serves as the primary payer for many community mental health services in Mississippi. However, because the state has not expanded Medicaid under the Affordable Care Act, coverage remains limited for low-income individuals who fall within the coverage gap. Additionally, many private insurance plans have inadequate mental health coverage or may not be reimbursed for all services provided in community settings.

Mississippi has a significant shortage of licensed mental health professionals, particularly in rural and underserved areas (HRSA,2023; U.S. Census Bureau, n.d.). This puts additional pressure on community-based counselors, who often have large caseloads and struggle to meet service demand (DMH, 2022; HRSA,2023; U.S. Census Bureau, n.d.). Community mental health centers serve more than 110,000 Mississippians, according to the Mississippi Centers' Association 2018 Economic Impact Statement (DMH, 2022; HRSA,2023; U.S. Census Bureau, n.d.). Conversely, several of the regional mental health facilities in Mississippi closed due to a lack of funding and staffing

shortages, which has decreased access to mental health treatment in various areas of the state (DMH, 2022; United States of America vs. The State of Mississippi, 2019). Mississippi has one of the highest poverty rates in the U.S., and poverty is closely linked to increased rates of mental illness and trauma (HRSA,2023). Community mental health counselors frequently work with clients who experience chronic stress, financial instability, food insecurity, and lack of access to basic needs, which exacerbates mental health issues (DMH, 2022). Mississippi has high rates of ACEs, including domestic violence, substance abuse, and child abuse, which contribute to long-term mental health issues (DMH, 2022; HRSA,2023; United States of America vs. The State of Mississippi, 2019). Counselors must be equipped to address the effects of severe trauma, often without sufficient resources or training in trauma-informed care (HRSA,2023; United States of America vs. The State of Mississippi, 2019). Individuals from Mississippi struggle with high rates of substance use disorders, particularly opioid addiction (DMH, 2022; HRSA,2023; U.S. Census Bureau, n.d.). Mental health counselors must often address co-occurring disorders, where clients face both mental illness and substance abuse, requiring specialized care that may not always be available in community settings (DMH, 2022; United States of America vs. The State of Mississippi, 2019).

The shortage of mental health professionals means that counselors in Mississippi frequently experience high caseloads and are expected to serve many clients with complex needs (United States of America vs. The State of Mississippi,2019). This can lead to burnout, secondary trauma, and reduced effectiveness in providing care (Benjamin & Carolissen, 2015; Branson, 2019; Green et al., 2014; Melaki & Stavrou,

2023). Community mental health counselors often receive low salaries despite the intensity and complexity of their work (HRSA,2023; United States of America vs. The State of Mississippi, 2019). Many counselors report inadequate funding for services, limited access to professional development opportunities, and a lack of resources to manage client care effectively (United States of America vs. The State of Mississippi).

The state of Mississippi has stringent licensing requirements for counselors, making it difficult for new professionals to enter the field (United States of America vs. The State of Mississippi, 2019). Additionally, there may be insufficient training opportunities, particularly for specialized skills like trauma-informed care, substance abuse counseling, and working with marginalized populations (United States of America vs. The State of Mississippi, 2019).

Mental health stigma remains high in Mississippi, particularly in rural and conservative areas. Some individuals may be reluctant to seek help due to cultural or religious beliefs, further complicating outreach efforts (DMH, 2022; HRSA,2023; U.S. Census Bureau, n.d.). Counselors must work to reduce stigma and educate communities on the importance of mental health care. Mississippi's racial and ethnic minority populations, particularly African Americans, face significant disparities in accessing mental health care. Historical and systemic racism have contributed to mistrust of medical and mental health services among some communities (HRSA,2023; U.S. Census Bureau, n.d.; United States of America vs. The State of Mississippi, 2019). Counselors need cultural competency to effectively work with diverse populations, particularly when addressing historical trauma and systemic oppression (Sue et al., 2009).

**Telehealth**

While telehealth services have expanded, particularly during the COVID-19 pandemic, many rural areas of Mississippi still lack reliable internet access, making it difficult for clients to engage in virtual counseling (HRSA,2023; Mills & Mills, 2024). Counselors must navigate these technological barriers to ensure that remote and rural populations can still receive care. Counselors may not always be adequately trained to deliver telehealth services, particularly in a way that is trauma-informed and culturally sensitive (HRSA,2023; Leim et al., 2020). Implementing telehealth also requires additional funding and support for technology infrastructure, which may be lacking in underfunded community mental health centers (HRSA,2023; Leim et al., 2020). The challenges faced by community mental health counselors in Mississippi are multifaceted, combining systemic, socioeconomic, and workforce-related issues. Addressing these problems will require comprehensive reforms, including increased funding, expansion of mental health resources in rural areas, efforts to reduce stigma, and more robust training and support for counselors. Additionally, trauma-informed and culturally sensitive care is essential to improving mental health outcomes in the state (DMH, 2022; HRSA,2023; Leim et al., 2020; U.S. Census Bureau, n.d.; United States of America vs. The State of Mississippi).

## Summary and Conclusions

In this chapter, I reviewed the literature related to trauma-informed care practices, education, and training, specifically focusing on how community-based mental health counselors view their level of preparedness to work with traumatized populations. The

existing literature highlights significant gaps in training and education that impact the effective implementation of trauma-informed care (Felter et al., 2022; Foltz et al., 2023; Leim et al., 2020; Melaki & Stavrou, 2023; Wyche, 2021). Numerous studies have revealed that graduate curricula often lack sufficient emphasis on trauma-informed practices, resulting in master's-level clinicians entering the field without the skills and knowledge necessary to provide comprehensive care for trauma-affected clients (Felter et al., 2022; Foltz et al., 2023; Melaki & Stavrou, 2023; Wyche, 2021).

Due to these training deficits, novice clinicians frequently encounter challenges that can affect their professional performance and well-being (Leim et al., 2020; Wyche, 2021). The literature identifies several recurring themes related to counselors' experiences with trauma exposure, including burnout, compassion fatigue, maladaptive coping mechanisms, secondary traumatization, displaced distress, inadequate trauma-informed care knowledge, and job dissatisfaction (Benjamin & Carolissen, 2015; Green et al., 2014; Last et al., 2022; Melaki & Stavrou, 2023; Rossi et al., 2012; Sutton et al., 2022). Additional barriers, such as limited practice scope, reimbursement challenges, and burnout, hinder counselors' ability to provide high-quality care (Cook et al., 2021; HRSA, 2023).

There is limited research that captures counselors' own narratives and individualized perspectives on their preparedness for trauma-informed care and how it influences their professional identity. Community-based counselors' readiness to provide trauma-informed care relies on a complex blend of knowledge, practical skills, support systems, and personal resilience (Baird & Kracen, 2006; Carr, 2024; Dixon & Schwarz,

2014; Last et al., 2022). Despite these requirements, many counselors face significant obstacles, including limited training, high caseloads, and the impacts of vicarious trauma. Adequate supervision, organizational support, and cultural sensitivity are crucial for fostering counselors' preparedness and professional identity (Baird & Kracen, 2006; Blehm, 2024; Bradford & de Amorim Levin, 2020; Last et al., 2022).

Preparedness for trauma-informed care is described in the literature as an adaptive and ongoing process that demands continuous learning, reflective practice, and self-care (Baird & Kracen, 2006; Blehm, 2024; Bradford & de Amorim Levin, 2020; Branson, 2019; Ivicic & Motta, 2017; Last et al., 2022). Counselors often report receiving insufficient training on managing their emotional well-being while working with traumatized clients, which limits their ability to provide sustainable care (HRSA, 2023; NIMH, 2023; Plath & Fickling, 2022; Rossi et al., 2012; Shoji et al., 2015). This finding underscores the importance of programs and supervisors proactively cultivating healthy professional habits and fostering resilience within clinical settings.

The literature highlights a significant gap in counselor education programs, which often fail to adequately prepare students for the complex demands of community-based mental health work with trauma-affected clients. This study provided insight into counselors' perceptions of their preparedness to implement trauma-informed care, thereby contributing to the development of educational standards, supervision practices, training protocols, and continuing education. By examining counselors' narratives and experiences, this study aims to expand understanding of trauma-informed care and promote systemic investment in trauma-informed approaches that strengthen counselors'

effectiveness and well-being. The following chapter will outline the study’s methodology and describe the approach used to explore these perspectives.

# Chapter 3: Research Method

## Introduction

The purpose of this qualitative constructivist grounded theory study was to generate a theoretical understanding of how counselors working in community-based settings perceived their preparedness to provide trauma-informed mental health care. In this chapter, I provided an overview of the identified research design, the role of the researcher during the investigation, the methodology of the study, and steps to ensure trustworthiness.

## Research Design and Rationale

The central research question for this study was: *How do community-based mental health counselors view their level of preparedness to work with traumatized populations?* The central phenomenon I explored centered on counselors' perceptions and descriptions of their preparedness to provide trauma-informed care within community mental health settings. Using a constructivist grounded theory approach, I examined these experiences through the co-construction of knowledge between researcher and participants, consistent with the purpose of this study (Charmaz, 2014). This approach allowed me to examine counselors' perspectives in depth and within their individual contexts.

Grounded theory, initially introduced by Glaser and Strauss (1967), was established as a systematic method for developing theory grounded in empirical data. Traditional grounded theory employs a systematic process of data collection and constant comparative analysis to identify emerging patterns and construct theory grounded in

participants' experiences (Charmaz, 2014). The constructivist iteration of grounded theory builds on this foundation while integrating a more interpretive and reflexive lens (Charmaz, 2014). Therefore, the researcher's interactions with participants are crucial in shaping the data and subsequent findings (Charmaz, 2014).

The constructivist grounded theory method recognizes that counselors' experiences and perspectives develop within their specific contexts, histories, and social environments (Charmaz, 2014). Unlike traditional grounded theory, which aims to identify an objective reality, constructivist grounded theory emphasizes understanding participants' subjective meanings and lived experiences (Charmaz, 2014). This distinction was essential for guiding my examination of how counselors interpreted their preparedness and responded to the challenges of working with traumatized populations.

Constructivist grounded theory was particularly appropriate for understanding the lived experiences of community-based mental health counselors. By prioritizing participants' subjective realities, I gained rich and nuanced insights into how counselors perceived and constructed their sense of preparedness. This approach enabled me to capture diverse perspectives, highlight areas where counselors expressed confidence, and identify gaps where they experienced uncertainty (Charmaz, 2014). Understanding these variations was critical for explaining how counselors' experiences shaped their trauma-informed practices.

Moreover, applying grounded theory in this context yielded practical implications for counselor education, supervision, and trauma-informed practice. By examining community-based counselors' perceived levels of preparedness, I identified findings that

may guide the development of targeted trauma-informed training initiatives and policy improvements. These insights proved valuable for mental health organizations and policymakers seeking to strengthen effective and sustainable trauma-informed practices. Recognizing both areas of strength and perceived gaps in preparedness guided improvements in training programs aimed at better equipping counselors to address the challenges of working with trauma-affected populations.

## Role of the Researcher

In a constructivist grounded theory study, I played an integral and participatory role in co-constructing knowledge with participants (Charmaz, 2014). This approach emphasized collaboration between the researcher and participants, as both contributed their experiences, values, and interpretations to the development of the emerging theory (Charmaz, 2014). In this study, I generated a theoretical understanding of how community-based mental health counselors construct their sense of preparedness to work with traumatized populations. My role as the researcher was multifaceted, reflexive, and deeply engaged.

As the primary researcher, my community mental health counseling background shaped my interest in this study and my interpretive lens throughout the research process. I have worked extensively with individuals and families who have experienced significant trauma, and these professional experiences informed the questions I asked and the sensitivity with which I approached participants' narratives. Keeping with Charmaz's (2014) constructivist grounded theory approach, I recognized that my professional history positioned me as a co-constructor of meaning rather than a detached observer. To manage

potential bias, I engaged in reflexive memoing, sought feedback from my dissertation committee, and incorporated member checking to ensure that participants' voices remained central in shaping the emergent theory.

As a researcher, I acted simultaneously as an observer and a co-constructor of meaning. In this role, I was required to actively listen to participants, facilitate open dialogue, and maintain mutual respect and trust (Charmaz, 2014; Patton, 2015). Recognizing potential biases and preconceptions, I practiced reflexivity by continuously examining how my perspectives shaped interactions and interpretations (Charmaz, 2014). This reflective stance was essential for ensuring that my beliefs about trauma and counselor preparedness did not overshadow the genuine perspectives shared by participants.

Ethical considerations were paramount throughout the study. Maintaining informed consent, upholding confidentiality, and handling data responsibly were critical ethical standards that guided my practice (Charmaz, 2014; Patton, 2015; Ravitch & Carl, 2021; Remley & Herlihy, 2020). Additionally, given the sensitive nature of discussing trauma, I had to remain attentive to participants' emotional states and be prepared to offer appropriate resources should any distress emerge during the interviews (Patton, 2015; Ravitch & Carl, 2021; Remley & Herlihy, 2020). The trauma-informed perspective was vital to creating a safe and respectful space where counselors felt empowered to share their experiences openly.

Constructivist grounded theory aligned with trauma-informed principles by fostering a collaborative, empowering, and non-hierarchical interview environment

(Charmaz, 2014). Through this lens, I engaged with the data iteratively, allowing initial findings to inform subsequent interviews and deepen the inquiry. This approach honored the complex and multifaceted experiences of community-based mental health counselors while valuing their unique insights. It ensured that the resulting theory authentically reflected their voices and perspectives on preparedness to work with trauma-affected populations.

In constructivist grounded theory studies, the interaction between the researcher and participants informs theory development and facilitates mutual learning and change (Charmaz, 2014; Lynch, 2008). Through this study, my role extended beyond data collection and analysis to include advocacy. By accurately representing participants' views on their preparedness for trauma-informed care, the research findings may contribute to enhancing training programs, support systems, and trauma-informed policies within mental health settings. The methodology section will provide a detailed explanation of how these principles were applied throughout the research process.

## Methodology

In this methodology section, I outlined the constructivist grounded theory framework that guided the study. The findings reflected the distinctive contexts and demands of community-based mental health work, rendering the resulting theory relevant and applicable to real-world practice. This study employed a constructivist grounded theory approach to develop a theory grounded in participants' specific contexts rather than to produce a universal explanation. This approach ensured that the resulting theory remained relevant for mental health organizations seeking to strengthen counselor

training and support within community settings. Throughout this section, I described the recruitment procedures, data collection methods, and data analysis processes used in the study.

**Participant Selection Logic**

I initially aimed to recruit between 10 and 15 master's level counselors and licensed professional counselors practicing in Mississippi; the final sample consisted of 12 participants. All participants were required to have completed a master's program in counseling or a related mental health field, have experience working in community-based mental health settings, and have provided trauma-informed care within those settings. Participation in the study was voluntary, and counselors self-identified as meeting these criteria before being selected to participate.

Recruitment initially began through purposeful sampling to ensure that participants met the inclusion criteria and could provide meaningful insight related to the research question. Purposeful sampling was later supplemented by snowball sampling, which relied on participants' professional networks to help identify other eligible counselors. By combining these sampling strategies, I supported the inclusion of diverse voices and experiences, which allowed for a broader understanding of how community-based mental health counselors perceive their preparedness to provide trauma-informed care. An additional requirement for participation was that all counselors must have had experience working directly with trauma survivors and were either currently employed or had been employed in community-based mental health settings. These criteria were used to ensure that the data collected reflected authentic experiences of counselors who have

provided trauma-informed care in real-world settings. Including participants with different professional roles, training backgrounds, and years of experience allowed for an examination of how these factors influenced their sense of preparedness.

Purposeful sampling also made it possible to identify areas where counselors felt underprepared or unsupported, highlighting how preparedness may vary based on specific roles or contexts (Ravitch & Carl, 2021). For instance, counselors working in community-based environments such as clinics, shelters, or schools often encounter unique challenges and levels of support, which were considered when selecting participants.

Participants were identified and recruited through professional counseling networks, social media groups, and agency contacts across Mississippi. An electronic recruitment flyer and study invitation were distributed via email and posted to professional counselor forums. Interested individuals contacted me directly through the email provided on the flyer to verify eligibility, receive the informed consent form, and schedule an interview.

The goal was to recruit between 10 and 15 participants, with the final number determined by data saturation, the point at which no new ideas or themes emerged from the interviews. Recruitment continued until saturation was achieved, ensuring that the findings provided a comprehensive understanding of how counselors perceived their preparedness to work with traumatized populations. By combining purposeful, snowball, and theoretical sampling, I was able to capture a diverse and relevant sample of community-based counselors. Through the use of this approach, I strengthened the

credibility of the study and ensured that the data collected were rich, detailed, and aligned with the overall purpose of developing a constructivist grounded theory that reflects the complexity of counselors' lived experiences.

**Sampling**

The sampling strategy for this study I used followed a step-by-step process that incorporated purposeful, snowball, and theoretical sampling to recruit community-based mental health counselors who worked with traumatized populations. I began with purposeful sampling to select participants based on their direct and relevant experience in trauma-informed care (Patton, 2015; Ravitch & Carl, 2021). This strategy aligned with the research question: How do community-based mental health counselors view their level of preparedness to work with traumatized populations? By deliberately selecting participants who met specific inclusion criteria, I collected data that were rich, meaningful, and directly related to the study's objectives. Through this initial step, I established a strong foundation for understanding the experiences of individuals whose perspectives were most relevant to addressing the research question.

After completing purposeful sampling, I used snowball sampling to expand the recruitment pool by drawing on the professional networks of initial participants (Ravitch & Carl, 2021). In this phase, I invited participants to recommend colleagues who met the study criteria and were interested in contributing to the research (Patton, 2015; Ravitch & Carl, 2021). This approach enabled me to reach counselors engaged in trauma-informed care who were difficult to access through traditional recruitment methods. I maintained a targeted recruitment process by asking participants to share information about the study

with peers, thereby promoting inclusivity and diversity within the sample (Ravitch & Carl, 2021).

As the study progressed, I used theoretical sampling to build upon the data collected through purposeful and snowball sampling (Patton, 2015; Ravitch & Carl, 2021). Theoretical sampling refined and enhanced the dataset by addressing gaps and exploring emerging ideas. This sampling strategy supported the development of a constructivist grounded theory that captured the complexity of counselors' experiences with trauma-informed care. The findings highlighted both strengths and gaps in preparedness, offering valuable insights for improving training and support systems for mental health professionals in community-based settings. Together, these strategies ensured that the study's findings were robust, comprehensive, and authentically represented the experiences of community-based mental health counselors working with traumatized populations (Charmaz, 2014; Ravitch & Carl, 2021).

**Instrumentation**

In this constructivist grounded theory study on how community-based mental health counselors viewed their preparedness to work with traumatized populations, I collected data using multiple tools designed to address the research question (Charmaz, 2014). The primary instruments included a demographic form (see Appendix A), individual virtual semistructured and open-ended interviews, and reflexive journaling. I developed these tools to promote a nuanced understanding of counselors' experiences and perceptions (Charmaz, 2014; Ravitch & Carl, 2021).

### ***Demographic Form***

The demographic form (see Appendix A) served as the initial instrument for gathering participants' background information (Patton, 2015; Ravitch & Carl, 2021). It collected data on age, gender, years of counseling experience, highest education level, trauma-informed care training, work setting, and relevant certifications. Additional items included cultural background and languages spoken, given their potential influence on trauma-informed care delivery (Patton, 2015; Ravitch & Carl, 2021). I used the data collected from this form to provide context for understanding participants' diverse perspectives and to identify patterns or variations based on factors such as experience level, training, or work environment. Collecting this foundational information deepened the study's contextual understanding and supported transferability by situating participants' responses within their lived contexts (Ravitch & Carl, 2021).

### ***Semistructured interview***

I used semistructured interviews as the primary method for exploring counselors' experiences and perspectives on their preparedness to provide trauma-informed care (McDougall, 2000; Patton, 2015; Ravitch & Carl, 2021). The interview protocol (see Appendix B) included open-ended questions designed to elicit detailed narratives about participants' training, preparedness, and challenges in working with traumatized populations. I conducted all interviews virtually through Zoom using a secure, password-protected link. The interview protocol was developed using constructivist grounded theory principles to ensure consistency between the research question and the data collected (McDougall, 2000; Patton, 2015; Ravitch & Carl, 2021).

The conversational format encouraged participants to share their experiences in depth, while follow-up questions prompted further reflection on key areas (McDougall, 2000; Ravitch & Carl, 2021). I also observed nonverbal cues, such as body language and facial expressions, to gain deeper insight into participants' comfort levels, emotional responses, and the intensity of their experiences (McDougall, 2000; Patton, 2015). To address the sensitivity of trauma-related topics, I informed participants that they could pause or stop the interview at any time and that I would provide resources or referrals for additional support as needed.

Virtual semistructured interviews were provided to include participants unable to attend in person due to geographical, scheduling, or accessibility constraints (McDougall, 2000; Patton, 2015; Ravitch & Carl, 2021). These interviews followed the same semistructured format as the in-person interviews, ensuring consistency in data collection (Ravitch & Carl, 2021). Virtual interviews also offered a private, familiar setting for participants, which was particularly beneficial when discussing sensitive topics (Ravitch & Carl, 2021). This approach enabled participation from a broader demographic and geographic range while reducing logistical barriers such as travel time and expenses (Ravitch & Carl, 2021). Through these instruments, the study adopted a participant-centered approach, allowing for a comprehensive exploration of community-based counselors' perspectives.

### ***Reflexive Journaling***

As the researcher, I used reflexive journaling to document my thoughts, emotional responses, and insights related to participants' experiences with preparedness and trauma-

informed care. This process allowed me to reflect on my evolving understanding of the research context, ethical considerations, and emotional challenges experienced throughout the study. By recording regular reflections, I tracked shifts in my perspective and identified patterns that emerged over time. Reflexive journaling supported self-examination by helping me remain aware of my biases, assumptions, and personal experiences that could influence the research process (Charmaz, 2014). Engaging in this practice deepened the study by providing a nuanced understanding of my role as the researcher and complemented the data collected through interviews and other methods (Charmaz, 2014; Ravitch & Carl, 2021). Through consistent reflection, I gained deeper insight into my emotional and intellectual engagement with the study, contributing to a more grounded and comprehensive analysis (Charmaz, 2014; Patton, 2015; Ravitch & Carl, 2021).

**Procedures for Recruitment, Participation, and Data Collection**

In this study, I adopted recruitment, participation, and data collection methods that aligned closely with the central research question: *How do community-based mental health counselors view their level of preparedness to work with traumatized populations?* I collected data using demographic forms, semistructured interviews, and memo writing. Each participant had an opportunity to contribute at each point in data collection by completing a written demographic form and participating in a one-on-one virtual interview. By tailoring these components, I aimed to provide rich, meaningful data contributing to a constructivist grounded theory analysis.

***Recruitment Strategies***

Recruitment efforts targeted community-based settings where counselors frequently engaged with trauma-affected populations, including mental health clinics, nonprofit organizations, schools, shelters, and correctional facilities. Outreach involved contacting community mental health center administrators or directors to explain the study's purpose and to seek permission to recruit staff. The approved recruitment method was a flyer (see Appendix C), which informed potential participants about the study.

I also contacted professional networks such as local chapters of the American Counseling Association (ACA) and other counselor associations that distributed study information to their members. Recruitment materials included study details and contact information to ensure accessibility for interested participants. Purposeful sampling guided recruitment to ensure the inclusion of diverse perspectives on preparedness (Ravitch & Carl, 2021). I sought participation from counselors with varying levels of experience, training in trauma-informed care, and work settings across urban, suburban, and rural areas. I also considered demographic factors such as age, gender, cultural background, and professional specialization to ensure that the findings reflected the diversity of community-based counseling environments. To supplement these efforts, I used snowball sampling by encouraging initial participants to refer eligible colleagues, which helped reach counselors who were not easily accessible through traditional recruitment channels.

Data collection involved three key components: demographic forms, semistructured interviews, and reflective journaling. Participants completed a demographic form at the start of the study, electronically. I used this form to collect

contextual information such as age, gender, years of experience, educational background, professional certifications, type of work setting, and trauma-related training. These data points provided insights into how demographic and experiential factors influenced counselors' perceptions of preparedness (Charmaz, 2014; Patton, 2015; Ravitch & Carl, 2021). Identifying information, such as names and workplaces, was excluded to ensure confidentiality.

The primary method of data collection was semistructured interviews conducted virtually. This format allowed for flexibility and depth, enabling participants to explore their experiences and perceptions of preparedness for trauma-informed care. Open-ended questions focused on several key areas, including participants' self-assessments of preparedness, the types and adequacy of trauma-related training received, challenges encountered in trauma-informed care, and reflections on available resources and support systems. At the conclusion of each interview, participants were thanked for their time, provided with a brief debriefing summary of the study's purpose, and reminded that they could withdraw their participation at any time without penalty or consequence. No follow-up interviews were required; however, participants were contacted as needed for brief clarification or to participate in member checking to ensure the accuracy and credibility of the interpreted data.

***Memoing***

I used memoing during and after interviews to record observations, impressions, and potential biases to maintain reflexivity. Reflexive memos supported iterative analysis, aligning with grounded theory principles by allowing emergent themes to guide

subsequent data collection and interpretation (Charmaz, 2014; Patton, 2015). Through the integration of targeted recruitment, inclusive participation criteria, and comprehensive data collection methods, I sought to uncover the experiences of community-based mental health counselors and the factors that shaped their perceptions of preparedness to work with traumatized populations.

**Data Analysis Plan**

The data analysis plan for this study followed a constructivist grounded theory approach to develop a theory based on how community-based mental health counselors perceived their preparedness to work with traumatized populations. Constructivist grounded theory uses an iterative and inductive process that involves interpreting participants' experiences and identifying patterns through systematic coding and constant comparison (Charmaz, 2014; Patton, 2015; Ravitch & Carl, 2021). This approach ensured that the emerging theory was grounded in the shared experiences and perspectives of the participants.

I analyzed data concurrently with data collection, progressing through several phases: initial coding, focused coding, axial coding, theoretical coding, and memo writing. Each phase allowed me to examine the data in depth and identify categories that represented counselors' lived experiences with trauma-informed care.

Moreover, each data source directly addressed the central research question: *How do community-based mental health counselors view their level of preparedness to work with traumatized populations?* Data from the demographic questionnaire provided contextual information such as years of experience, education, and practice setting, which informed my interpretation of the interview data. Semistructured interviews served as the

primary data source and were analyzed using Charmaz's (2014) constructivist grounded theory coding methods, open, focused, and theoretical, to identify key categories and emerging relationships. During coding, I applied constant comparison to examine similarities and differences within and across interviews and refined categories through memo writing and reflection.

I managed data organization and coding using Microsoft Word and Excel, which allowed me to accurately track codes, categories, and theoretical notes throughout the analysis. Discrepant or deviant cases were not excluded but were carefully examined to challenge and refine my interpretations, ensuring that all perspectives were represented. This process kept the analysis grounded in participants' voices and aligned with the principles of constructivist grounded theory. These analytic procedures strengthened the credibility, dependability, and confirmability of the study's findings and supported the overall trustworthiness of the research.

***Initial Coding***

In the first phase, initial coding involved breaking the data into smaller, meaningful units through a line-by-line analysis of the transcripts. I assigned descriptive labels, or codes, to each data segment to reflect participants' words and experiences. This process kept the analysis grounded in the data and centered on participants' perspectives of their preparedness for trauma-informed care (Charmaz, 2014; Patton, 2015; Ravitch & Carl, 2021). During this phase, I identified key phrases, concepts, and recurring language that revealed counselors' self-assessed readiness, challenges, and strategies for engaging with trauma-affected clients. The flexible structure of constructivist grounded theory

enabled me to review and refine codes iteratively, ensuring they accurately represented participants' insights (Charmaz, 2014; Ravitch & Carl, 2021).

### *Focused Coding*

In the next phase, focused coding, I refined and grouped the initial codes into broader categories or themes related to the research question. This phase shifted the analysis from descriptive insights to analytical exploration, revealing patterns and relationships that illustrated counselors' views on their preparedness (Charmaz, 2014; Ravitch & Carl, 2021). Using constant comparison, I examined similarities and differences across data points and identified themes such as perceived strengths, training gaps, and systemic factors influencing counselors' readiness to work with traumatized populations. This iterative process strengthened the emerging themes and ensured that they accurately reflected the data (Charmaz, 2014; Patton, 2015).

### *Axial Coding*

During the axial coding phase, I examined the relationships among identified categories to understand the conditions, contexts, and outcomes that shaped counselors' preparedness. This phase allowed me to analyze in greater depth how factors such as prior training, supervision, organizational support, and personal resilience influenced counselors' confidence and effectiveness in trauma-informed care. Through this analysis, I developed a cohesive understanding of the factors that contributed to or hindered counselors' preparedness for working with traumatized clients (Charmaz, 2014; Ravitch & Carl, 2021).

### *Theoretical Coding*

In the final phase, theoretical coding, the findings from the earlier phases were synthesized to develop a comprehensive theory explaining counselors' preparedness. The categories and relationships identified during axial coding were integrated to construct a framework that reflected the complex interplay of factors influencing counselors' readiness (Ravitch & Carl, 2021). The resulting theory described the processes, mechanisms, and contextual factors that shaped how community-based counselors perceived their preparedness for trauma-informed practice, offering insights into effective strategies and areas for improvement (Charmaz, 2014).

### *Memo Writing*

Throughout the analysis process, I engaged in memo writing to document my reflections, insights, and emerging interpretations. Memos aided in capturing the evolution of themes and categories, facilitating transparency and trustworthiness in the research process. This practice also supported theory development by bridging the analytical steps and ensuring that the findings remained grounded in the data (Charmaz, 2014; Ravitch & Carl, 2021).

### *Achieving Data Saturation*

By analyzing data concurrently with the data collection process, I was able to identify recurring themes and achieve data saturation, where no new insights emerged (Charmaz, 2014). Saturation signaled that the core categories and theoretical framework were well-developed and grounded in participants' perspectives (Charmaz, 2014; Ravitch & Carl, 2021).

This constructivist grounded theory data analysis plan generated an in-depth understanding of how community-based mental health counselors perceived their preparedness to work with traumatized populations (Charmaz, 2014). By systematically examining counselors' experiences, challenges, and strategies, this approach ensured that the resulting theory was reflective of their lived realities and offered valuable insights into improving counselor education, training, supervision, and trauma-informed care practices (Charmaz, 2014).

## Issues of Trustworthiness

To align with the research question, *How do community-based mental health counselors view their level of preparedness to work with traumatized populations?*, I ensured trustworthiness by adhering to Charmaz's (2014) constructivist grounded theory methodology.

Trustworthiness in qualitative research refers to the accuracy and integrity of the research process, data, and findings (Ravitch & Carl, 2021). Lincoln and Guba (1985) identified four components of trustworthiness: credibility, transferability, dependability, and confirmability.

This study's trustworthiness was established through strategies that ensured rigorous and reflective research practices. Credibility was achieved through prolonged engagement with participants, iterative data analysis, and member checking to confirm that the findings resonated with their experiences. Transferability was addressed by providing thick, rich descriptions of the research context, participant demographics, and findings, enabling readers to determine applicability to other settings. Dependability was

ensured by maintaining an audit trail documenting decisions made throughout the research process, including detailed accounts of data collection and analysis. Finally, confirmability was supported through reflexivity, bracketing personal biases, and triangulating data sources to minimize researcher influence.

By integrating these trustworthiness strategies, I established an ethical and credible foundation for understanding how community-based mental health counselors perceived their preparedness to work with traumatized populations.

**Credibility**

Credibility was viewed as a form of internal validity, ensuring that the study measured what it intended to study (Ravitch & Carl, 2021). The data collected were representative of participants' experiences and perspectives (Ravitch & Carl, 2021). Credibility was achieved through prolonged engagement, persistent observation, triangulation, and member checking. Through prolonged engagement and observation, I engaged deeply with participants to build trust and rapport, particularly given the sensitive nature of trauma-informed care. Spending extended time with participants allowed for a comprehensive understanding of their perceptions and experiences.

Data were triangulated across three data points to ensure credibility (Ravitch & Carl, 2021). Triangulation involved the use of multiple data sources, methods, and perspectives to corroborate findings (Ravitch & Carl, 2021). Different types of data were used to enrich and verify insights, and consultation with committee members' perspectives on emerging themes (Ravitch & Carl, 2021). Employing Charmaz's (2014)

analytic methods to draw conclusions from the data further strengthened the study's credibility.

### *Member Checking*

After the data were analyzed, member checking was used to share interpretations and findings with participants to validate their accuracy and strengthen credibility. Member checking allowed participants to review and confirm the researcher's interpretations of the data (Ravitch & Carl, 2021). Participants were invited to review summaries of their interviews or initial themes to ensure that their perspectives were accurately represented (Ravitch & Carl, 2021). This technique enhanced credibility by confirming that the interpretations aligned with participants' views (Charmaz, 2014; Ravitch & Carl, 2021).

## Transferability

Transferability referred to how the methods and findings could be applied to other studies and contexts, allowing readers to determine whether the results were relevant to their own settings (Ravitch & Carl, 2021). My sampling strategy supported the inclusion of counselors from diverse backgrounds working in community-based mental health settings. To enhance transferability, I provided detailed descriptions of the research context, participant characteristics, and study settings (Charmaz, 2014; Ravitch & Carl, 2021). These descriptions of participants' backgrounds, experiences, and work environments allowed readers to assess how closely the study context aligned with their own (Charmaz, 2014; Ravitch & Carl, 2021).

Through purposeful sampling, I sought to select participants with varied experiences and backgrounds in community-based trauma-informed care (Charmaz, 2014; Ravitch & Carl, 2021). The diversity within the sample provided a broader perspective and increased the likelihood that the findings would resonate with counselors in similar settings. Readers were able to determine whether the experiences shared by participants applied to other contexts based on the detailed information provided (Charmaz, 2014; Ravitch & Carl, 2021).

Moreover, the information provided about the data collection process allowed for greater transferability. The demographic form offered detailed contextual descriptions of participants, including the settings and environments in which they worked, serving as the contextual foundation of this study. These details helped readers understand the nuances of participants' work environments and assess the applicability of the findings to their own contexts (Charmaz, 2014; Ravitch & Carl, 2021).

**Dependability**

In this methodology section, I described each procedure in detail and provided references to the appendices containing the research instruments to ensure that future researchers have sufficient information to replicate the study (Ravitch & Carl, 2021). I established dependability by presenting a clear account of what I planned, implemented, and documented so that the research process could be followed and evaluated by others (Charmaz, 2014; Shenton, 2004). To enhance dependability, I incorporated three key strategies: maintaining an audit trail, applying a code–recode process, and engaging in peer debriefing (Ravitch & Carl, 2021).

An audit trail served as a detailed record of all research activities, including decisions, methodological choices, and data analysis processes (Ravitch & Carl, 2021). I documented each step of the research process, including data collection methods, coding procedures, memo writing, and adjustments made during the study (Ravitch & Carl, 2021). This audit trail provided transparency and allowed others to evaluate the rigor of the study. During data analysis, I enhanced dependability by conducting a code–recode process (Ravitch & Carl, 2021). After an initial coding round, I set the data aside, returned to it after a period, and coded it again. This strategy confirmed the consistency of coding and identified areas that required further refinement or clarification.

**Confirmability**

Confirmability referred to the extent to which the findings were shaped by participants' experiences rather than by my own biases or preconceptions (Charmaz, 2014; Ravitch & Carl, 2021). To ensure confirmability, I followed a structured analysis process guided by Charmaz's (2014) constructivist grounded theory methods, which involved systematic coding and iterative analysis. I used bracketing to intentionally set aside my assumptions, allowing me to remain focused on participants' perspectives during data collection and analysis (Charmaz, 2014, p. 116). Additionally, I incorporated member checks to confirm or dispute identified themes with each participant throughout the study (Charmaz, 2014; Ravitch & Carl, 2021). An external audit was conducted by a researcher not involved in the study, who reviews the data, codes, and interpretations to ensure findings are derived from the data itself (Ravitch & Carl, 2021). This independent review provided an additional check on confirmability, helping to verify that the research

process and interpretations were transparent and justifiable (Charmaz, 2014; Ravitch & Carl, 2021).

Furthermore, I engaged in self-reflection throughout the research process. I documented my biases, assumptions, and experiences that may influence the research, which were recorded in a reflective journal (Charmaz, 2014; Ravitch & Carl, 2021). Reflexivity was an essential component of constructivist grounded theory, as my perspectives and assumptions inevitably influenced the research process (Charmaz, 2014; Ravitch & Carl, 2021). By engaging in reflective journaling, I documented personal thoughts, reactions, and assumptions throughout the study, which helped distinguish between participant-derived insights and my own interpretations (Charmaz, 2014). This transparency enhanced confirmability by clarifying how my perspectives may have influenced the analysis (Charmaz, 2014; Ravitch & Carl, 2021).

Triangulation across three data sources helped confirm the findings and reduce the impact of personal biases, further ensuring the study's confirmability (Charmaz, 2014; Ravitch & Carl, 2021). As with credibility, using multiple sources of data enhanced confirmability by providing a broader basis for interpretation. Consistent findings across these sources suggested that they were genuinely representative of participants' experiences rather than shaped by researcher bias (Charmaz, 2014; Ravitch & Carl, 2021). Because this study followed a constructivist grounded theory approach, intra- and intercoder reliability measures were not applied. Instead, consistency and trustworthiness were maintained through constant comparison, memo writing, reflexive journaling, and member checking (Charmaz, 2014; Lincoln & Guba, 1985).

## Ethical Procedures

Before data collection began, I obtained approval to conduct this study from the Walden University Institutional Review Board (IRB Approval No. 05-06-25-0570212). All research activities were conducted in alignment with Walden University's ethical standards and federal guidelines for research involving human participants. Institutional permissions were secured prior to recruitment to ensure that all procedures followed the appropriate ethical and professional requirements.

Participation in this study was voluntary, and each participant provided informed consent before taking part. I obtained informed consent electronically through an emailed consent form and demographic questionnaire (see Appendix A). The consent form described the study's purpose, procedures, potential risks, and participants' rights, including their right to withdraw at any time without penalty. I reviewed the consent form verbally at the beginning of each interview to confirm participants' understanding and to allow time for questions. I began each interview only after participants confirmed their consent to proceed.

All data was treated as confidential, not anonymous, since participants' identities were known to me but protected through strict confidentiality measures. Pseudonyms were assigned to each participant, and any identifying information was removed from transcripts, demographic forms, and notes. Participant contact information was stored separately from all data to protect privacy and ensure that identities could not be connected to their responses.

All electronic data, including audio recordings, transcripts, and consent forms, was securely stored on a password-protected laptop and in encrypted digital folders accessible only to me. I stored any printed materials in a locked file cabinet in a private office. I removed identifying details from all reports and analyses. In compliance with Walden University's policy, I will retain data for five years after the study's completion and then permanently delete or destroy it.

Ethical considerations related to data collection included protecting participant privacy, maintaining appropriate professional boundaries, and being mindful of potential power dynamics during interviews. As a licensed professional counselor and researcher, I recognized the importance of reducing any perceived authority by creating a supportive, conversational atmosphere in which participants felt comfortable sharing their experiences. Participants were reminded that their involvement was completely voluntary and that they could choose not to answer questions or stop the interview at any time. Because the study focused on trauma-informed care, I approached interviews with empathy and sensitivity, remaining alert to emotional triggers and ensuring that participants felt safe throughout the process.

Protections for confidential data included limiting access to only myself as the researcher, maintaining encrypted files, and safeguarding data throughout collection, analysis, and reporting. Findings were presented only in aggregate form or with pseudonyms in all reports, presentations, and publications to preserve participant confidentiality.

No incentives were offered for participation, and no conflicts of interest were identified. Snowball sampling referrals were handled discreetly to protect participant privacy and ensure that no identifying information about referrals was shared.

Authenticity and respect for participants' experiences were central to this study. I used a culturally responsive and trauma-informed approach throughout the research process to ensure that participants' voices were heard and accurately represented (Charmaz, 2014; Ravitch & Carl, 2021). These practices reflected my commitment to maintaining ethical integrity, trustworthiness, and participant protection while ensuring that the findings authentically represented their experiences and perspectives.

## Summary

In this chapter, I described the methodology and procedures that guided the implementation of this study. I also outlined the strategies used to ensure the trustworthiness of the research and the ethical treatment of participants. Trustworthiness in this constructivist grounded theory study was established through credibility, transferability, dependability, confirmability, and authenticity (Charmaz, 2014; Ravitch & Carl, 2021). Each criterion contributed to the rigor and integrity of the study by ensuring that the findings were grounded in participants' experiences and could be meaningfully applied to similar settings (Charmaz, 2014; Ravitch & Carl, 2021). Through this study, I aimed to provide a trustworthy and ethically sound contribution to understanding counselors' preparedness for trauma-informed care in community-based settings by employing practices such as reflexivity, triangulation, detailed description,

and collaborative meaning-making. Moreover, in Chapter 4, I review and explain the results of the study.

# Chapter 4: Results

## Introduction

In this chapter, I present the themes and subthemes that emerged in direct response to the research question: How do community-based mental health counselors view their level of preparedness to work with traumatized populations? The findings included five major themes: Preparedness through training and education, experiential learning and supervision, knowledge of trauma-informed care, support and well-being, and personal and professional attributes that collectively illustrate how counselors constructed their preparedness. Grounded in Charmaz's (2014) constructivist grounded theory methodology, I generated a data-driven understanding of counselors' experiences, perspectives, and challenges in trauma-informed practice. Data were collected through in-depth interviews with 12 community-based mental health counselors who worked with trauma-affected clients across diverse settings, providing the foundation for the results presented in this chapter.

## Setting

I selected participants through purposive sampling to reflect a range of professional backgrounds, clinical settings, and years of experience. I conducted individual interviews through a secure Zoom session to encourage comfort, openness, and confidentiality during data collection.

At the time of the study, participants' professional experiences, and the meanings they constructed around their preparedness for trauma-informed care, were influenced by several organizational and contextual factors. Many participants worked within agencies

that were under financial strain, with some reporting ongoing budget cuts, increased caseloads, and reduced access to clinical supervision and training opportunities. These systemic limitations often created environments characterized by high stress and burnout, which participants linked to feelings of inadequate support and compromised professional growth. Similar to participants' experiences, my professional background in community mental health and diverse clinical settings provided firsthand insight into the systemic challenges, resilience, and adaptability required of counselors serving traumatized populations.

In addition to organizational constraints, some participants were navigating recent or ongoing changes in leadership, staff turnover, and restructuring within their agencies. These transitions disrupted team cohesion and reduced institutional continuity, factors participants described as detrimental to both their well-being and their ability to engage in reflective trauma work. For example, several counselors noted that inconsistent supervision or shifting agency priorities made it difficult to advocate for trauma-informed practices or maintain consistent standards of care. On a personal level, some counselors shared that they were concurrently managing their own stressors, including family responsibilities, the aftermath of the COVID-19 pandemic, and prior unresolved trauma. These experiences, while challenging, also deepened their empathy and commitment to trauma-informed care. Participants often described a "dual awareness" both as providers and individuals affected by trauma, which informed their clinical approach and shaped their responses throughout the study.

Although most participants had received some form of trauma-related professional development, such as workshops, continuing education, or short courses, formal coursework and certifications in trauma-informed care were largely absent. Of the 12 participants, 10 reported having no specialized certification in this area. Consequently, many counselors expressed a reliance on experiential learning and peer collaboration to build competence, which often occurred in resource-limited or unsupportive organizational environments.

Understanding these personal and organizational influences is essential for contextualizing the findings presented in this chapter. The emergent themes and interpretations were deeply shaped by the systemic realities, professional settings, and lived experiences of the counselors who participated in this study. What follows is a detailed presentation of the thematic findings, guided by the principles of constructivist grounded theory and supported by rich participant narratives.

## Demographics

Participants included 12 counselors working or having past experience working in community-based mental health settings. Demographically, the sample included counselors ranging in age from 21 to over 60. Nine were identified as female and three as male. Racial and ethnic self-identifications included African American/Black ($n$ = 5), White/Caucasian ($n$ = 5), Hispanic/Latino ($n$ = 1), and one participant who identified as both African American/Black and Native American/Indigenous.

Educationally, all participants held at least a master’s degree in counseling or a related field, and one participant held a doctoral degree. Their post-master’s clinical

experience varied from 1–3 years (*n* = 4), 4–6 years (*n* = 5), and more than 11 years (*n* = 3). Most counselors worked in outpatient or school-based settings and served diverse client populations, including children, adolescents, adults, families, and groups. Participants' post-master's clinical experience ranged from 1 to more than 11 years, and most served diverse client populations, including children, adolescents, adults, families, and groups. Religious affiliations varied, with Christianity being the most commonly reported background.

**Figure 1**

*Participant Demographics*

| Participant ID | Age | Gender | Race/ethnicity | Education level | Post-Master's Counseling Experience | Primary Client Population |
|---|---|---|---|---|---|---|
| 001 | 21-30 | Female | African American/Black | Master's Degree | 4-6 years | Children (under12), Adolescents (12-17), Adults 18-64), Older Adults (65+), Families |
| 004 | 21-30 | Female | African American/Black | Master's Degree | 1-3years | Adolescents (12-17) |
| 005 | 41-50 | Female | White/Caucasian | Master's Degree | 4-6 years | Children (under12), Adolescents (12-17), Adults 18-64), Older Adults (65+), Families, Groups |
| 006 | 41-50 | Female | African American/Black | Master's Degree | 11+ years | Children (under12), Adolescents (12-17), Adults 18-64), Older Adults (65+), Families, Groups |
| 007 | 21-30 | Female | White/Caucasian | Master's Degree | 4-6 years | Children (under12), Adolescents (12-17) |
| 009 | 41-50 | Female | White/Caucasian | Doctoral Degree | 11+ years | Children (under12), Adolescents (12-17) |
| 010 | 21-30 | Male | African American/Black | Master's Degree | 1-3years | Children (under12), Adolescents (12-17), Adults 18-64), Older Adults (65+) |
| 011 | 51-60 | Female | White/Caucasian | Master's Degree | 11+ years | Children (under12), Adolescents (12-17) |
| 012 | 31-40 | Female | African American/Black | Master's Degree | 1-3years | Children (under12), Adolescents (12-17), Adults 18-64), Families, Group |
| 013 | 31-40 | Male | African American/Black/ Native American/ Indigenous | Master's Degree | 1-3years | Children (under12), Adolescents (12-17), Adults 18-64) |
| 017 | 31-40 | Female | White/Caucasian | Master's Degree | 4-6 years | Children (under12), Adolescents (12-17) |
| 019 | 41-50 | Male | Hispanic/Latino | Master's Degree | 4-6 years | Adults 18-64), Groups |

Figure 1 includes a detailed overview of each participant's self-reported background, which provides important context for interpreting the emergent themes discussed in the following sections.

## Data Collection

For this study, I collected data from 12 community-based mental health counselors who provided services to trauma-affected clients in a variety of settings across Mississippi. Using a constructivist grounded theory methodology, semistructured interviews served as the primary data collection method (Charmaz, 2024). I designed the interview protocol to explore participants' perceptions of their preparedness to provide trauma-informed care and to uncover the contextual factors that shaped their professional readiness.

Each participant completed a demographic questionnaire prior to the interview to provide background information relevant to their professional and personal characteristics. The form collected data on participants' age, gender, race/ethnicity, education level, counseling experience, trauma-related training, and client populations served. These demographic insights ensured variation within the sample and supported a deeper contextual interpretation of the interview data.

After obtaining demographic information, individual interviews were scheduled. Semistructured, open-ended interviews were conducted using Zoom, a secure virtual platform (Zoom Video Communications, 2024). The flexibility in location and format allowed participants to choose comfortable and private environments, supporting open and candid responses. With participant consent, each interview was audio-recorded using

secure, encrypted digital tools. Zoom automatically generated audio files and corresponding automated transcripts, which served as initial drafts of the verbatim records. To ensure accuracy and trustworthiness, each transcript was reviewed alongside the original audio recording. Every transcript was checked twice to correct any misinterpretations, omissions, or errors produced by the automated transcription system. This rigorous review process ensured that the final transcripts captured participants' words as closely as possible, including pauses, repetitions, and other verbal nuances. Once verified, the finalized verbatim transcripts were prepared for coding and subsequent data analysis. Interviews lasted approximately 60 to 90 minutes and were scheduled over a 4-week period. All interviews were conducted individually to maintain confidentiality. Field notes and reflective memos were maintained throughout the data collection process to capture contextual observations and researcher reflections.

There were no significant deviations from the data collection procedures outlined in Chapter 3. However, one minor variation included offering extended scheduling flexibility to accommodate counselors' demanding workloads. Some interviews were rescheduled or conducted outside typical business hours, including evenings and weekends, to ensure participant convenience and comfort. No participants withdrew from the study; however, two interviews were excluded after it was determined that the participants did not meet the eligibility criteria.

An unusual circumstance that emerged during data collection was the emotional intensity expressed by some participants when discussing their experiences working with highly traumatized clients. In these cases, I paused the interview to offer support, reaffirm

confidentiality, and provide space for reflection. While these moments were emotionally charged, they generated particularly rich insights into the toll of trauma work and underscored the importance of trauma-informed support for counselors themselves.

As a researcher, these experiences also required reflexivity. Witnessing participants' emotions reminded me of my own professional experiences in community mental health, which at times resurfaced during the interviews. I used reflexive journaling to acknowledge these reactions and to separate my perspective from participants' narratives while still recognizing the shared realities of trauma work (Charmaz, 2014). This reflexive process influenced how I interpreted the data and led me to pay closer attention to counselors' descriptions of emotional strain, organizational support, and coping strategies. These insights became central to the development of the theme support and well-being, underscoring that counselor preparedness is not only a matter of training and skills but also of sustaining emotional resilience in the face of trauma exposure.

Overall, the data collection process was participant-centered and aligned with constructivist grounded theory principles. The integration of in-depth interviews, demographic data, and reflexive journaling established a strong foundation for the subsequent phases of data analysis.

## Data Analysis

The analysis process in this constructivist grounded theory study followed Charmaz's (2024) inductive and iterative methodology, moving from raw data to increasingly abstract interpretations through a systematic process of initial coding, focused coding, category development, and theme construction. I analyzed the data using

constant comparative methods, allowing for emerging patterns to be refined through memo-writing, theoretical sampling, and reflective engagement.

The initial step of data analysis involved reviewing each interview transcript line by line during the initial coding phase to capture meaningful segments of data grounded in participants' exact language. Each transcript and corresponding recording were reviewed at least once to ensure accuracy. The preliminary codes reflected participants' thoughts, feelings, and descriptions related to their preparedness for trauma-informed care.

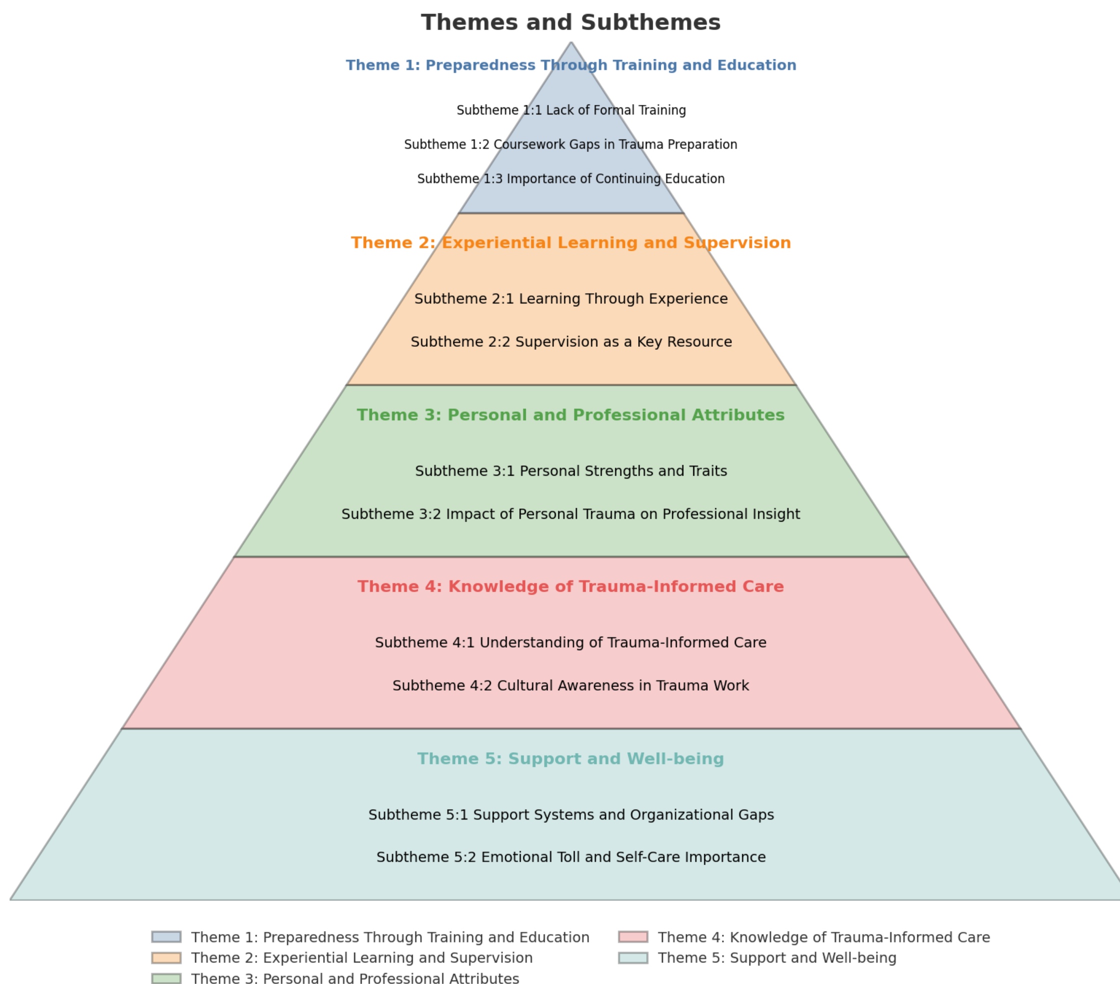
During focused coding, similar codes were grouped and compared across cases, allowing for the development of preliminary categories that revealed commonalities and contrasts in participants' experiences. Axial coding further refined the relationships among categories and subcategories, while memo writing supported analytic depth and reflexivity throughout the process (Charmaz, 2024). Themes were refined through the constant comparative method, which involved systematically comparing codes across participants and data sources to ensure that categories remained grounded in the full dataset.

**Themes**

From the analysis, five core thematic categories emerged. These themes are represented in Figure 2.

**Figure 2**

*Themes and Subthemes*




This pyramid figure illustrates the five major themes (colored layers) and their corresponding numbered subthemes listed beneath each theme, depicting the hierarchical organization of the findings.

These categories formed the foundation of the emerging theory of trauma-informed preparedness, which posits that counselors' sense of readiness develops not

solely through academic preparation but through a dynamic interplay of experiential learning, supportive supervision, personal reflection, and organizational context.

While most participants acknowledged inadequate formal preparation, two participants reported graduate training that included trauma-focused coursework and internships. These participants noted a gap between theoretical knowledge and practical application. Participant 004 stated, “I had classes, but I still felt unprepared when I met my first trauma client face-to-face.” These discrepant cases reinforced rather than contradicted the emergent themes, highlighting that even structured training can fall short without practical, supported experience.

## Evidence of Trustworthiness

To ensure rigor and integrity in this qualitative constructivist grounded theory study, multiple strategies were used to establish trustworthiness. The components of trustworthiness, credibility, transferability, dependability, and confirmability, as originally proposed by Lincoln and Guba (1985), were operationalized throughout data collection and analysis. The procedures described in Chapter 3 were implemented as planned, with minor adjustments to enhance methodological transparency and responsiveness to participants.

Credibility was strengthened through prolonged engagement with the data and participants, member checking to ensure that participants’ voices were accurately reflected, and the use of verbatim transcripts that were reviewed multiple times for accuracy (Creswell & Poth, 2018; Lincoln & Guba, 1985). Transferability was supported by providing thick, rich descriptions of the study setting, participant demographics, and

contextual factors, enabling readers to determine the applicability of the findings to their own settings (Merriam & Tisdell, 2016). Dependability was addressed through consistent data collection and analysis procedures, complemented by the use of reflexive journaling to document the researcher's evolving thoughts, decisions, and potential biases during the study (Charmaz, 2024; Ravitch & Carl, 2021). Confirmability was established through reflexivity, including bracketing of personal assumptions, and triangulation of data sources to ensure the findings reflected participants' perspectives rather than researcher interpretations (Lincoln & Guba, 1985; Shenton, 2004). Collectively, these measures ensured that the study's findings were trustworthy, consistent, and firmly grounded in participants' lived experiences.

**Credibility**

Credibility refers to the confidence in the accuracy and authenticity of the study's findings, ensuring that participants' voices are represented faithfully (Lincoln & Guba, 1985). In this study, I established credibility through prolonged engagement with participants, triangulation, member checking, and reflexive journaling. Each interview was conducted with attentiveness to depth and detail, using follow-up prompts to elicit clarification and expand upon key ideas. Interviews lasted between 60 and 90 minutes, allowing participants sufficient time to reflect on their experiences and provide rich, nuanced accounts.

Member checking was integrated during the interviews. I summarized key responses in real time and invited participants to confirm or clarify meanings, which enhanced the accuracy of the data. In addition, each recording was carefully reviewed

multiple times to ensure that transcriptions were accurate and complete. Reflexive journaling also contributed to credibility. After each interview, I documented how my follow-up questions might have shaped participant responses. These entries enabled me to refine my interviewing techniques in subsequent sessions, deepening the quality of data collection. Journaling further provided a space to record emerging codes and assess consistency across participants' narratives, reinforcing the accuracy of interpretations.

Triangulation was achieved through the incorporation of multiple data sources, including interview transcripts, demographic questionnaires, and reflective journal entries. Cross-verifying these sources ensured that categories and themes were supported by multiple forms of evidence, thereby strengthening the overall credibility of the findings.

**Transferability**

Transferability was addressed through detailed descriptions of the research context, participant characteristics, and practice settings (Lincoln & Guba, 1985; Merriam & Tisdell, 2016). Participants represented a diverse range of ages, educational backgrounds, clinical roles, years of post-master's experience, and client populations. These contextual details, presented in the settings and demographics sections, allow readers to assess the relevance of the findings to other contexts or populations. No significant changes were made to the transferability strategies described in Chapter 3. The inclusion of detailed participant quotations further enhanced transferability by conveying participants' unique voices and the complexity of their experiences.

**Dependability**

Dependability refers to the consistency and stability of the research process over time, ensuring that the study's findings are grounded in systematic and transparent procedures (Lincoln & Guba, 1985). In this study, dependability was supported by maintaining a consistent research process and documenting decisions through reflexive journaling. For example, I noted in my journal occasions when participants' stories of supervision and training gaps strongly resonated with my own professional experiences. Recognizing this alignment, I bracketed my reactions in writing to ensure that participants' voices were prioritized over my interpretations. Journaling also enabled me to document decisions regarding adjustments to interview prompts as new themes emerged, creating a transparent record of the analytic process and reinforcing dependability (Charmaz, 2014; Ravitch & Carl, 2021).

My journal entries often served as a parallel source of data, prompting me to question assumptions, acknowledge potential biases, and reflect on how my professional background shaped interpretations. Reflexive journaling thus enhanced transparency and contributed to the overall trustworthiness of the constructivist grounded theory process (Charmaz, 2024; Tracy, 2010). To further strengthen dependability, I sought feedback from committee members with expertise in qualitative research at key stages of the study. Their guidance validated interpretations, highlighted potential biases, and reinforced rigor in the analytic process (Creswell & Poth, 2021).

All interviews were conducted solely by me using a consistent semistructured protocol. While minor adaptations were made in response to participant answers, the

guiding questions remained unchanged. This consistency in data collection, combined with reflective documentation and committee feedback, ensured that the study maintained a dependable and transparent process from data collection through analysis.

**Confirmability**

Confirmability was supported through multiple strategies designed to reduce researcher bias and ensure that findings were grounded in participants' perspectives. Reflexive journaling was employed throughout the research process to bracket personal assumptions and remain attentive to how my professional background and dual identity as a counselor and researcher could influence data interpretation (Berger, 2015; Tufford & Newman, 2012). For example, I documented moments when my dual identity surfaced during data analysis and intentionally questioned whether my interpretations reflected participants' voices or my own professional lens. This process enhanced transparency and minimized bias, aligning with Charmaz's (2024) constructivist grounded theory approach. In addition, analytic memos and evolving coding notes created an audit trail that made findings traceable to the original data (Charmaz, 2024; Saldaña, 2021). The consistent use of direct participant quotations to support themes further reinforced that interpretations were firmly grounded in participants' accounts (Lincoln & Guba, 1985). No deviations from the confirmability strategies outlined in Chapter 3 were necessary. Instead, the continued practice of reflexivity and transparency strengthened the overall trustworthiness of the study (Ravitch & Carl, 2021).

# Results

The purpose of this study was to explore how community-based mental health counselors perceive their level of preparedness to work with traumatized populations. Guided by Charmaz's (2014) constructivist grounded theory, the findings were co-constructed through ongoing dialogue with participants, reflexive analysis, and the constant comparison of data. The following themes address the research question by illustrating how preparedness develops through lived experience, training, supervision, trauma knowledge, well-being, and personal attributes.

## Theme 1: Preparedness Through Training and Education

In direct response to the research question "How do community-based mental health counselors view their level of preparedness to work with traumatized populations?" Theme 1 illustrates that participants constructed preparedness around gaps in formal training that were offset by continuing education and targeted professional development. Nearly all participants emphasized that no amount of formal education could fully prepare them for the realities of trauma work. The participants repeatedly described how direct client interactions shaped their clinical judgment and therapeutic adaptability. Several shared that confronting real-life cases, particularly those involving complex trauma, revealed gaps in their academic training and simultaneously fostered professional growth. For instance, Participant 011 stated, "I feel confident now, but only because I've been doing it for years. Not because of training." Similarly, Participant 004 explained, "When a teen opened up about sexual trauma, I froze because we never

practiced that in school. But now, after working in the field for several years, I don't feel as uncomfortable."

My reflexive journal captured recurring observations during coding, revealing that participants frequently linked their sense of preparedness to gaps in coursework. Writing these reflections allowed me to recognize when my assumptions about the sufficiency of training diverged from participants' lived experiences, ultimately guiding me to refine this subtheme more accurately (Charmaz, 2024; Kolb, 1984; Schön, 1983).

These findings informed the theory generated from this study by illustrating preparedness as a developmental and experiential process rather than a fixed outcome of formal training. Although education provided an essential foundation, participants consistently described it as insufficient. This distinction became central to the emergent theory, clarifying that preparedness is constructed through the recognition of training gaps, which create the foundation for continued growth through practice and supervision, concepts further expanded in Theme 2.

***Subtheme 1:1 Lack of formal training***

Counselors commonly reported that their formal education lacked in-depth instruction on trauma-specific interventions. While general counseling principles were covered in their programs, many participants reported feeling unprepared to address trauma-related diagnoses such as posttraumatic stress disorder, dissociation, and complex grief. Participants described learning trauma-specific approaches largely after graduation through independent study and trial-and-error with clients. This lack of trauma-focused curriculum contributed to participants' feelings of insecurity early in their career.

Participant 001 stated, “I had no idea how to handle dissociation. I had to research it after the session.” This gap underscores the need for dedicated trauma-focused courses and practical skill-building modules within counselor education and training programs.

***Subtheme 1:2 Coursework Gaps***

Even when trauma-related topics were present in coursework, they were often superficial or theoretical. Counselors emphasized that real-world trauma cases required applied skills such as recognizing trauma responses, managing emotional triggers, and using trauma-informed techniques that were not covered in their classes. Participant 017 stated, “At first, I was overwhelmed. I wasn't prepared for the emotional weight clients bring.”

***Subtheme 1:3 Importance of Continuing Education***

Given the limitations of their initial training, many participants turned to continuing education units (CEUs), workshops, and professional conferences to strengthen their trauma-informed care skills. These ongoing learning opportunities were described as critical to staying updated with best practices, evidence-based interventions, and cultural sensitivity. Participant 007 stated, “My coursework didn't directly cover trauma. I had to learn through CEUs and on-the-job experiences.”

Through memoing, I documented how participants’ accounts of limited coursework consistently converged into a shared sense of underpreparedness. Member checking during interviews further confirmed that participants viewed these training gaps as a widespread experience shaping their perceptions of preparedness. These narratives demonstrate that preparedness was not experienced as a fixed competency but as a

developmental process. In direct response to the research question, participants constructed preparedness as a continually negotiated concept that began with gaps in graduate training and extended through continuing education. This reflects Charmaz's (2014) emphasis on meaning-making as a process shaped by both structural limitations and personal agency. In direct connection to the central research question, "How do community-based mental health counselors view their level of preparedness to work with traumatized populations?" Theme 1 demonstrates that preparedness was not experienced as a static skill acquired during graduate school but as an ongoing, co-constructed process shaped by continuing education and professional development.

### Theme 2: Experiential Learning and Supervision

Linked to the research question, "How do community-based mental health counselors view their level of preparedness to work with traumatized populations?" Theme 2 reflects participants' view that preparedness develops through experiential learning and sustained supervision, where confidence and skill are co-constructed in practice. This theme was intentionally distinguished from formal training and education because participants clearly differentiated between knowledge gained in academic settings and the skills developed through direct practice and guided supervision. While Theme 1 highlighted gaps in coursework and the need for continuing education, Theme 2 illustrates how counselors emphasized "learning by doing" and the essential role of supervision in bridging theory and practice (Borders et al., 2014; Kolb, 1984).

In my reflective journal, I noted that although participants consistently described supervision as a central resource, I initially underestimated its significance in shaping

preparedness. Revisiting these notes underscored supervision's recurring importance and prompted me to re-examine the data with greater attention to its role in counselor preparedness. Counselors described supervision and on-the-job experience as the most valuable aspects of their trauma preparation, with experiential learning emerging as the primary means of developing competence. Many participants explained that they learned by being "thrown into" real-world situations and adapting over time.

Participant 004 shared,

"I had like one class that covered trauma, and I had a practicum site where trauma cases were common. That's where I learned the most. But when I actually entered the field in community mental health, I was just thrown into situations and had to figure it out."

Similarly, Participant 007 reflected, "I can't really think off the top of my head, to be honest, of coursework, really. Like I said, I feel like it was just general. I feel like being in the field and supervision is what has helped me." Collectively, these accounts emphasized that most meaningful learning occurred post-graduation, highlighting a persistent gap between academic training and the realities of practice.

***Subtheme 2:1 Learning Through Experience***

Hands-on experience with clients was cited as one of the most impactful teachers. Counselors described learning to adapt to client needs, build resilience, and develop a strong understanding of trauma through trial and error. This experiential learning often compensated for the gaps left by insufficient formal training.

Participant 001 explained,

> "Well, my supervision has been very helpful. Um, I feel like I can talk to someone who's been in the field for years, a lot longer than me, considering they're in a supervisor position. I often find myself learning a lot more the more I talk to other people about it, as far as, like, supervision goes. But I do feel like supervision has probably been the most helpful."

***Subtheme 2:2 Supervision as a Key Resource***

During internships and professional practice, supervision emerged as a cornerstone of preparedness. Supervisors provided real-time feedback, practical tools, and emotional support that textbooks could not offer. This mentorship was especially valuable for early-career counselors navigating complex trauma cases. Participant 010 explained, "My supervisor at the agency gave me more tools than any textbook ever did".

Memoing captured my reflections on how participants described supervision as both technical and relational, shaping their professional identity. Member checking validated this interpretation, as counselors affirmed that their preparedness developed most within these co-constructed supervisory spaces. Supervision, therefore, became both a technical and relational co-construction of preparedness. As counselors voiced, their sense of readiness developed not from textbooks alone but through shared meaning-making with supervisors and peers. This interpretation illustrates how preparedness is socially constructed within mentoring relationships, aligning with Charmaz's (2014) principles of interaction and context in grounded theory. These accounts illuminate how counselors conceptualized preparedness in direct connection to the central research

question, emphasizing supervision as a co-constructed space where confidence, competence, and professional identity developed through relationships with others.

**Theme 3: Personal and Professional Attributes**

Addressing the research question "How do community-based mental health counselors view their level of preparedness to work with traumatized populations?" Theme 3 indicates that counselors understood preparedness through personal traits, lived experiences, and reflective practices that shaped their clinical judgment with traumatized clients. Through our co-constructed dialogue, it became evident that counselors viewed preparedness not only in terms of formal training but also through the lens of their personal characteristics and life experiences. As participants shared stories of resilience, cultural background, and identity, I reflected on how these narratives resonated with my assumptions as a practitioner. This theme therefore highlights how preparedness was jointly shaped by what participants narrated and how I interpreted those meanings in the analytic process (Carvalho et al., 2021; Gibson et al., 2010). Counselors reflected on internal qualities, such as empathy, curiosity, adaptability, and faith, that helped them persevere in difficult work. This finding underscores the importance of intrapersonal development alongside professional skill acquisition. Some even cited their personal trauma or family experiences as shaping their approach, bridging the personal and professional realms.

Participant 005 stated,

> "It's, um… Well, it's definitely been… At least with this agency, it is more exhausting, completely physically and mentally exhausting, because of the high

> rate of clients that we have to see on a given day. It does lead to it's leading to burnout for sure. It's um, it's not something that I don't think anyone could foresee keeping up at this pace for a long time. It's definitely like a feeling, essentially like use and abuse. You see all these clients for a short time, so they're going to get the most out of that person. Opposed to …providing a quality of care for the client. It's been a learning process. I've definitely learned what I don't want to work for and… hopefully how not to ever be in this position again if I can help it."

***Subtheme 3:1 Personal Strengths and Traits***

Participants highlighted personal qualities such as resilience, empathy, emotional regulation, and faith as foundational to their ability to do trauma work. Many described how these attributes allowed them to maintain composure in emotionally charged sessions, demonstrating strength under pressure. These traits were not necessarily developed through formal education but emerged from personal growth, life experiences, and reflective practice. Participant 009 stated,

> "I guess I think I have the ability to hear and not freak out. When I hear things that I think the general public might, you know, have trouble hearing would get really anxious about possibly or to be able to hear tough stuff and not ...you know, get overwhelmed or you know. So I think it's given me strength."

***Subtheme 3:2 Impact of Personal Trauma on Professional Insight***

As participants reflected on their personal histories and attributes, they co-constructed preparedness as inseparable from their sense of self and professional identity. For example, Participant 013 stated,

> "It made me kind of, like, relive certain traumas, which was the main reason I wanted to help people… because of my own trauma I went through, and not just not having anybody to go to… Since that trauma, I think, is what got me into community mental health counseling. It made me realize, uh, kind of learn a lot about myself and how I dealt with my own traumas by helping clients and listening to them… You know, giving them suggestions, those coping mechanisms."

Participants expressed that these lived experiences often became the foundation of their professional purpose. Having endured adversity, many participants explained that they developed a deeper sense of empathy and an enhanced ability to connect with clients' experiences of suffering. Participant 019 reflected, "I realized it takes a lot of compassion just to understand various perspectives, so I have changed a lot."

Memoing was critical in helping me connect participants' lived experiences with their professional self-concepts. During member checking, counselors reinforced that these personal attributes were not peripheral but central to how they constructed preparedness for trauma work. Together, these accounts underscore the importance of self-awareness and reflective processing in shaping trauma-informed counseling identities. This finding aligns with literature emphasizing the influence of counselors'

personal histories and reflective capacity in enhancing trauma-informed care (Knight, 2018) and with professional ethical standards that identify self-awareness as a core component of counselor competence (American Counseling Association [ACA], 2014). Such accounts answer the research question by showing that preparedness was not only learned but lived, reflecting Charmaz's (2014) call to foreground participant meaning-making in theory development. As counselors reflected on their personal histories, it became clear that preparedness was not only taught but lived. In addressing the research question, participants described preparedness as rooted in personal traits and lived experiences, affirming constructivist grounded theory's emphasis that meaning is co-constructed through personal and social contexts.

**Theme 4: Knowledge of Trauma-Informed Care**

In addressing the research question "How do community-based mental health counselors view their level of preparedness to work with traumatized populations?" Theme 4 frames preparedness as inseparable from understanding trauma-informed care principles, including safety, trust, collaboration, and cultural responsiveness, which are essential for preventing misdiagnosis and re-traumatization. Counselors discussed their evolving understanding of trauma-informed care as a comprehensive, relational framework rather than a checklist of techniques. Participants gave highly reflective definitions of trauma-informed care, rooted in empathy, client safety, and contextual awareness. This finding indicates a strong conceptual alignment with trauma-informed care principles, even when technical preparation varied among participants. Participants described trauma-informed care as essential for accurately diagnosing and treating

clients, with several warnings that overlooking trauma can lead to misdiagnosis or re-traumatization.

Participant 017 stated,

> "Being able to recognize… that what they're going through is trauma response, and then… figuring out how that manifests for them. So, whether that is… You know, um, like, learning their triggers, um, learning what their trauma response symptoms are specifically and then learning how to… cope with that, or to overcome those things."

***Subtheme 4:1 Understanding of Trauma-Informed Care***

Participants demonstrated an evolving, holistic understanding of trauma-informed care, viewing it as a mindset focused on safety, trust, and empowerment rather than a checklist of interventions. They stressed the importance of seeing beyond symptoms to understand the client's history and context. Participant 013 explained, "Everybody needs to have some type of trauma-informed education. Being trauma-informed isn't a checkbox, as it, is more of a mindset". Preparedness was therefore co-constructed as a mindset rather than a checklist. This framing, articulated by Participant 013 and echoed by others, illustrates how counselors defined trauma-informed care as central to addressing the research question on preparedness.

***Subtheme 4:2 Cultural Awareness***

Directly aligned with the research question, "How do community-based mental health counselors view their level of preparedness to work with traumatized populations?", Theme 5 situates preparedness within the context of support and well-

being, emphasizing that organizational resources and counselor self-care sustain trauma-informed practice. Cultural awareness also emerged as a critical component of trauma-informed care, as participants highlighted how trauma is often compounded by cultural identity, marginalization, and systemic inequities. Counselors recognized the necessity of understanding clients' cultural backgrounds to avoid assumptions and provide appropriate interventions. Participant 009 stated, "Being trauma-informed means you're not just treating symptoms, you're considering the whole story". They emphasized that cultural humility and active listening were essential to ensure that trauma-informed practices were not only effective but also respectful of each client's lived experience.

Through memoing, I observed a recurring tension between participants' strong conceptual understanding of trauma-informed care and the organizational barriers that hindered its practical application. Member checking confirmed that participants viewed trauma-informed care knowledge as inseparable from preparedness, reinforcing the salience of this theme. Preparedness was thus framed as inherently linked to an understanding of trauma-informed care principles. In relation to the central research question, participants' reflections revealed that feeling prepared required constructing readiness through a trauma-informed lens grounded in empathy, safety, and cultural awareness.

**Theme 5: Support and Well-being**

Participants described the significant emotional labor involved in trauma work and emphasized the importance of support systems and self-care practices. Counselors consistently acknowledged the demanding nature of this work, often citing its physical

and psychological effects, including sleep disruption, burnout, and secondary trauma (Figley, 1995; Stamm, 2010). To cope, they engaged in diverse self-care strategies such as prayer, exercise, boundary setting, and clinical supervision. These practices reflected a deep awareness of the personal toll of trauma work and a commitment to sustaining their longevity in the profession. For example, Participant 001 noted, “It’s made me more empathetic, but also more vigilant about my own boundaries.”

My reflective journal documented the emotional reactions I experienced while coding participants’ accounts of burnout and secondary trauma. These reflections helped me recognize how my own responses mirrored those of participants, which, in turn, informed my understanding of the centrality of counselor wellness in preparedness (Maslach & Leiter, 2016).

***Subtheme 5:1 Support Systems and Organizational Gaps***

Participants shared concerns about limited systemic and organizational support, citing high caseloads, minimal debriefing, and insufficient supervision. The organizational structure in many agencies was described as unsustainable. Counselors frequently voiced that the demands of trauma work were not matched by adequate support, leading to burnout and turnover. Without institutional resources such as trauma-informed supervision, peer support groups, or flexible caseload management, counselors struggled to sustain their emotional well-being. This lack of organizational support revealed a clear disconnect between the expectation to deliver high-quality trauma care and the realities of the conditions under which counselors worked.

Participant 004 stated,

"My boss, who is my clinical director, says he's always available to help, but he's not actually available. It's like, hey, look, let's try this technique and follow up with me, and let me know if this works, then he disappears. So it's not a lot of support, and no training has been provided. Training twice a year, and trauma is barely touched on. The most we've talked about is sexual trauma. But we also didn't go too in-depth in that."

***Subtheme 5:2 Emotional toll and Self-Care***

The emotional impact of trauma counseling was universally acknowledged. Counselors described feeling physically and emotionally drained, with some reporting symptoms of secondary traumatic stress. To counterbalance these effects, participants emphasized the importance of engaging in intentional self-care practices. Common strategies included prayer, exercise, vacations, and seeking their own therapy. Self-care was framed not only as personal maintenance but also as a professional responsibility. Despite differences in practice, all participants agreed that self-care was a non-negotiable aspect of both surviving and thriving in trauma-focused roles.

Participant 009 stated,

"Taking time for myself, taking vacations, enjoying friendships, and things outside the profession, you know, sleep, diet. My own therapy, all of that being important. Being present and taking care of my own family, and feeling that you know things are fairly well there too."

By situating wellness strategies at the core of their preparedness, participants demonstrated that self-care and organizational support were not optional but

fundamental. Their reflections underscored that preparedness was experienced as relational and contextual, confirming Charmaz's (2014) assertion that grounded theory must remain anchored in participants' lived realities. My memos documented how participants' emphasis on wellness was tied to their survival in the field rather than mere professional preference. Member checking affirmed that counselors consistently viewed self-care and organizational support as essential components of preparedness, not optional practices. Directly addressing the research question, participants emphasized that preparedness could not be sustained without both organizational resources and personal wellness practices. This finding illustrates that preparedness was co-constructed at the intersection of individual resilience and systemic support.

**Discrepant Cases**

Two participants reported more extensive trauma-specific graduate training than their peers. However, they acknowledged that practical application required further growth. Rather than contradicting the themes, these discrepant cases reinforced the overall finding that preparation for trauma-informed care is deeply experiential and continues to evolve beyond academic settings.

Participant 010 stated,

> "Currently in private practice, I was already going through TFCBT, the trauma-focused cognitive behavior therapy certification course, so that kind of already geared me to understand a little bit more in-depth. To be honest, before that in community mental health, it was more on a case-by-case scenario, just learning on the job. They would give you, like, you know, those Relias courses to give you

> those, you know, screen, like those, um. Ongoing compliance things to do to keep your things up to date, but there weren't really actual classes to go to learn how to do TIC properly. They did do those things, like informational. So you did take a day off and they kind of took you to a college and did like a presentation, but when it came to like an actual application in the field, there really was nothing, no, actually, I feel like there was no real guidance for it."

Participant 009 explained,

> "Sometimes I think I have a… maybe a negative, not a negative view, but like I'm skeptical of certain things. So, I don't view those things as positively or as supportive as maybe other people who haven't had a lot of experience with those agencies and things."

Across all five themes, a consistent thread emerged: participants emphasized that no amount of formal education alone could fully prepare them for the realities of trauma work. While Theme 1 highlighted gaps in coursework and the limited scope of trauma-related training, Theme 2 illustrated how preparedness was constructed primarily through experiential learning and supervision. Themes 3, 4, and 5 expanded this understanding by demonstrating how personal traits, evolving conceptualizations of trauma-informed care, and the presence or absence of organizational support shaped counselors' professional development. Collectively, these findings indicate that preparedness is not a singular outcome of academic training but a multifaceted, developmental process co-constructed through education, lived experience, and systemic context.

## Summary

The central research question guiding this study was: How do community-based mental health counselors view their level of preparedness to work with traumatized populations? Through in-depth interviews with 12 community-based counselors, five major themes emerged that collectively addressed this question. Counselors described a general lack of formal trauma-related preparation within their graduate training programs, often relying instead on experiential learning and supervision as their primary sources of trauma-informed development. While some participants pursued continuing education and certifications, most emphasized that their preparedness was shaped through real-world practice, supportive supervision, and personal initiative.

Participants underscored that trauma-informed care is not a static set of techniques but a comprehensive mindset rooted in empathy, cultural awareness, and relational safety. They also noted the emotional toll of trauma work, citing the need for organizational support and intentional self-care to sustain effectiveness in this demanding field. Personal attributes, including lived experiences of trauma, were described as equally central to their sense of preparedness.

Together, these findings suggest that preparedness is not a fixed outcome of education but a dynamic, developmental process co-constructed through the interaction of training, practice, personal attributes, and organizational context. Counselors repeatedly articulated that their professional growth depended less on what they learned in classrooms and more on what they encountered in practice, how they processed those experiences, and the support available to them. This points to a broader theoretical

understanding that preparedness for trauma-informed counseling is best conceptualized as a relational and evolving state shaped by counselors' ongoing negotiation between individual capacities and systemic realities.

Despite differences in education and experience, a shared narrative emerged: preparedness for trauma-informed counseling is deeply contextual, evolving over time, and grounded in both professional development and personal reflection. These findings establish the foundation for the grounded theory presented in Chapter 5, which examines how counselors construct their sense of preparedness and considers the implications for counselor education, clinical supervision, and agency practice. In sum, the five themes: Preparedness Through Training and Education, Experiential Learning and Supervision, Personal and Professional Attributes, Knowledge of Trauma-Informed Care, and Support and Well-Being, offer a co-constructed response to the central research question.

In addition to interview narratives, demographic information such as years of experience, licensure status, and practice setting was used to contextualize participants' accounts. The triangulation of interview data, demographic forms, and reflexive journaling contributed to a richer and more nuanced understanding of how preparedness was constructed.

Throughout the analytic process, I engaged in memoing to capture emerging insights, reflexive considerations, and theoretical connections that shaped the interpretation of participants' experiences. Member checking further ensured that the meanings attributed to participants' accounts accurately reflected their perspectives, thereby strengthening the credibility of the findings. By integrating participants' voices

with reflexive memoing and collaborative member feedback, this chapter establishes a grounded and trustworthy foundation for the interpretive analysis presented in Chapter 5.

# Chapter 5: Discussion, Conclusions, and Recommendations

## Introduction

In this qualitative constructivist grounded theory study, I developed a theoretical understanding of how community-based mental health counselors perceive their preparedness to work with traumatized populations. Returning to the central research question, each theme presented in Chapter 4 is interpreted here not as an objective truth but as an analytic account co-constructed from participants' voices and my interpretive lens, consistent with Charmaz's (2014) view that grounded theory represents a process of shared meaning-making. Drawing from in-depth interviews with 12 counselors, this chapter presents a co-constructed framework that explains the interplay among personal, professional, and organizational factors shaping counselors' readiness to deliver trauma-informed care.

In this chapter, I return to the central research question to interpret how the five themes collectively construct a co-constructed and theoretically grounded understanding of preparedness. This interpretation is consistent with Charmaz's constructivist grounded theory, which views findings as interpretive renderings of participants' meanings rather than discovered facts. Through iterative analysis, five major themes emerged: (a) preparedness through training and education, (b) experiential learning and supervision, (c) knowledge of trauma-informed care, (d) support and well-being, and (e) personal and professional attributes. woven across these themes was a recurring insight: no amount of education can fully prepare you for trauma work. This finding became the cornerstone of the emergent theory and underscored that preparedness is a dynamic, relational, and

context-dependent process rather than a static outcome or the sole product of graduate training.

In this chapter, I interpret the study's findings by situating them within existing scholarship and theoretical frameworks, particularly professional identity theory and constructivist grounded theory. I also reflect on the study's limitations, offer recommendations for future research and practice, and discuss the implications for positive social change. Returning to the central research question, I interpret how the five themes collectively construct a co-constructed understanding of preparedness. This interpretation aligns with Charmaz's (2014) constructivist grounded theory, which views findings as interpretive renderings of participants' meanings rather than discovered facts.

## Interpretation of the Findings

These findings represent an interpretive account co-constructed with participants. Through reflexive engagement with their narratives, I developed an analytic understanding of preparedness that emphasizes interaction, context, and shared meaning-making. Within the constructivist grounded theory framework, the analytic process involved iterative coding, memoing, and reflexive engagement, all of which shaped how preparedness was understood in relation to the research question. My positionality as both counselor and researcher influenced these interpretations; through ongoing reflexive memoing, I remained attentive to how my professional experiences informed, and at times challenged, my understanding of participants' accounts.

My background in community mental health counseling further shaped how I interpreted the findings. Consistent with Charmaz's (2014, 2024) constructivist grounded

theory, I acknowledge that the results presented here are not neutral discoveries but co-constructed interpretations influenced by my professional experiences with trauma-exposed populations. Through ongoing memoing, I examined how my perspectives informed coding decisions, theme development, and theoretical integration. Member checking served as a collaborative safeguard, ensuring that my interpretations resonated with participants' intended meanings. By engaging in this reflexive process, I sought to balance my professional insights with participants' authentic voices, maintaining transparency and honoring the co-constructed nature of the grounded theory that emerged.

Together, the five themes provide a comprehensive answer to the research question: How do community-based mental health counselors view their level of preparedness to work with traumatized populations? By portraying preparedness as a dynamic, relational process shaped by training, experience, trauma-informed care knowledge, personal attributes, and support. The findings of this study both confirm and extend the existing body of literature on trauma-informed care and counselor preparedness. Consistent with previous research, the findings showed that graduate counseling programs often lack structured trauma-specific education, leaving new counselors unprepared to address the complexities of trauma (Felter et al., 2022; Foltz et al., 2023; Courtois & Gold, 2009). Participants in my study echoed these concerns by describing significant gaps in coursework and training. Each theme contributes uniquely to understanding how community-based counselors construct preparedness, aligning with both constructivist grounded theory and professional identity theory. Throughout

analysis, memoing served as a tool to capture emerging insights, track analytic decisions, and document shifts in interpretation. These memos functioned as bridges between participants' words and my theoretical interpretations, ensuring that the emergent theory was grounded in participants' experiences while reflecting my interpretive role.

**Preparedness Through Training and Education**

Participants consistently described significant gaps in their graduate education when it came to trauma-specific preparation. Through their narratives, participants revealed that coursework often skimmed the surface of trauma but left them unprepared for the complex realities of practice. As Participant 004 reflected, "When a teen opened up about sexual trauma, I froze because we never practiced that in school."

The analysis supports what the literature has long documented: counselor education programs frequently underemphasize trauma-focused content (Felter et al., 2022; Foltz et al., 2023; Courtois & Gold, 2009). The findings extend this knowledge by illustrating how counselors experience and internalize these gaps. Rather than merely critiquing their training, participants described carrying these limitations into practice and actively working to reconcile them through continuing education, on-the-job learning, and supervision. In this sense, preparedness emerged not as a competency attained at graduation, but as a lifelong process of adaptation that began with recognizing the insufficiency of formal training.

**Experiential Learning and Supervision**

If formal education provided an incomplete foundation, experiential learning and supervision served as the structure counselors relied on to develop confidence and

competence. Many described supervision as their lifeline during early encounters with trauma cases. Participant 010 captured this sentiment: “My supervisor at the agency gave me more tools than any textbook ever did.”

Supervision was not merely a technical resource; it became a relational space where counselors tested their ideas, processed emotional reactions, and shaped their professional identities. This aligns with professional identity theory, which frames mentorship and supervision as relational contexts in which identity and competence coalesce (Gibson et al., 2010). The analysis extends this understanding by demonstrating that when coursework lacks sufficient depth, supervision and real-world practice serve as the primary training grounds for developing trauma-informed counseling competence.

**Personal and Professional Attributes**

Another central theme was the role of counselors’ personal attributes and lived experiences in shaping preparedness. Traits such as empathy, resilience, and adaptability were repeatedly named as sustaining forces. For some participants, lived experiences with trauma shaped their sense of purpose and strengthened their capacity for empathy. As Participant 013 explained, “Because of my own trauma I went through… that’s the main reason I wanted to help people.”

The analysis aligns with Carvalho et al. (2021) and Gibson et al. (2010), who emphasized that counselors develop professional identity through reflective and meaning-making processes. They also resonate with Knight’s (2018) assertion that lived experiences enhance reflective capacity. In this study, personal histories were not separate from professional preparedness; they were integral, illustrating how counselors

draw upon personal reservoirs of strength and pain to co-create their identities as trauma-informed practitioners.

**Knowledge of Trauma-Informed Care**

Counselors consistently defined trauma-informed care not as a checklist of interventions but as a mindset and relational stance centered on empathy, cultural awareness, and safety. Participant 013 summarized this perspective: "Being trauma-informed isn't a checkbox; it's more of a mindset." This conceptualization aligns with Butler et al. (2011) and Sutton et al. (2022), who describe trauma-informed care as a holistic and evolving framework. However, the analysis revealed a tension counselors viewed trauma-informed care as essential yet struggled to sustain it under heavy caseloads and organizational pressures. This pattern supports Rossi et al.'s (2012) concern that without systemic reinforcement, trauma-informed care practices often wane. The present study extends this literature by demonstrating that trauma-informed care knowledge remains fragile without institutional support, relying on both individual commitment and organizational infrastructure to endure.

**Support and Well-being**

Participants were candid about the emotional toll of trauma work. They spoke of exhaustion, disrupted sleep, and compassion fatigue. Yet they also described resilience strategies such as prayer, exercise, therapy, and boundary-setting. Participant 001 reflected, "It's made me more empathetic, but also more vigilant about my own boundaries."

These narratives reflect patterns identified in the literature on secondary traumatic stress and burnout (Figley, 1995; Stamm, 2010; Sutton et al., 2022). My findings extend this by demonstrating that support and well-being are not peripheral to preparedness but are its backbone. Without sustainable support structures, counselors struggle to maintain preparedness. Recognizing wellness as integral to professional readiness, rather than an optional add-on, is essential for sustaining effective trauma-informed practice.

***Integrating the Themes into a Grounded Theory***

Collectively, the five themes offer a comprehensive, co-constructed understanding of how community-based mental health counselors perceive their preparedness to work with traumatized populations. Preparedness was co-constructed as a developmental process influenced by training, supervision, personal attributes, trauma-informed knowledge, and systemic support, an interpretation aligned with Constructivist Grounded Theory's focus on relational meaning-making. This aligns with Charmaz's Constructivist Grounded Theory, which emphasizes theory as an interpretive rendering of participants' meanings rather than a detached report of facts (Charmaz, 2024).

This theory reframes preparedness as a relational and evolving state that counselors continuously construct through the interplay of self, practice, and system. It aligns with professional identity theory by demonstrating how preparedness is intertwined with identity development, and it extends constructivist grounded theory by illustrating how meaning-making occurs within the lived realities of community-based practice (Carvalho et al., 2021; Gibson et al., 2010).

## Limitations of the Study

As with all qualitative research, this study includes limitations that influenced both the research process and the interpretation of its outcomes. These limitations are important to acknowledge to contextualize the scope and applicability of the findings. One limitation is the reliance on self-reported data, which reflects counselors' perceptions rather than direct observations of their practice. While participants offered rich narratives, their accounts may have been influenced by recall bias or by the emotional weight of discussing trauma-related work. However, integrating strategies such as member checking, reflexive journaling, and triangulation of perspectives enhanced the study's overall credibility, ensuring that the interpretations remained grounded in participants' lived experiences (Charmaz, 2014; Lincoln & Guba, 1985).

A second limitation relates to the study's context. All participants worked in community-based mental health settings within a specific region of the United States. While this focus provided an in-depth understanding of counselors' lived experiences, readers should exercise caution in generalizing these findings to counselors in private practice, inpatient facilities, or other geographic areas where systemic structures differ.

Another limitation concerns theoretical saturation. While 12 participants offered deep and meaningful insights, the evolving nature of grounded theory suggests that additional perspectives could have further enriched or nuanced the categories. Theories generated through constructivist grounded theory are not designed to be universal; rather, they represent co-constructed interpretations that remain partial and situated within a specific context.

Finally, my positionality as both counselor and researcher influenced the study's process. My reflexive journals revealed moments when my assumptions about counselor preparedness diverged from participants' experiences. Rather than undermining trustworthiness, acknowledging and interrogating these moments enhanced transparency regarding how my perspective shaped coding decisions and theoretical development. To reduce potential misinterpretation, I incorporated member checking during interviews and follow-up communications. By summarizing participants' responses and inviting clarification, I ensured that my interpretations aligned with their intended meanings. Although member checking cannot fully eliminate bias, it provided a collaborative safeguard that strengthened the study's overall credibility.

Together, these limitations remind readers that the theory developed in this study is contextually bound and co-constructed, offering one situated interpretation of how preparedness is understood in community-based trauma counseling. As with all qualitative research, the findings are not intended to be statistically generalizable to all counselors or settings. Instead, this study supports transferability through detailed descriptions of participants' experiences, allowing readers to assess the applicability of the findings to their own contexts (Lincoln & Guba, 1985). By situating the results within community-based mental health, this research provides insights that may resonate with similar trauma-focused counseling environments while acknowledging that perspectives may differ across settings and populations.

## Recommendations

Grounded in the findings and limitations of this study, several recommendations are proposed for counselor education, supervision, community-based agencies, and future research. These recommendations are consistent with the constructivist grounded theory framework, which conceptualizes preparedness as a dynamic process co-constructed among counselors, educators, supervisors, and organizational systems.

### Recommendations for Counselor Education

Participants' responses to the central research question emphasized persistent training gaps, indicating that counselor education programs should integrate trauma-informed care as a core curricular element rather than an elective. Participants consistently reported that limited coursework left them underprepared for trauma work. Embedding applied trauma-focused courses, experiential simulations, and opportunities for structured reflection would better prepare counselors to meet the realities of clinical practice (Felter et al., 2022; Foltz et al., 2023). Because participants directly linked these educational gaps to their sense of preparedness, their recommendations for counselor education reflect a direct response to the research question.

### Recommendations for Supervision and Professional Development

Supervision emerged as one of the most critical resources for developing counselor preparedness. Training for supervisors should emphasize trauma-informed supervision practices that integrate technical skill development with emotional and relational support. Agencies should also provide ongoing opportunities for professional

growth, including workshops, continuing education units (CEUs), and peer consultation groups, to ensure that learning continues beyond graduate education.

**Recommendations for Community-Based Agencies**

Participants emphasized that organizational culture either sustained or undermined preparedness. Their lived experiences underscored that addressing the research question requires systemic solutions as much as individual effort. Consistent with these findings, agencies should align policies, supervision models, and caseload expectations to support trauma-informed practice and counselor well-being. Organizational culture significantly influenced counselors' capacity to maintain trauma-informed approaches. Agencies should therefore prioritize reducing caseload burdens, providing regular trauma-specific training, and establishing structured support systems such as debriefing groups and reflective supervision. Investing in these organizational supports enhances counselor preparedness, mitigates burnout and turnover, and ultimately improves client outcomes.

**Recommendations for Future Research**

Future studies could expand upon this research by incorporating client perspectives, offering an additional lens on counselor preparedness and the effectiveness of trauma-informed care. Longitudinal research may also illuminate how preparedness evolves across career stages, particularly as counselors transition from graduate training to independent practice. Comparative quantitative studies across geographic regions or clinical settings could further examine the transferability of the emergent theory and generate more generalizable results. Future constructivist grounded theory studies may

also benefit from systematic memoing and rigorous member checking. Memoing provides a reflexive space for researchers to examine their assumptions, while member checking fosters collaboration with participants to refine interpretations and strengthen trustworthiness.

## Implications

This study carries implications for positive social change at multiple levels. At the individual level, counselors can use these findings to advocate for ongoing professional development and intentional self-care practices. At the organizational level, agencies can strengthen trauma-informed supervision and workplace policies to better support staff. At the educational level, counselor training programs can integrate applied, trauma-focused coursework to more effectively prepare students for the realities of practice. At the policy level, these findings support advocacy for funding allocations and systemic reforms to address persistent gaps in trauma-informed services. Given that community mental health agencies often serve clients with high rates of trauma and complex psychosocial needs, the lack of trauma-specific training identified by participants has significant implications for counselor education and organizational policy (Felter et al., 2022; Foltz et al., 2023; Bride, 2007). Ultimately, the emergent theory underscores that strengthening counselor preparedness requires investment in training, supervision, organizational supports, and counselor wellness. By addressing these needs across individual, organizational, educational, and policy domains, the counseling field can reduce disparities in trauma-informed care, promote sustainable counselor development, and improve outcomes for the communities most impacted by trauma.

## Conclusion

This study demonstrates that preparedness for trauma-informed counseling is not a static competency achieved at graduation, but a dynamic process co-constructed over time. Preparedness unfolds through training, supervision, personal reflection, and organizational support. Counselors repeatedly emphasized that their growth was shaped less by what they learned in classrooms and more by what they discovered through practice, relationships, and self-reflection. To meet the needs of trauma-affected populations, the counseling profession must embrace preparedness as a developmental, relational, and systemic process. By investing in trauma-specific training, supportive supervision, and counselor wellness, the field can cultivate a more resilient, effective, and compassionate mental health workforce.

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# Appendix A: Demographic Form

| Age:<br><br>☐ 21-30<br>☐ 31-40<br>☐ 41-50<br>☐ 51-60<br>☐ 61+ |
|---|
| Gender:<br><br>☐ Female<br>☐ Male<br>☐ Non-binary/Third Gender<br>☐ Prefer not to say<br>☐ Other (please specify): ________________________ |
| Preferred Pronouns: |
| Race/Ethnicity (select all that apply):<br><br>African American/Black<br>☐ Asian<br>☐ Hispanic/Latino<br>☐ Native American/Indigenous<br>☐ White/Caucasian<br>☐ Multiracial<br>☐ Other (please specify): ________________________<br>☐ Prefer not to say |
| Religious/Spiritual Background: |
| Highest Level of Education Completed:<br>☐ Bachelor's Degree<br>☐ Master's Degree<br>☐ Doctoral Degree<br>☐ Other (please specify): ________________________ |

| How many months of experience post-master's graduation do you have in counseling?<br><br>☐ Less than 1 year<br>☐ 1-3 years<br>☐ 4-6 years<br>☐ 7-10 years<br>☐ 11+ years |
| --- |
| Do you hold any national or state level licensures or credentials? |
| If yes, please list all certifications and licensures you currently hold. |
| Describe your primary work setting (select all that apply):<br>☐ Community Mental Health Center<br>☐ School<br>☐ Shelter<br>☐ Correctional Facility<br>☐ Nonprofit Organization<br>☐ Private Practice<br>☐ Hospital or Healthcare Setting<br>☐ Other (please specify): ______________________ |
| How many months/years of experience do you have in a community mental health setting? |
| Trauma-Informed Care Training Received:<br><br>☐ None<br>☐ Workshop(s) or Short Course(s)<br>☐ Certificate Program<br>☐ Graduate Coursework<br>☐ Professional Development Training<br>☐ Other (please specify): ______________________ |

| Certifications in Trauma-Informed Care or Related Areas:<br><br>☐ None<br>☐ Certified Clinical Trauma Professional (CCTP)<br>☐ Licensed Professional Counselor (LPC) with Trauma Specialty<br>☐ Licensed Clinical Social Worker (LCSW) with Trauma Specialty<br>☐ Other (please specify): ______________________ |
|---|
| Primary Client Population (select all that apply):<br><br>☐ Children (under 12)<br>☐ Adolescents (12-17)<br>☐ Adults (18-64)<br>☐ Older Adults (65+)<br>☐ Families<br>☐ Groups (e.g., support groups, group therapy)<br>☐ Other (please specify): ______________________ |
| Additional Languages Spoken Fluently (if any): |
| Cultural Background or Relevant Identifiers: |
| Please offer a time you would be available for a 60–90-minute interview (include time zone) and how would you like to be contacted. |
| Please provide the name and contact information of another individual you know who may be eligible for the study. |
| If you would like a copy of the final results, please provide an email address for that purpose: |

Appendix B: Interview Protocol

## Background and Experience

Describe your experience working with clients who have or are experiencing trauma.

## Training and Education

How did your training prepare you for working with trauma-affected clients in your current setting?

What about your training or supervision prepared you for this work?

Probe: Give me an example of coursework that was required in your program that prepared you to provide trauma-informed care.

Probe: Describe your perceptions of your counselor preparation to provide the level of care needed to implement trauma-informed care? What specific experiences or training have influenced your level of preparedness?

What personal strengths or qualities do you think have helped you in providing trauma-informed care?

What additional training or resources would have been helpful?

## Understanding of Trauma-Informed Care

How would you define trauma-informed care in your own words?

In what ways do you feel trauma-informed care is essential to your role?

What are your perceptions of the needs of traumatized clients in counseling?

## Preparedness for Trauma-Informed Care

Describe your first experience in managing a client with trauma.

How prepared do you feel to provide trauma-informed care?

Describe any situations in which you felt particularly unprepared to address trauma with a client.

## Challenges and Support Systems

What are some of the biggest challenges you face in providing trauma-informed care?

Can you describe any support systems, such as colleagues, supervisors, or organizational resources, that help you manage these challenges?

## Organizational and Environmental Factors

How would you describe the level of support you receive or received from your organization in providing trauma-informed care?

What specific policies, resources, or practices in your workplace that help (or hinder) your ability to work with trauma-affected clients?

## Personal Growth and Self-Care

In what ways has working with trauma-affected clients affected your personal and professional life?

What self-care practices or coping strategies do you use to manage the emotional demands of your work?

How have you grown or changed as a counselor since you began working in trauma-informed care?

## Reflections and Recommendations

What advice do you have for other counselors entering the field or working with trauma-affected populations?

What else would you like to share about your perspectives on counseling individuals who have had traumatic experiences in a community mental health setting?

What do you think the field of counseling could do to improve the treatment of individuals with trauma?

Are there any additional comments you would like to share about your experiences or insights on trauma-informed care?

Appendix C: Sample Flyer

# RESEARCH STUDY PARTICIPANTS NEEDED!!!

## Are You a Community-Based Mental Health Counselor?

## I Want to Hear About Your Experiences with Trauma-Informed Care!

### Study Purpose

I am conducting a research study to explore the experiences, training, and preparedness of community-based counselors in providing trauma-informed care to clients. Your insights can help improve understanding and support for counselors working with trauma-affected populations.

**Who Can Participate?**

- 18 years or older
- Master's Level Counselor, Provisionally Licensed Counselor, Licensed Professional Counselor
- Practice in the state of Mississippi
- Have experience in community mental health settings
- Experience providing trauma-informed care

**What's Involved:**

- A one-on-one interview lasting approximately 60-90 minutes
- Conducted at your convenience virtually
- An opportunity to share your experiences and insights confidentially

Your Participation Matters!!

By sharing your experiences, you'll contribute to important research that seeks to enhance support systems and resources for community-based counselors.

All information provided will be audio-recorded and will be kept confidential.To protect your privacy, the published study will not share any names or details that identify you.

**To confidentially volunteer**

**Contact:**

**Email:**