The Trauma-Competent Clinician: A Qualitative Model of Knowledge, Skills, and Attitudes Supporting Adlerian-Based Trauma Psychotherapy

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Abstract

We present in this article qualitative data to empirically support the idea Adlerians have many of the foundational skills, beliefs, and knowledge required to be trauma-competent clinicians. In doing so, we posit evidence-based trauma-counseling competencies for trauma counselor education, training, and development using applied principles of Individual Psychology; this strengths-based model requires a fundamental belief in recovery and resilience that relies heavily on social interest and includes encouragement, holism, and lifestyle considerations.

Keywords: Individual Psychology, trauma competency, qualitative research, trauma-competent counseling, professional competencies, traumatic stress

> No experience is in itself a cause of success or failure. We do not suffer from the shock of our experiences—the so-called *trauma*—but instead make out of them whatever suits our purposes. We are not determined by our experiences but are *self-determined* by the meaning we give to them. . . . As soon as we find and understand the meaning a person ascribes to life, we have the key to the whole personality.
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> —Adler, 1931/2010, p. 24

Despite the epigraph to this article being one of the only times Adler directly addressed the issue of trauma by that name, we present here, on the basis of our qualitative research, the idea that Adler and his contemporary adherents in fact had a trauma-competent foundation. We identified specific attitudes, knowledge, and skills demonstrated by trauma-competent clinicians, many of which align with Adler's tenets of Individual Psychology and contemporary Adlerian research. Although there is increasing discussion in the Individual Psychology literature on the links between Adler's theory and the assessment and treatment of trauma (Duba Sauerheber & Disque, 2016; Garner, Baker, & Hagelgans, 2016; Henning, 2013; Hjertaas, 2013; Lemberger & Lemberger-Truelove, 2016; Millar, 2013; Mozdzierz, 2015;

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Saltzman, Matic, & Marsden, 2013; Sperry, 2016), we found no literature specifically or empirically linking Individual Psychology to trauma-competent clinical practice, a term we use to describe clinical practice informed by the knowledge, skills, and attitudes essential to healing from the effects of traumatic stress. A recent article by Watkins Van Asselt, Soli, and Berry (2016) noted the dearth of trauma competency research available and presented the results of a brief study from which the authors concluded there was a need for trauma competencies in counselor education. This call, along with a need for trauma competencies to ensure informed ethical practice reflected in the broader counseling and counselor education literature (Myers, 1992; Sue, Arrendondo, & McDavis, 1992; Toporek, Lewis, & Crethar, 2009), leads us to offer here evidence that Adlerian psychotherapy, when paired with current trauma-specific knowledge and skills, is empirically supported through qualitative research as trauma-competent clinical practice. To respond to this call for clinicians to have trauma competency, we first surveyed the literature and developed a thesis that relates Individual Psychology to trauma counseling. Then, without using an Adlerian framework, we surveyed 45 trauma counselors concerning what they perceived as trauma competencies and trauma training. Their responses were analyzed using qualitative methods to assess meaning in their responses through the themes that emerged. We conclude by discussing the relationships among the five themes that emerged and the principles and practice of Individual Psychology.

Trauma and Individual Psychology

Trauma results when negative life events overwhelm an individual's coping resources and ability to cope adaptively with a traumatic stressor (van der Kolk, 2014). Stress becomes trauma "when the intensity of the frightening events becomes unmanageable to the point of threatening physical and psychological integrity" (Lieberman & Van Horn, 2008, p. 15). In this way, trauma can affect the life tasks of love and marriage, friendship, work (Dreikurs, 1953), spirituality, leisure (Mosak & Dreikurs, 1967), and parenting and family (Dinkmeyer, Dinkmeyer, & Sperry, 1987).

In the past 5 years there has been a rise in publications in the Adlerian literature that relate to trauma and Individual Psychology (Garner et al., 2016; Henning, 2013; Hjertaas, 2013; Lemberger & Lemberger-Truelove, 2016; Millar, 2013; Saltzman, Matic, & Marsden, 2013; Duba Sauerheber & Disque, 2016; Sperry, 2016). For example, Garner et al. (2016) discussed the traumas of first responders through the lens of Individual Psychology, and Hjertaas (2013) explored how experiences of trauma are linked to Adlerian concepts of core beliefs, lifestyle, and feelings of belonging in clients, and

how eye-movement desensitization and reprocessing (EMDR), a form of trauma therapy, relates to Individual Psychology. Further, Saltzman et al. (2013) presented via case studies the usefulness of Adlerian art therapy for working with survivors of sexual abuse and assault, and they emphasized the importance of social interest, relational connection, and mistaken goals in the trauma narrative of the lifestyle.

In a discussion on Individual Psychology in Japan, Kajino (2012) touched on aspects of Individual Psychology and trauma at a societal level in the context of natural disasters, referring to the sense of cosmic inferiority that can follow such events. Originally considered an anxiety disorder related to the neurobiology of fear, post-traumatic stress disorder (PTSD) is now better understood as a disorder of shame (International Society for Traumatic Stress Studies, 2014), as a result of Judith Herman's (1997) work as a pioneering expert on trauma. Before this understanding of PTSD as a shame disorder was published in the trauma-specific literature, Smith (2009) investigated the relationship between inferiority, attachment, and traumatic shame, and presented evidence for Adlerian psychotherapy as an "experience of increased social interest that reduces the effects of shame" (p. 241).

In earlier literature, Harrison (2001) discussed the usefulness of Adlerian principles in counseling survivors of sexual abuse, particularly the emphasis on encouragement, belief in clients' motivation to move from a felt minus to a perceived plus, and awareness that mistaken ideas exist in private logic. Strauch (2001) examined trauma symptoms from an Adlerian perspective, including the roles of holism and purposiveness of behavior, and concluded that social embeddedness and lifestyle are the "two most important Adlerian concepts to consider when assessing and treating traumatic reactions" (p. 247). Even earlier, Butler and Newton (1992) used an Adlerian lifestyle interview to identify personality characteristics of children of trauma, including apperceptions of lack of control and the world as an unsafe place, which the authors summarized as a lack of social interest. In an unpublished research paper, Mueller (2012) presented a brief case for the relationship between Individual Psychology and evidence-based trauma interventions (e.g., cognitive behavioral approaches, trauma systems therapy), and connected the Crucial Cs (connection, capability, count, courage; Lew & Bettner, 1996) to behavioral symptoms of trauma in children. Tedrick Parikh and Watcher Morris (2011) argued that crisis theory, which is deeply intertwined with studies of trauma and traumatic stress, was originated by Alexandra Adler when she studied survivors of the historic Cocoanut Grove nightclub fire. In particular, they stated that "Alexandra Adler's study of 500 survivors of the fire laid the foundation for post-traumatic stress as a psychological construct" (p. 377). Tedrick Parikh and Watcher Morris (2011) also arrived at a conclusion similar to that of Watkins Van Asselt et al. (2016):

"Crisis theory and crisis intervention skills are vital for clinicians to have, yet they are often taught as a sidebar if at all" (p. 377).

Today, trauma and its severe, persistent negative physical and psychological consequences are a significant public health concern in the United States (Beck & Sloan, 2012; Brown et al., 2009; Lupien, McEwen, Gunnar, & Heim, 2009; Solomon & Johnson, 2002). The vast majority of U.S. residents have experienced one or more PTSD-level event as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013). In a national sample, 82.2% reported a lifetime cumulative exposure to a traumatic event (Beck & Sloan, 2012). The Adverse Childhood Experiences Study (ACES) showed a significant, positive relationship between negative childhood experiences and increased risk of many lifelong physical and mental health issues, such as substance use and abuse, depression, suicide attempts, chronic obstructive pulmonary disease, ischemic heart disease, liver disease, sexually transmitted diseases, and smoking (V. J. Edwards, Holden, Felitti, & Anda, 2003). Adler (1931/2010) understood the importance of formative childhood experiences; he believed that by age 5, children had already developed a lifestyle and "fixed their deepest and most lasting conceptions of what to expect from the world and from themselves" (p. 23).

The most frequently encountered traumas reported in clinical practice include childhood sexual assault, physical or sexual assault, natural disasters, domestic violence, and school and work-related violence (James & Gilliland, 2013). Solomon and Johnson's (2002) review of post-traumatic stress treatment outcome research concluded that (a) most individuals in the United States experience at least one traumatic event and (b) the sharp increase in published literature and variety of new treatment modalities related to post-traumatic stress injury make sense in the context of increased experiences of traumatic stress. Given the prevalence of traumatic and adverse experiences presented here, one can conclude that professional counselors in a variety of mental health settings will likely work with trauma survivors; it is thus imperative that their training include foundational trauma knowledge and trauma-competent clinical reasoning skills (Layne et al., 2014).

Maniacci and Johnson-Migalski (2013), in writing on the fourfold process of the development of psychopathology and trauma, posited that Adler actually wrote a lot about trauma (but called it *shock*), including the three factors of "overburdening childhood situations" (Adler 1932/2012, as cited in Maniacci & Johnson-Migalski, 2013): organ inferiority, neglect and abuse, and pampering. Maniacci and Johnson-Migalski also discussed how Adler's descriptions match trauma literature's Type I single-incident and Type II complex trauma categorizations (Terr, 1991). The fourfold process (Ansbacher & Ansbacher, 1956, p. 293) is as follows: (a) an event happens, (b) the event is

perceived, (c) the event is apperceived (i.e., perceived with meaning attached to it), and (d) a response to the event is nonconsciously chosen. The authors then give a directive for Adlerians treating trauma: "We need to holistically comprehend a person by relying on the tenets of Individual Psychology. We need to understand the person that experiences the trauma, the situation, the goodness of fit, phenomenology, striving, psychology of use, biopsychosocial, and ultimately . . . nonconscious and conscious meaning and response" (Maniacci and Johnson-Migalski, 2013, p. 183).

As we demonstrate here, this increase in reports of and research on post-traumatic stress, as well as the need for more trauma-competent clinicians, can be met with a well-established clinical solution: the therapeutic techniques of Individual Psychology. According to the American Counseling Association (ACA, 2014), specialized training and supervision are required before counseling in any specialty area; without formal trauma training to support ethical and informed clinical practice with a vulnerable population, counselors are at risk of practicing outside the bounds of their professional competency (Ratts, Toporek, & Lewis, 2010). This study provides a foundation for better understanding the elements of trauma-competent clinical practice in the context of Individual Psychology using a qualitative content analysis (Schreier, 2012) that examines experiences of mental health professionals who self-identify as trauma competent.

Method

We invited licensed mental health-care professionals who self-identified as trauma counselors from a wide variety of mental health disciplines to participate in this qualitative study, which was approved by the institutional review board at a university in the southeastern United States. Research questions included: What do trauma counselors' experiences reveal about trauma-counseling competency and core trauma concepts? What are trauma counselors' perceptions about trauma competency? What concepts emerge from trauma counselors' perspectives that may assist counselor educators in developing competency-based trauma training? We intentionally did not invite only those who identify as Adlerian therapists, or include any language specific to Individual Psychology in our interviews, in order to reduce any potential bias in our results. We selected participants from a pool of experts, including nationally certified trauma counselors across the United States who were affiliated with professional organizations in trauma, published authors, and graduate-level mental health faculty.

Eligible participants included fully licensed mental health professionals with a graduate degree in the mental health field and three or more years of

experience as certified trauma therapists. Forty-five certified trauma counselors agreed to participate and completed the online survey. Of those, 39 licensed mental health professionals met criteria for inclusion. The majority of participants were female, with an age range of 25 to 70+ years, with the highest proportions among the 50–55 age range. Participants had a minimum of 5 years as a licensed mental health professional; years providing trauma counseling ranged from 0 to 25+ years, with the highest proportions among the 5–10 years range. Participants belonged to professional associations in trauma, and populations served by participants included sexual violence survivors, intimate partner violence survivors, veterans, natural disaster survivors, and terrorism survivors. Participants' current work settings include private practice, private psychiatric or medical hospital, and victims' assistance organization, where they work in various roles, such as clinical supervision, administration, teaching, and research and evaluation.

We sent via e-mail an informed consent form, a structured interview questionnaire, and the Supervisee Levels Questionnaire–Revised (SLQ-R) (McNeill, Stoltenberg, & Romans, 1992) to prospective participants before the coding process. E-mail follow-ups were conducted for feedback about the categories and subcategories emerging from the data. The SLQ-R identified participants with advanced counseling skill indicated by a score of 3 and 3i (integrated) (McNeill et al., 1992). We determined the number of participant responses to use in analysis according to data saturation rather than analysis of a fixed number of participant responses (Francis et al., 2010). Before data collection we set an initial analysis sample at 20 and stopping criteria at 5. Saturation was achieved when no new codes emerged (Francis et al., 2010) and each subcategory was represented at least once (Schreier, 2012). In this case, saturation occurred at Response Number 34. To ensure saturation, we coded an additional five surveys, which yielded a total of 39 survey responses included in our data set. We calculated the range of SLQ-R scores for the 39 to be 145–183, and we found a mean of 175.6 and standard deviation of 9.39. Cronbach's alpha for the 39 SLQ-R items was .671.

The qualitative analysis consisted of what Schreier (2012) referred to as the pilot phase, which involves three stages: trial coding, consistency check, and adjusting the coding frame. The research team worked independently to code the first questionnaire and then convened on multiple instances to develop an initial coding frame, to compare codes, and to agree on a final coding frame. When developing the initial coding frame's preliminary categories, subcategories, definitions, and examples were established and organized according to hierarchical levels within the frame. The team met again during the pilot phase to revise the coding frame and become familiar with each category and subcategory, and to reach a consensus on the coding frame and eliminate overlap between categories. In the main analysis phase,

subsequent data sets were coded independently by two research team members using the coding frame, then verified by a third research team member. At the time of research, all team members were doctoral students in a counselor education program. The third-party auditor was a clinical psychologist and trauma clinician with more than 20 years of experience. In the event of coding disagreement, dialogue continued until consensus. The coding frame was then updated to reflect emerging codes from the remaining surveys. The coding team reviewed the final coding frame and codebook and identified numerous necessary modifications: repositioning particular subcategories under alternate categories, renaming subcategories, extending definitions, and condensing categories. The resulting categories and subcategories are discussed here. Trustworthiness was achieved by (a) use of double coding, an ongoing coding frame developed and continually revised by the coding team; (b) external auditing of the final coding frame and analysis of unidimensionality and mutual exclusivity; and (c) reflexivity in data interpretation.

Results

Qualitative content analysis of the data yielded three categories and 33 supporting subcategories (see Table 1). We then organized these categories and subcategories into a further set of four divisions by their relationship to a corresponding concept of Individual Psychology based on a thorough review of primary sources of Adler's works and the contemporary Individual Psychology literature, and a final division that includes attitudes and beliefs, knowledge, and skills related exclusively to trauma and that cannot be paired to an Adlerian principle (see Discussion). By name these divisions are social interest, encouragement, lifestyle, holism, and trauma specific. We organized the divisions by frequency, defined as *f*. The social interest division has by far the highest frequency ($f = 304$), followed by encouragement ($f = 2$), lifestyle ($f = 64$), and holism ($f = 39$). The trauma-specific division has a high frequency ($f = 177$) but is second to social interest.

The attitudes and beliefs category ($f = 130/n = 33$, where n is the number of people whose responses were analyzed) includes codes that speak to participants' ideas regarding the attitudes, beliefs, and trauma-specific values held by trauma-competent counselors. This category contains seven subcategories (see Table 1). The following is an excerpt from participant narratives demonstrating these attitudes and beliefs endorsed by trauma-competent counselors: "Trauma competency is when one has the ability to address the needs of the client that has been traumatized with respect, connection and an ability to help them resolve the trauma without reliving it. Create safety

and connection with respect and compassion. Listening to the trauma narrative without judgment or overreacting is critical to trauma competency."

The knowledge category ($f = 140/ n = 38$) describes the trauma-focused knowledge and core trauma concepts essential to the trauma-competent counselor. The knowledge category is composed of eight subcategories (see Table 1). The following excerpt demonstrates this trauma-specific knowledge: "The competent practitioner should know what occurs in the brain and body with trauma, some basic neurophysiology. Knowing the physiological and psychological effects of trauma and how it can affect the responses and behaviors of individuals. Knowing the basic framework of recovery and techniques of treatment as well as what current research finds on trauma treatment techniques. Understanding the effects of various overlapping layers of oppression on survival of traumatic events."

The skills category ($f = 366/ n = 39$) is the largest, with 18 subcategories (see Table 1). This category involves trauma-focused skills and interventions used by trauma-competent counselors, as demonstrated by one participant: "I have found that my ability to stay present with my clients while they tell their stories of trauma has made major strides with clients feeling safe to work with me as well as helping them get healthier. Being able to explain the science behind why they are having the emotional and physical reactions they have had since the traumatic event(s) has made a world of difference for them as well. Another skill/ability that I have found helpful is being able to help my clients stay emotionally present during their session(s)."

Discussion

Our research shows that each division of subcategory results (i.e., social interest, encouragement, lifestyle, holism, and trauma specific; see Table 2) either corresponds directly to a concept of Individual Psychology or is addressed somewhere in the extant and contemporary Adlerian literature.

Social Interest

Social interest, also called community feeling, is the core principle of Adlerian psychology and is widely considered the central concept of Adlerian theory (Ansbacher & Ansbacher, 1956), as well as the key factor in a healthy and functional personality (Dreikurs, 1964). Just as Adler believed social interest was the crux of healthy human functioning, so, too, our results show that it is by far the most essential ingredient of trauma-competent clinical practice. One of the subcategories in our results, demonstrate intentionality, relates directly to this heart of Adlerian therapy. To demonstrate intentionality, therapist guides clients "toward mutually agreed-on treatment

Table 1
Attitudes, Skills, and Knowledge of Trauma-Competent Counselors

Categories and Subcategories	Definition: "Trauma-competent counselors . . ."	Example
Attitudes and beliefs (*f* = 130/*n* = 33)		
Respect (*f* = 14)	Demonstrate respect for clients as experts of their own unique experiences and individualized treatment needs.	"Survivor as expert on their own adaptations and experiences."
Acceptance (*f* = 8)	Demonstrate acceptance of survivor and his or her experience.	"Willingness to extend humanity and acceptance to someone who feels outcast or shunned."
Nonjudgment (*f* = 17)	Demonstrate a nonjudgmental and neutral attitude.	"Ability to listen and hear without judgment and 'pity' but rather emphasizing the positive aspects of surviving the experience and moving on with life."
Openness to new knowledge and experience (*f* = 30)	Are open to broadening their knowledge and clinical experience, and maintain active involvement in professional development and consultation.	"It requires a personal dedication to reach out to academic professionals to gain as much knowledge as possible."

Confidence ($f = 32$)	Demonstrate confidence in clients' ability to recover from the effects of trauma.	"Demonstrate absolute confidence, backed by competency that the client will recover."
Clients are in control ($f = 14$)	Demonstrate that survivors are in control of their recovery experience.	"Allow them to maintain control during treatment in terms of duration, the ability to stop treatment during a session, disclosing only so much as they are comfortable with."
Self-care is a priority ($f = 15$)	Are aware that counselor well-being is critical and focus on maintaining own health by prioritizing self-care.	"The stability and well-being of the therapist is critical to trauma competency."
Knowledge ($f = 140/n = 38$)		
Demonstrate foundational trauma knowledge including prevalence, trauma theory, and principles of trauma-informed care ($f = 29$)	Demonstrate knowledge about common elements of evidence-based interventions, core trauma concepts, and trauma-competent practice.	"A professional who has been competently trained to work with clients presenting with trauma issues and/or provide these clients with trauma-informed care."
Demonstrate foundational knowledge about trauma-competent clinical skills ($f = 24$)	Demonstrate knowledge about common elements of trauma-focused intervention and treatment.	"Knowing relevant appropriate interventions for use with survivors of traumatic events."
Current trauma literature ($f = 6$)	Demonstrate an understanding of current trauma literature and evidence-based practice.	"An understanding of best practices [or] empirically validated theories and interventions."
Contextual and systemic factors ($f = 6$)	Demonstrate an understanding of contextual and systemic factors.	"The context of where and how they live is important to me."

Table 1 (cont'd)

Categories and Subcategories	Definition: "Trauma-competent counselors . . ."	Example
Neurobiology of trauma ($f = 43$)	Demonstrate an understanding of the neurobiology of trauma and how the brain processes traumatic experience.	"I believe it is the responsibility of the clinician to understand the nature of trauma from a neuropsychological perspective."
Effects of trauma on functioning ($f = 18$)	Demonstrate an understanding of the effects of trauma on individual domains of functioning (cognitive, emotional, physical, spiritual, relational, identity).	"Be mindful of the multiple ways that trauma may have affected this client's life, vocational, physical, and mental well-being."
Trauma symptomology varies ($f = 8$)	Demonstrate understanding that trauma symptoms vary and are adaptations for survival.	"I am conscious of the varied ways people can present after experiencing trauma."
Practice within limits of clinical competency ($f = 6$)	Are responsible for providing effective treatment and so must know the limits of their clinical competence and seek clinical supervision or appropriate referral when necessary.	"Knowing one's limitations and collegially collaborating with other professionals."

Skill (*f* = 366/*n* = 39)

Demonstrate professional competence (*f* = 5)	Are trauma informed and demonstrate professional competence in core trauma knowledge and trauma-focused intervention and treatment.	"Demonstrates professionalism and competency in knowledge and skills."
Demonstrate a strengths-based approach with affirmative language (*f* = 25)	Empower survivors through affirming language and interventions to emphasize their strengths and positive attributes.	"Convey belief that the most difficult part was already done by client by surviving the trauma."
Demonstrate lightness and humor (*f* = 5)	Demonstrate lightness and humor where appropriate without minimizing client's trauma experience	"Create an experience that counters the original trauma experience."
Establish collaborative therapeutic alliance (*f* = 33)	Establish a collaborative therapeutic alliance and mutually agreed-on treatment goals.	"The client and the therapist are a team that works together for the benefit of the client."
Develop therapeutic relationship (*f* = 13)	Are aware of the importance of the therapeutic relationship to trauma work and demonstrate skill in developing this critical relationship.	"Clinical relationship as a holding environment and one focus of the intervention."
Demonstrate trauma-focused clinical skills (*f* = 13)	Demonstrate trauma-focused clinical skills and evidence-based interventions.	"Possessing specific skills to assist clients overcome the residual pain of trauma."
Demonstrate client-centered counseling skills (*f* = 21)	Demonstrate client-centered counseling skills.	"The basic Rogerian principles are applicable unconditional positive regard, genuineness, and empathy."

Table 1 (cont'd)

Categories and Subcategories	Definition: "Trauma-competent counselors . . ."	Example
Demonstrate assessment skills ($f = 10$)	Demonstrate competency in clinical assessment or measurement completed before reprocessing emotional memory.	"The trauma practitioner should also know how to gauge readiness for processing through the trauma."
Demonstrate diagnostic skills ($f = 7$)	Demonstrate competency in the diagnosis of post-traumatic stress as well as provide differential diagnosis.	"Understand the diagnostic criteria for PTSD versus chronic distress perpetuated by developmental, attachment, and complex trauma."
Demonstrate intentionality ($f = 39$)	Demonstrate intentionality by guiding clients toward mutually agreed-on treatment goals.	"Be intentional. Set an intention and keep moving toward it."
Provide psychoeducation on the neurobiology of trauma and trauma treatment ($f = 27$)	Provide psychoeducation about the neurobiology of trauma and trauma treatment to normalize client experience.	"Helping the client understand traumatic symptoms and why they are experiencing these symptoms."
Address traumatic beliefs ($f = 10$)	Address traumatic beliefs and negative meanings attached to self, other, and the world.	"It's a problem with learning and memory not one's identity, value, worth, morality or any other meaning."

Teach coping and emotional regulation strategies ($f = 14$)	Teach coping and emotional regulation strategies for managing trauma-related symptoms.	"Demonstrate experientially how to reach and run emotional brain."
Reprocess traumatic memory ($f = 40$)	Demonstrate competency in reprocessing traumatic memory and developing a coherent trauma narrative.	"Memory reconsolidation through neuroplasticity."
Keep the client emotionally present ($f = 28$)	Maintain connection by keeping the client emotionally present while reprocessing traumatic memory.	"Keep the client grounded with what is going on in the room and in the connection with the therapist."
Therapist remains emotionally present ($f = 18$)	Maintain connection with clients by remaining emotionally present while reprocessing traumatic memory.	"To stay present and not get taken in by the story."
Maintain client safety ($f = 51$)	Do no harm by using minimally invasive interventions while ensuring physical and emotional safety.	"The counselor's role is to provide support, structure, emotional safety."
Facilitate reconnection ($f = 7$)	Facilitate reconnection to others including teaching relational and communication skills.	"Develop a new pattern of communication and relationship skills."

Table 2
Adlerian Principles Related to Trauma-Competent Attitudes, Knowledge, and Skills

Category	Subcategory	Frequency
Division: Social interest		**304**
Attitudes and beliefs	Openness to new knowledge and experience	30
	Nonjudgment	17
	Respect	14
	Acceptance	8
Knowledge	Practice within limits of clinical competency	6
Skills	Maintain client safety	51
	Demonstrate intentionality	39
	Establish collaborative therapeutic alliance	33
	Keep the client emotionally present	28
	Demonstrate client-centered counseling skills	21
	Therapist remains emotionally present	18
	Teach coping and emotional regulation strategies	14
	Develop therapeutic relationship	13
	Facilitate reconnection	7
	Demonstrate professional competence	5
Division: Encouragement		**62**
Attitudes and beliefs	Confidence (in clients' ability to recover from the effects of trauma)	32

Skills	Demonstrate a strengths-based approach with affirmative language	25
	Demonstrate lightness and humor	5
Division: Lifestyle		**64**
Skills	Reprocess traumatic memory	40
	Address traumatic beliefs	10
	Clients are in control	14
Division: Holism		**29**
Attitudes and beliefs	Self-care is a priority	15
Knowledge	Trauma symptomology varies	8
	Contextual and systemic factors	6
Division: Trauma specific		**177**
Knowledge	Neurobiology of trauma	43
	Demonstrate foundational trauma knowledge (e.g., theory and principles of trauma-informed care)	29
	Demonstrate foundational knowledge about trauma-competent clinical skills	24
	Effects of trauma on functioning	18
	Current trauma literature	6
Skills	Provide psychoeducation on neurobiology of trauma and its treatment	27
	Demonstrate trauma-focused clinical skills	13
	Demonstrate assessment skills	10
	Demonstrate diagnostic skills	7

goals" and "sets intentions and keeps moving toward them" (see Table 1); for Adlerian therapists the core intention and goal is to help increase the client's social interest.

Therapeutic alliance. Five of the subcategories in social interest relate to the core conditions of the therapeutic alliance: nonjudgment, respect, acceptance, establish collaborative therapeutic alliance, and develop therapeutic relationship (see Table 2). Adler emphasized the "unconditional expression of social interest on the part of the psychotherapist" (Adler 1956, as cited in Watts, 1998, p. 6). Watts (1998) demonstrated the parallels between Adler's social interest and Rogers's core conditions of empathy, congruence, and unconditional positive regard through primary source research, so we assigned these five subcategories to the social interest division. Rogers's core conditions are taught in counseling programs as the basis of the therapeutic alliance, although as Watts (1998) noted, "Rogers apparently did not mention Adler in his writings," nor "specify how Adler's teachings and demonstrations were influential for him" aside from "two brief, nondescript statements" (p. 4).

Coping resources. Two of the subcategories, therapist remains emotionally present and teach coping and emotional regulation strategies, address coping skills of the therapist and client, respectively. As D. Edwards, Gfroerer, Flowers, and Whitaker (2004) showed, there appears to be a relationship between coping and social interest. Kern, Gfroerer, Summers, Curlette, and Matheny (1996) found that social interest and belonging are related to adults' perceived coping resources, thus indicating adults' coping resources are linked to feelings of belonging. Adler believed it essential for individuals to take an active approach to confronting problems and the demands of life, and that social interest was critical for this approach (Ansbacher & Ansbacher, 1956).

Connection. Four subcategories in the social interest division relate to the concept of human connection, which is inherent in the concept of striving for belongingness as it relates to *Gemeinschaftsgefuhl* (Sweeney, 1989). Openness to new knowledge and experience includes "active involvement in professional development and consultation," and "requires a personal dedication to reach out to academic professionals to gain as much knowledge as possible" (see Table 1). Practice within limits of clinical competency involves "collegially collaborating with other professionals"; keep the client emotionally present refers to keeping the client "in the connection with the therapist"; and facilitate reconnection refers to a clinician's ability to help a client reconnect with others (see Table 1). The final subcategory of the social interest division is maintain client safety, which rests on the principle of "do no harm" and involves providing "support, structure, emotional safety." To keep another safe is to be fundamentally socially interested in that person's well-being. In Adler's (1931/2010) own words, "Treatment itself is an

exercise of co-operation and a test of co-operation. We can succeed only if we are genuinely interested in others. We must be able to see through their eyes and hear through their ears" (p. 70). From the high frequency of subcategories related to social interest, we can conclude that it is an important trait of trauma-competent clinicians.

Encouragement

Encouragement is one of the essential constructs of Individual Psychology (Adler, 1946), and for Adler it was the basis of psychotherapy because it served to help the client develop social interest (Ansbacher, 1978). Three subcategories make up the encouragement division: confidence, demonstrate a strengths-based approach with affirmative language, and demonstrate lightness and humor. Encouragement, according to Dinkmeyer and Dreikurs (1963), is a heavily chronicled activity in Adlerian practice, and it is crucial to the lifestyle summary process, to understanding mistaken goals, and to using what is now commonly called a strengths-based model. Although encouragement is a principle inextricably related to social interest, we chose to include encouragement as its own division for increased specificity and to show greater nuance in applications of Adlerian concepts to trauma-competent practice.

The subcategory of confidence represents the therapist's confidence in the client's ability to recover from the effects of trauma (see Table 1). "Encouragement is the action required by the therapist to inspire or instill 'courage' in the client, particularly courage to engage the community" (Main & Boughner, 2011, p. 269). Confidence, then, when considered through the lens of Individual Psychology, in which the effects of trauma are considered a lack of social interest (Butler & Newton, 1992), serves as a precise synonym for Adler's concept of encouragement. As stated by Main and Boughner (2011), "The therapist, in cooperation with the client, must co-create an emotional case for change. This emotional case is best anchored in the client's sense of belonging, usefulness, equality, and agency. This co-created emotional case is conceived in the therapist's deep belief in the [clients'] ability to contribute to their community" (p. 273).

Related to confidence is the subcategory of demonstrate a strengths-based approach with affirmative language, which includes "convey[ing] belief that the most difficult part was already done by client by surviving the trauma" (see Table 1). A strengths-based approach such as the one described in our results relates to the idea of encouragement as actionable hope in Adlerian therapy (Main & Boughner, 2011) and involves the therapist reminding clients of all of the ways in which they have been resilient.

The last subcategory of the encouragement division, demonstrate lightness and humor, is well supported by the Adlerian literature (Adler,

1946; Dixon, Willingham, Chandler, & McDougal, 1986; McBrien, 1993; Rutherford, 1994). McBrien (1993) made the case for the connection between humor and encouragement and defines humor as a holistic experience. Rutherford (1994) discussed the use of humor in Adlerian psychotherapy on Adler's (1946) recommendation to "not take yourself too seriously" (p. 174). In more of his own words, Adler (1946) said, "Laughter, with its liberating energy, its freedom-giving powers, goes hand in hand with happiness, and represents, so to speak, the keystone of this affect" (p. 276).

Lifestyle

Adler (1931/2010) said: "We must never treat one symptom or one single aspect of someone's personality. We must discover the wrong assumption people have made in choosing their life style, the way their mind has interpreted their experiences, the meaning they have ascribed to life, and the actions with which they have responded to the impressions received from their body and environment" (p. 51). According to our results, Adler's concept of lifestyle can be a highly useful tool for trauma-competent clinicians. Lifestyle, in Adler's view, is the source of purposive behavior and mistaken goals, which are related to the way clients have come to understand the world and their respective, perceived places in it. Lifestyle assessments are a core feature of Adlerian therapy and serve to provide a thorough understanding of human functioning (Rasmussen, 2003). "Trauma caused by violence can particularly affect the sense of belonging" (Hjertaas, 2013, p. 189), and Curlette and Kern (2010) used the BASIS-A Inventory to help establish the importance of meeting the need to belong in lifestyle. More recently, Leeman, Dispenza, and Chang (2015) presented a case for lifestyle as a predictor of post-traumatic growth, Hjertaas (2013) examined how traumatic events are integrated into an individual's lifestyle, and Millar (2013) discussed the role of purposive behavior and the lifestyle in the context of trauma.

Three subcategories comprise the lifestyle division in our results: reprocess traumatic memory; address traumatic beliefs; and clients are in control, which, put simply, refers to clients being in control of their own recovery experience, which is similar to therapists taking the "one-down position" (Adler, as cited in Ansbacher & Ansbacher, 1956). As Butler and Newton (1992) found, trauma survivors lose their social interest by adopting apperceptions of lack of control and safety. Trauma therapists, then, provide a safe place for clients to learn a healthy sense of control. The concept of clients being in control of their recovery experience directly relates to the idea reflected in lifestyle assessments, especially as presented by Powers (2003), that clients are the authority and that we as clinicians are not to impose our own meanings on their narratives.

The subcategory of address traumatic beliefs requires the therapist to "address traumatic beliefs and negative meanings attached to self, other, and the world" (see Table 1); this subcategory is a near-exact match to the Adlerian concept of private logic. In fact, Adler had much to say on the topic of traumatic meaning, although he may have not used that adjective. He said, "Human beings live in the realm of *meanings*. We do not experience things in the abstract; we always experience them in human terms. . . . No human being can escape meanings. We experience reality only through the meaning we ascribe to it: not as a thing itself, but as something interpreted" (Adler, 1931/2010, p. 15). He also said, "The meaning we ascribe to life becomes . . . the guardian angel or the pursuing demon of our life" (Adler, 1931/2010, p. 22).

The subcategory of reprocess traumatic memory involves therapists "developing a coherent trauma narrative" and facilitating "memory reconsolidation through neuroplasticity" (see Table 1). Regarding such processing of traumatic memories, Adler (1931/2010) said, "Among all psychic expressions, some of the most revealing are individuals' memories. Their memories are the reminders they carry about with them of their own limitations and of the meaning of events. There are no 'chance memories.' . . . These memories represent their life story, a story they repeat to themselves" (p. 70). Related to the concept of lifestyle is the Adlerian tenet of purposive behavior, which is perhaps difficult to reconcile with what we now understand about the physiological effects of trauma (van der Kolk, 2014). Strauch (2001), as Millar (2013) also noted, provided a potential explanation for the interactions between lifestyle and trauma symptomatology: "As long as the traumatic event remains un-integrated with the lifestyle, it will be re-enacted in various situations . . . essentially becoming a *psychological tumor* . . . [that] will divert a person's goal directedness" (p. 252). Contrary to this trauma competency subcategory, however, is the assertion that "'working through' or desensitizing these [trauma] memories is not a primary task of Adlerian therapy. . . . It is the current life-style we are exploring, not past history" (Slavik, Carlson, & Sperry, 1993, p. 121, as cited in Millar, 2013, p. 256), belying a need for more trauma-specific skills, knowledge, attitudes, and sensitivity that may need to be added to the Individual Psychology literature to facilitate trauma-competent clinical practice.

Holism

"Individual Psychology mandates that a person must be understood in a holistic, phenomenological, teleological way" (Maniacci & Johnson-Migalski, 2013); such a holistic approach is supported in current trauma treatment literature (van der Kolk, 2014) and reflected in our research results.

The holism division is composed of three subcategories: self-care is a priority, trauma symptomatology varies, and contextual and systemic factors.

The subcategory of self-care is a priority is reflected in the statement "The stability and well-being of the therapist is critical to trauma competency" (see Table 1) and is supported by the Adlerian literature, for example, in the statement: "Admitting that we as counselors need to make time for self-care is a healthy acknowledgement of our humanness, not a personal shortcoming" (Wolf, Thompson, & Smith-Adcock, 2012, p. 169). Self-care is addressed in the Adlerian literature in the context of counselor education (Wolf et al., 2012; Wolf, Thompson, Thompson, & Smith Adcock, 2014), which draws from the evolution of the empirically supported, Adlerian-based Indivisible Self model of wellness (IS-Wel; Myers & Sweeney, 2005a), the Wheel of Wellness (Witmer, Sweeney, & Myers, 1998), and the related Five-Factor Wellness Inventory (5F-Wel; Myers & Sweeney, 2005b). The IS-Wel recognizes the "reciprocal actions of the mind on the body" (Adler, as cited in Ansbacher & Ansbacher, 1956, p. 255) and the holistic factors of well-being. The Indivisible Self is presented as a basis for wellness and comprises the creative, coping, social, essential, and physical selves; these selves are also understood in terms of local, institutional, global, and chronometrical contexts. Thus, Adlerians have an empirically validated tool (i.e., the IS-Wel) and at least two examples of using that tool to support self-care in professional development (Wolf et al., 2012; Wolf et al., 2014).

The second subcategory in the holism division is trauma symptomatology varies, which is defined as a demonstration of "understanding that trauma symptoms vary and are adaptations for survival" (see Table 1). Maniacci and Johnson-Migalski (2013) presented this very topic in their discussion on trauma and self-destructive behavior from the perspective of Individual Psychology, and they noted that Adlerian theory can help account for the "variability of trauma reactions" (p. 169). Maniacci and Johnson-Migalski (2013) also offered clear and succinct support for the final subcategory in holism, contextual/systemic factors: "By embracing holism, Adlerians recognize the interplay between the person and the environment toward the initiation of psychopathology" (p. 172), which is represented in the idea of person × situation, where, using a metaphor, person refers to lifestyle and personality factors and situation is the social context. Both sides are "always present, but context is key" (Maniacci & Johnson-Migalski, p. 172).

Trauma Specific

In the final division, trauma specific, we present nine subcategories: neurobiology of trauma, demonstrate foundational trauma knowledge, demonstrate foundational knowledge about trauma-competent clinical skills, effects of trauma on functioning, current trauma literature, provide

psychoeducation on neurobiology of trauma and its treatment, demonstrate trauma-focused clinical skills, demonstrate assessment skills, and demonstrate diagnostic skills. Little is available in the Individual Psychology literature about trauma-specific research, although Adlerians are beginning to call attention to this dearth of information. According to Millar (2013), "Despite Adler's forward thinking, he could not have been expected to predict all the developments in the understanding of trauma and trauma therapy that have taken place since his death in 1937" (p. 245). In many ways, however, Adler's statements have been supported by contemporary trauma research. For example:

- "We see that mind and body are both expressions of life: they are parts of life as a whole. We begin to understand their reciprocal relations within that whole" (Adler, 1931/2010, p. 33).
- "In Individual Psychology we are really concerned with the daily interactions of mind and body. Individuals—mind and body—come to us for treatment, and if our treatment is misconceived we will be unable to help them" (Adler, 1931/2010, p. 33).
- "To a certain degree, every emotion finds some bodily expression" (Adler, 1931/2010, p. 45).
- "By means of the involuntary nervous system, the tension is communicated to the whole body. Thus with every emotion the whole body is subject to tension" (Adler, 1931/2010, p. 47).

These statements have been wholly supported by recent research on the mind–body connection in the assessment and treatment of trauma (van der Kolk, 2014).

Assessment and diagnostic skills. Adlerians often rely on the lifestyle assessment, particularly the BASIS-A Inventory (Curlette, Kern, & Wheeler, 1996; Kern, Gormley, & Curlette, 2008; Peluso, Stoltz, Belangee, Frey, & Peluso, 2010; Wheeler, 1996), a tool designed to help assess the client's style of life as presented by Adler. This could be a good foundation for trauma-competent therapy. For full ethical and informed practice, "The trauma practitioner should also know how to gauge readiness for processing through the trauma" (see Table 1). Such readiness for processing varies depending on one's orientation. The PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013) provides a baseline understanding of the extent and intensity of the client's trauma symptoms, which is useful as a pre- and posttest around trauma processing. A Mental Status Exam result of oriented times four (time, place, person, situation; i.e., the client is not in active psychosis) is an indicator that a client is capable of traumatic memory processing (Briere & Scott, 2014).

Neurobiology of trauma. As Hjertaas (2013) noted, much of trauma research includes details of "neuropsychological expression . . . [that] needs to be incorporated into an Adlerian framework" (p. 192). In her call for greater

focus on somatic aspects of trauma symptoms, Millar (2013) addressed some of the psychobiology of trauma and makes the case for understanding purpose in terms of safeguarding behavior in psychological as well as biological and social terms. From an Adlerian perspective, Sperry (2016) presented an informative and well-researched, yet accessible, primer on the neurobiology of trauma in the context of Individual Psychology, and Mozdzierz (2015) discussed aspects of the neurobiology of trauma in his 2014 Ansbacher lecture, which begins to address this literature gap.

Limitations

A possible limitation of this study involves the lack of a measure to quantify trauma-competent knowledge, skills, and attitudes. The Supervisee Levels Questionnaire–Revised (SLQ-R; McNeill et al., 1992) based on the Integrated Developmental Model (IDM; Stoltenberg, McNeill, & Delworth, 1998) was used in the current study but does not specifically measure trauma-related competencies. Additionally, some data were considered insufficient for inclusion in the study and were coded as insufficient for coding.

Conclusions and Implications

Adler was perhaps the first trauma-competent clinician, and Adlerians are already, in many ways, trauma-competent clinicians if they are following the Individual Psychology tenets of social interest, encouragement, lifestyle, and holism. The research we presented here is a call to action to Adlerians to keep engaging in the current trauma literature and stay informed on the theory and principles of trauma-informed care. Trauma is a growing public health concern, and we are poised to address this concern through our clinical skills. It is the task, then, of contemporary Adlerians to learn more about trauma-specific interventions in service of helping others realize the truth of what Adler (1931/2010) already knew about humans: "Each person behaves as if they could rely upon a certain interpretation of life," and that the "individual is faced exclusively with such problems that can be solved only with sufficient social interest" (Adler, 1964, p. 25).

Despite the considerable overlap between Adlerian principles and trauma-competent clinical practice, Henning (2013) asked an important question regarding the tension between Adlerian and trauma-specific therapies:

> Can the therapist give simplistic answers or automatically advocate social embeddedness or community feeling when the family and community have actively, repeatedly, and severely harmed the client and then pathologized her or him for having longstanding functional and interpersonal difficulties as a

> result, or when they ignored or helped to hide the harm in order to protect the façade of a happy family or caring community? (p. 272)

It is clear that, in terms of trauma therapy, Individual Psychology may in some ways "need to expand to incorporate new developments, which are somewhat foreign to its basic tenets. It may, however, simply be that the basic tenets of Individual Psychology are correct but merely need to be understood in a slightly new way" (Johansen & Belt, 2005, as cited in Hjertaas, 2013, p. 193).

Future Research

The two subcategories we found in most need of further research were maintain client safety, in the social interest division, and reprocess traumatic memory, in the lifestyle division. These are two subcategories that get at the heart of trauma therapy work, but there is yet little in the Individual Psychology literature on the topics. We found no research specifically addressing client safety, in the context of trauma therapy or otherwise, and as noted earlier, Slavik et al. (1993) said, "'Working through' or desensitizing these [trauma] memories is not a primary task of Adlerian therapy. . . . It is the current life-style we are exploring, not past history" (p. 121, as cited in Millar, 2013, p. 256)—yet Adler (1931/2010) said, regarding lifestyle, "Early memories are especially significant" (p. 71). We believe there is a need for research on the relationship between early recollections and traumatic memories, and how early recollections as a therapeutic intervention can relate to trauma processing. The trauma literature states that minimizing the risk of iatrogenic harm is an important piece of effect trauma therapy (Messer & Wampold, 2002; Wampold et al., 2010). How might an Adlerian clinician approach this task?

The discourse between Millar (2013) and Henning (2013) regarding Herman (1997) and van der Kolk's (2014) three stages of trauma therapy and Individual Psychology principles is an important step in bridging the gap between Adlerians' trauma-competent foundation, as shown in our research presented here, and the trauma-specific knowledge and skills that are crucial for ethical, informed clinical practice. The pairing of their articles mirrors what we found in our study: Individual Psychology already has many tools for addressing trauma, as represented by Millar's piece, but for Adlerians to ensure full trauma competency in their practice, trauma-specific research (e.g., understanding the differences between Type I and Type II trauma; the ways trauma symptoms may work against established Adlerian interventions, such as acting "as if"; providing appropriate and up-to-date psychoeducation on the neurobiology of trauma; the role of traumatic memory and

maintaining client safety) will need to inform the existing literature to fill in the gaps, as Henning provided.

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