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Abstract

BACKGROUND: Trauma and its consequences have been identified as a high-priority public health risk. A growing body of research reveals the devastating long-term consequences from common and widespread adverse events across the life span. In addition, recent research links medical procedures and medical illnesses with posttraumatic stress disorder. Nurses too are at risk and suffer vicarious trauma. Nurses must be able to recognize and assess for early trauma symptoms and assist in enhancing resilience in order to prevent and care for those with trauma. However, there is a lack of trauma-informed and trauma-specific training in nursing education. Given the ubiquity of traumatic events, the pervasive physical and emotional sequelae of trauma, and the existence of evidence-based treatment for trauma; there is a critical need to develop core competencies for nursing education and practice. **OBJECTIVE:** The purpose of this study is to develop and validate Trauma and Resilience Competencies for Nursing Education. **DESIGN:** An expert panel of 16 nurses met in 2018 to develop Trauma and Resilience Competencies for undergraduate and graduate nursing programs, and for psychiatric mental health nurse practitioner education. Following the Expert Panel's work and approval from the institutional review board, a modified e-Delphi survey was sent to experts in trauma and resilience to validate this work. **RESULTS:** The competencies were validated and edited to 88 competencies through two rounds of a Delphi survey. **CONCLUSIONS:** Implications for education, practice, and research are discussed. The Trauma and Resilience Competencies for Nursing Education will be disseminated widely through publications and are available online.

Keywords

nursing education—graduate, undergraduate, research—quantitative, psychiatric nursing practice, resilience

Introduction

The consequences of traumatic events have been identified as a high priority public health risk by numerous national and international organizations (Copeland, Shanahan, & Hinesley, 2018; U.S. Department of Health & Human Services, 2003; World Health Organization, 2013). The effects of physical trauma (suicide, homicide, unintentional physical injury) have been estimated to result in $671 billion per year in health care costs and lost productivity in the United States, and is reported to be the number 1 cause of death for ages 1 to 46 years in the United States (National Trauma Institute, n.d.). This estimate does not include the long-term costs of childhood adverse experiences, which correlates with an exponential increase in adult onset chronic medical diseases, mental health problems, and early mortality (Felitti & Anda, 2010).

The majority of people across six continents have experienced at least one traumatic event (70%) and 30% of people reported four or more traumatic events (Benjet et al., 2016). This survey is consistent with exposure to traumatic events reported in the United States (Center for Disease Control and Prevention, 2010). Traumatic event exposure using the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM-5*; American Psychiatric Association, 2013) criteria is high (89.7%), and exposure to multiple traumatic event types is the norm (Kilpatrick et al., 2013). In the past 10 years, the increasing incidence of suicide, drug-related deaths, domestic violence, mass and school shootings, terrorist attacks, natural disasters due to climate change, unending wars, reported rapes on campus, and referrals for child abuse and neglect attests to the increased prevalence of

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trauma-related incidences and consequently the adverse effects of trauma.

Prevalence rates of posttraumatic stress disorder (PTSD) range from 28.8% at 1 month to 17% at 12 months after a traumatic event (Santiago et al., 2013). However, those who have suffered adverse life experiences or stressors score significantly higher on a trauma symptom scale than those who have suffered Criterion A events (Mol et al., 2005). According to the *DSM-5*, Criterion A events include directly experienced or witnessed events that involve death or threatened death, actual or threatened serious injury, or actual or threatened physical or sexual violation (American Psychiatric Association, 2013). PTSD symptoms in the absence of the full disorder, or subthreshold PTSD, can still result in significant functional impairments and a greater incidence of other psychiatric disorders such as major depression, social anxiety, alcohol, and drug use (McLaughlin et al., 2015; Mota et al., 2016).

The long-term deleterious sequelae of traumatic events and adverse experiences on health are well documented. These events can result in profound emotional, physical, cognitive, and behavioral changes. An extensive literature review reveals the devastating long-term consequences across the life span from common and widespread adverse events in childhood (Copeland et al., 2018; Felitti & Anda, 2010). In addition, there is a growing recognition of the high incidence of PTSD after medical illness and procedures such as intensive care hospitalization (Johns Hopkins Medicine, 2015) and illnesses such as coronary heart disease (Vaccarino et al., 2013), myocardial infarction, cancer, and stroke (American Heart Association, 2015). These studies provide compelling rationale for the need for competent health-care providers to provide sensitive, culturally competent care aimed toward the recovery from trauma of such events.

As the largest group of health professionals, nurses are not immune to the deleterious adverse effects such as distress reactions, health risk behaviors, and psychiatric disorders that are associated with the consequences of trauma through caring for their patients' injury, illness and death, medical procedures, errors, and complications. In addition to the trauma everyone is exposed to, nurses are also exposed to vicarious trauma, which describes a profound shift in worldview after caring for those with trauma (Saakvitne & Perlman, 1996) or compassion fatigue, which refers to the significant emotional and physical toll that takes place when helpers are unable to refuel after caring for those with trauma (Figley, 1995). Research in mirror neurons provides evidence that our brains are hardwired to respond to other's pain and emotions (Oberman & Ramachandran, 2007). That is, the reactions experienced by the patient are shared or mirrored by the empathic nurse.

Nurses also are exposed to other occupational hazards such as workplace violence, bullying, mandatory overtime and shift work, and environmental hazards. Environmental hazards can include infectious exposures during nursing care, disaster and crisis situations, chemical and radiologic hazards. A 2017 survey of employed registered nurses in hospitals reported that 63% experience burnout (Kronos, 2017). These unique occupational hazards for nurses require self-care and resilience skills to mitigate the effects of vicarious trauma and adverse experiences. There is minimal attention paid to the pervasive impact of trauma on physical, cognitive, emotional, and spiritual health of nurses or their patients. Resilience skills to cope with adversity and trauma, and how to adapt to challenges are not typically included in nursing education.

The 2014 Scope and Standards for psychiatric mental health nurses (American Nurses Association & American Psychiatric Nurses Association, 2014) identifies trauma as a phenomenon of concern urging trauma-informed care and the reduction or elimination of restraints and seclusion in all levels of care. These and other obvious sources of potential retraumatization have been the focus of trauma-informed care (TIC; Muskett, 2013). Concerns about the lack of trauma content in nursing education have been raised by student nurses, nurses, and faculty (Molitierno, 2018; personal communication, National Organization of Nurse Practitioner Faculties [NONPF], Trauma & Resilience Special Interest Group, Annual Conference Atlanta, 2019). Stokes, Jacob, Gifford, Squires, and Vandyk's (2017) research validated these concerns and found that nurses had not received education about (TIC) and were not familiar with this term. Furthermore, the nurses noted that without knowledge of TIC, harmful care may occur. Participants suggested that trauma and trauma-informed care be integrated into nursing curricula. Foli and Thompson (2019) agree that nurses are often subjected to traumatic events and suggest that specific competencies addressing trauma-informed care are needed and could be included in the AACN Essentials for Baccalaureate Education. Chandler (2008, 2012) conducted several qualitative studies on implementing trauma-informed workshops in inpatient settings with nurses and staff. She found that the shift to a trauma-informed approach encouraged communication and collaboration between leadership and subordinates, staff and patients, and among staff within the units. Beckett, Holmes, Phipps, Patton, and Molloy (2017) found after a series of trauma-informed workshops to staff on an inpatient unit over 3 years, seclusion rates were reduced by 80%, staff felt more confident and were more motivated to be therapeutically engaged with patients, and the use of security staff on the unit was minimized.

Since there are guidelines for TIC (Fallott & Harris, 2009; Substance Abuse and Mental Health Services Administration [SAMSHA], 2014) and evidence-based treatments for trauma, it is imperative that individuals who suffer from psychological trauma receive these treatments to maximize the probability of positive treatment outcomes. The Institute of Medicine (2012) supports the need for trauma education and reports a lack of education in trauma assessment and training for health-care professionals. Despite the burgeoning scientific literature on the deleterious outcomes for those who suffer from traumatic stress, most nurses have only a cursory knowledge of how to care for those who have suffered significant trauma. Nursing education has not kept pace with integrating evidence-based care for trauma into curricula. A recent survey of advanced practice psychiatric nurses found that that majority of respondents did not feel that their graduate program prepared them well to treat trauma (Mabey, Wheeler, Ronconi, & Smith, 2017). The lack of trauma assessment and training in graduate programs is not unique to nursing as this content is not included in the curricula of most other mental health professional education either (Courtois & Gold, 2009; DePrince & Newman, 2011). This need prompted the American Psychological Association to develop Guidelines on Trauma Competencies for Education and Training in 2015 (American Psychological Association, 2015).

The prevalence of trauma and the profound physical and emotional sequelae of untreated trauma provide compelling rationale for the development of competencies for trauma and resilience for nursing education for both nurses' self-care and for patients. Competencies are essential for undergraduate, graduate, psychiatric advanced practice, and other specialty roles in nursing. A call for trauma competencies for nursing education was issued in *JAPNA*'s Guest Editorial in January 2018 (Wheeler, 2018).

Background of This Project

On receipt of a generous grant from the George Link Foundation http://www.nonprofitfacts.com/NY/George-Link-Jr-Foundation-Inc.html, the co-investigators for this project met to plan the project. The authors reviewed current competencies from nursing education and seminal articles in order to see what, if any, competencies currently existed relating to trauma and resilience.

An expert panel of 16 national experts in trauma and resilience from nursing education, practice, and research were identified by the authors in consultation with leaders in professional organizations from the American Psychiatric Nurses Association, the International Society of Psychiatric Nurses, the National Organization of Nurse Practitioner Faculties, and the International Society for the Study of Trauma and Dissociation and through the nursing literature on trauma. Several panel members had been involved in competency development in the past for other projects and a number of others were experts in curriculum development. These trauma experts were invited to participate in a workshop to develop Trauma and Resilience Competencies for Nursing Education at Fairfield University Egan School of Nursing and Health Studies June 23 to 24, 2018 in Fairfield, Connecticut. See Table 1 for expert panel and their areas of expertise.

The documents reviewed by the Expert Panel included the following: Essentials of Psychiatric Mental Health Nursing in the BSN Curriculum, collaboratively developed by American Psychiatric Nurses Association and the International Society of Psychiatric-Mental Health Nurses (2008), Psychiatric-Mental Health: Scope & Standards of Practice (2000), NONPF Psychiatric Mental Health Nurse Practitioner (PMHNP) 2003 & revised 2013 NP Competencies and Community/Public Health Nursing Competencies. In addition, the American Psychological Association Guidelines on Trauma Competencies for Education & Training (2015) and other relevant literature on trauma and resilience were reviewed and a shared Dropbox was set up with all materials for the Expert Panel members prior to an in-person 2-day Competency Development Workshop held in the Summer of 2018.

Eight domains were developed by the Principal Investigator and co–investigator for the competency categories for each level of nursing education, undergraduate, graduate, and PMHNP, after reviewing current nursing and trauma competencies and literature. The Expert Panel reviewed and approved the domains. These included following.

Self-resilience refers to the nurse's ability to cope with adversity and trauma, and adapt to challenges through physical, emotional, and spiritual resources and access to cultural and social resources.

Resilience refers to the patient's ability to cope with adversity and trauma, and adapt to challenges through physical, emotional, and spiritual resources and access to cultural and social resources.

Knowledge refers to recognizing the epidemiology of traumatic experiences and those who are at-risk; in addition to the neurobiological, developmental, social, cultural, and psychological factors related to trauma. This domain includes the ability to evaluate the literature commensurate with level of education.

Assessment skills focus on identifying and understanding the person's past and current adverse experiences, psychosocial and cultural history, strengths and resources, and symptoms as well as the long-term sequelae of trauma in order to develop a plan of care.

Table 1. Expert Panel.

Trauma expertise education (e); practice (p); research (r)
Audrey Beauvais DNP, MSN, MBA, RN (e) (r)
Terry Becker-Fritz, MS, RN, PMHCNS (p)
Ann Wolbert Burgess, DNSc, APRN, FAAN (e) (r) (p)
Genevieve Chandler, PhD, RN (e) (r)
Marion Donohoe, DNP APRN CPNP-PC (p) (e)
Laura Cox Dzurec, PhD, PMHCNS-BC, ANEF, FAAN (e) (r)
Linda Grabbe, PhD, FNP-BC, PMHNP-BC (e); (p) (r)
Elizabeth Janssen MA, NPP, PMHCNS, BC (p)
Candice Knight, PhD, EdD, APN, PMHNP-BC, PMHCNS-BC (e) (p) (r)
Jenna LoGiudice, PhD, CNM, RN (e) (p) (r)
Allyson Matney Neal, DNP, APRN, PMHNP-BC, PMHCCNS-BC, CPNP (e) (p)
Mary D. Moller, DNP, ARNP, PMHCNS-BC, CPRP, FAAN (e) (p) (r)
Kathryn E. Phillips,[a] PhD, MA, MSN, ANP-BC (e) (r)
Carole A. Shea, PhD, RN, CNS, FAAN (e)
Joyce Shea, DNSc, APRN, PMHCNS-BC (e) (r)
Kathleen Wheeler,[b] PhD, PMHNP-BC, APRN, FAAN (e) (p) (r)

Note. APRN = Advanced Practice Registered Nurse; CNS = clinical nurse specialist; PMHNP = psychiatric mental health nurse practitioner.
[a]Co–investigator. [b]Principal Investigator.

Diagnosis is based on critical thinking and identifies the problem and/or disorder by a systematic analysis of the history and symptoms and is appropriate for the nurse's level of education and specialty using either nursing diagnosis for BSN level of education or psychiatric diagnosis for graduate and PMHNP level of education.

Interventions for trauma-related problems and resilience are supported by the literature and research and include psychosocial, behavioral, pharmacological, and somatic treatments depending on the nurse's level of education and specialty.

Evaluation of the effects of interventions/treatment assesses the interaction of the person and the environment for indicators of improving or worsening.

Ethics/culture/policy includes professional values and issues relevant to the context and care of trauma survivors.

Developing Trauma and Resilience Competencies

The 2-day in-person Competency Development Workshop began with the Expert Panel members reviewing the literature of the definitions of trauma and resilience. The panel members decided to modify the SAMSHA definitions as follows:

Trauma is the experience of an event, series of events, or set of circumstances that is perceived by an individual as physically or emotionally harmful or life-threatening with adverse effects on the individual's functioning and cognitive, physical, social, emotional, or spiritual well-being (adapted from SAMSHA, n.d.).

Resilience refers to the ability of an individual, family, or community to cope with adversity and trauma, and adapt to challenges through individual physical, emotional, and spiritual attributes and access to cultural and social resources (adapted from SAMSHA, n.d.)

Trauma-informed care is a holistic approach to health care that fosters understanding and thoughtful responses to individuals who have experienced trauma in their lives, thus, supporting their resilience and self-efficacy (Hooper, Bassuk, & Oliver, 2009).

During the weekend competencies workshop, the panel developed a list of the assumptions that underlie the development of the competencies based on the literature reviewed prior to the workshop and on the guiding framework for nursing practice in Wheeler (2011, 2014). The assumptions are as follows:

- Most people have experienced trauma.
- Trauma can include any situation where the person perceives overwhelming helplessness.
- Traumatic events affect the victim as well as the helpers (vicarious trauma).
- There is both explicit and implicit bias in acknowledging trauma. Implicit bias prevents the person from recognizing the impact that trauma has on one's own as well as other's well-being and physical health.
- Trauma can include big "T" traumas such as natural disasters, war, and accidents; as well as small "t" traumas such as invasive dental or medical procedures, routine surgeries, workplace and personal bullying; and cumulative trauma such as poverty, racism, multiple deployments, and transgenerational trauma.
- Many chronic health conditions are strongly correlated with adverse childhood experiences (Felitti & Anda, 2010).
- Nurses at every level of practice encounter those who have suffered trauma.
- To provide compassionate care, nurses need self-awareness and knowledge of both resilience and trauma.

These competencies delineate the knowledge, attitudes, and skills needed to address the care of oneself and those who have been impacted by trauma. Three groups (undergraduate, graduate, and psychiatric advanced practice nurses) with five to six experts in each group were formed based on the individual's expertise and interest with a chair designated for each subgroup. Small group work began the first afternoon of the Workshop with each

subgroup charged with developing competencies appropriate for their level of nursing education. Day 2 began with a review of the undergraduate group's work. It was decided that the competencies for undergraduate nursing education would be foundational for all other levels of nursing education. The competencies for the graduate group included all graduate specialties as well as education and leadership programs. The psychiatric advanced practice competencies built on both the undergraduate and the graduate competencies. Comments and discussion then informed the higher levels of nursing education so that small group work could refine the work of each subgroup. Each competency was designated a skill, knowledge, or attitude and content appropriate for each competency was identified. At the end of the weekend, a working draft of 35 undergraduate competencies, 33 graduate competencies, and 45 psychiatric advanced practice nursing competencies had been developed with consensus reached among the Expert Panel members.

Delphi Methods

This research study was approved by the authors' university Institutional Review Board (IRB No. 531). An anonymous Delphi survey (McMillan, King, & Tully, 2016) was conducted to validate the competencies created by the Expert Panel (see Table 1). The Delphi technique is a systematic and anonymous way of getting expert consensus (Hsu & Sanford, 2007). After each round is completed, responses are collated and used to refine the statements used in the subsequent round of the survey (Hus & Sanford, 2007; McMillan et al., 2016). Iterative rounds of the Delphi are conducted until consensus is achieved among the experts (Hsu & Sanford, 2007).

Nurses ($n = 57$) from practice, education, and research who are experts in trauma and resilience who were not members of the Expert Panel were contacted to be part of the Delphi survey validation panel. These individuals were referred by professional nursing organizations (APNA, ISPN, and NONPF) that the authors contacted and asked for recommendations of nurses who specialize in trauma and resilience. Names were also obtained from referrals given by the Expert Panel.

Twenty-four individuals agreed to participate in the Delphi survey in order to validate the competencies. The Delphi participants held either a master's (36%) or doctoral (64%) degree with an average of 36.36 years of nursing practice. As for licensure, all were registered nurses with 73% nurse practitioner/advanced practice registered nurse (APRN) licensure and 46% clinical nurse specialist (CNS) licensure. When asked where they spend most of their time working as a nurse, 55% said they spend the majority of their time working in education, 27% said in practice, and 9% said in research, with most primarily employed in a college or university setting (64%) and 27% employed in outpatient clinical care. One respondent was retired. In terms of expertise, 8 of the 10 respondents stated they had advanced trauma training or education, such as eye movement desensitization and reprocessing, community resilience model, trauma resiliency model, and trauma focused cognitive behavioral therapy.

These participants were asked to respond to statements via a Likert-type scale and a comments section. Each question on the Delphi survey presented the validation experts with one of the competencies and asked them to rate its relevance, specificity, and comprehensiveness using a 5-point Likert-type scale (5 = *fully agree*, 3 = *somewhat*, and 1 = *none*). The following definitions were given:

- Relevance—refers to the extent the competency is significant to nursing education
- Specificity—is how well defined the competency is for trauma and resilience
- Comprehensiveness—is the degree to which the competency covers everything is should or if there are missing aspects that need to be added

A comments section was provided with each competency and respondents were asked to provide comments when they scored a competency below a 3 on any category.

Delphi Results

Of the 24 validation panel nurses that agreed to participate, 15 responded to the first round and 11 responded to the second round of the survey. Although a more robust response to the Delphi was desired, the authors wanted to ensure that the Delphi Panel members were trauma experts and did not want to compromise the results by seeking others who were not highly endorsed. Survey Monkey® software was used to develop the survey and responses were anonymous. Two rounds of the Delphi study were conducted between July and August of 2018. The first survey was open from July 19 to August 4, while the second was open from August 17 to 31. After the both rounds of the Delphi study, the number of competencies went from 112 to 88 (please see Table 2 for details on the number of competencies and their domains after each round of the Delphi). A response of 3 or higher was considered to be in agreement with the competency. Agreement percentages were calculated for each competency in each category of relevance, specificity, and comprehensiveness.

Competencies scoring below 80% in any category (relevance, specificity, or comprehensiveness) were

Table 2. Number of Competencies in Each Domain.

Time	Undergraduate	Graduate	Psychiatric nurse practitioner
Initial competencies created by the expert panel (total = 112)	4 Self-resilience	4 Self-resilience	5 Self-resilience
	3 Resilience	3 Resilience	3 Resilience
	8 Knowledge	7 Knowledge	8 Knowledge
	6 Assessment	5 Assessment	5 Assessment
	3 Diagnosis	1 Diagnosis	4 Diagnosis
	6 Interventions	5 Interventions	9 Interventions
	1 Evaluation	2 Evaluation	2 Evaluation
	4 Ethics, culture, policy, legal	6 Ethics, culture, policy, legal	8 Ethics, culture, policy, legal
	Total = 35	Total = 33	Total = 44
After the first round of the Delphi Survey (total = 88)	4 Self-resilience	2 Self-resilience	3 Self-resilience
	2 Resilience	2 Resilience	2 Resilience
	8 Knowledge	5 Knowledge	7 Knowledge
	6 Assessment	2 Assessment	5 Assessment
	2 Diagnosis	1 Diagnosis	3 Diagnosis
	7 Interventions	6 Interventions	9 Interventions
	1 Evaluation	1 Evaluation	1 Evaluation
	4 Ethics, culture, policy, legal	3 Ethics, culture, policy, legal	2 Ethics, culture, policy, legal
	Total = 34	Total = 22	Total = 32
Final competencies after the second round of the Delphi Survey (total = 88)	4 Self-resilience	2 Self-resilience	3 Self-resilience
	5 Resilience	1 Resilience	2 Resilience
	5 Knowledge	4 Knowledge	7 Knowledge
	5 Assessment	3 Assessment	5 Assessment
	1 Diagnosis	1 Diagnosis	3 Diagnosis
	8 Interventions	6 Interventions	8 Interventions
	2 Evaluation	1 Evaluation	1 Evaluation
	4 Ethics, culture, policy, legal	4 Ethics, culture, policy, legal	3 Ethics, culture, policy, legal
	Total = 34	Total = 22	Total = 32

reviewed and revised using feedback provided by the Delphi validation panel experts in the survey. The Expert Panel reviewed and approved all revisions to the competencies. If a competency was too general, it was either eliminated or changed to make it specific to trauma and resilience. If it was unable to be measured, key words were added using Bloom's taxonomy. When competencies were repetitive, they were consolidated or deleted. Competencies that were placed under the wrong domain were moved and competencies that were noted as missing were added. For competencies that were improperly leveled, the three levels were compared and reworded to ensure progression of skills across the levels of nursing (undergraduate, graduate, and psychiatric mental health nurse practitioner).

Following the first round of the Delphi survey, modest levels of agreement were reached on the 112 competencies. Agreement levels of 80% and above were reached on 108/112 (96.4%) competencies for relevance, 96/112 (85.7%) competencies for specificity, and 95/112 (84.8%) competencies for comprehensiveness. Reviewer comments indicated competencies: needed to be moved to a new domain, moved to a new educational level, be consolidated into one competency, were missing and needed to be added, and required word edits. Following edits and changes, the number of competencies was reduced from 112 to 88.

After the second round of the Delphi, the experts reached a high level of agreement on the final 88 competencies. However, the low response rate of 11 is a limitation to the study. Agreement levels of 80% and above were reached on 87/88 (98.86%) competencies for relevance, 80/88 (90.91%) competencies for specificity, and 82/88 (93.18%) competencies for comprehensiveness. For competencies that scored less than 80% in agreement in any category (relevance, specificity, or comprehensiveness), reviewer comments were used to improve the competency.

Table 3. Example of a Supraordinate Category With Subcategories.

Category	Undergraduate	Graduate	Psychiatric nurse practitioner
Domain: Assessment; Supraordinate Category	Assess patients by asking if they have experienced adverse experiences, for example, neglect, substance use in a caregiver, physical or sexual abuse, and how that has affected their health. K, S	Conduct a trauma-informed history and assessment on every patient. K, S	Demonstrate the ability to tailor a comprehensive trauma assessment based on patient's history, attachment style, dissociation, avoidance, triggers, current resources, and skills. S
Subcategory a	Identify developmental, cultural, family, and gender issues related to trauma. S	Assess patient's resilience through history and by administering evidence-based tools. K, S	Develop a trans-generational trauma genogram. K, S
Subcategory b	Identify and use assessment tools for trauma and resilience. K, S	Assess family dynamics affected by trauma. S	Order appropriate laboratory studies to screen for medical complications due to trauma. K, S
Subcategory c	Recognize the strengths and vulnerabilities of clients across the lifespan affected by trauma and stress. K		Order diagnostic tests to screen for neurocognitive dysfunction related to trauma. K, S
Subcategory d	Identify behavioral, emotional, cognitive, and physical symptoms resulting from abuse, neglect, military trauma, accidental events, medical procedures, medical illness, suicide attempts, natural disasters, torture, and so on. K, S		Recognize signs and symptoms of dissociation. K, S

Note. K = Knowledge; S = skill, A= attitude.

There are 34 undergraduate competencies. Of these, 33 had all experts (100%) agreeing that they were relevant, and one had 88% agreement that it was relevant. For specificity, 16 of the competencies had 100% agreement, with the remaining 13 ranging from 86% to 89% agreement, and 5 scoring at 63% to 75% agreement. Finally, for specificity, 24 of the competencies reached full agreement with the remaining 10 garnering 86% to 88% agreement, and 4 scoring between 67% and 75% agreement.

At the graduate level, there are 22 competencies. For the category of relevance, 21 of the 22 reached 100% agreement with the final competency receiving 89% agreement. Fourteen of the 22 competencies reached 100% agreement in specificity with the 6 competencies receiving 86% to 88% agreement, and 2 with 63% to 75% agreement for specificity. Finally, 18 of the 22 competencies reached 100% agreement for comprehensiveness with 4 competencies endorsing 86% to 88% agreement, and 1 competency receiving 75% agreement.

For the psychiatric mental health nurse practitioner competencies, 30 out of the 32 competencies had 100% of the experts agreeing that they were relevant. Of the remaining two competencies, one had 89% agreement and the other had 67% agreement for relevance. For specificity, 23 competencies received full agreement (100%) with eight scoring between 86% and 88% agreement and one having 75% agreement. Finally, 25 of the 32 competencies reached 100% agreement for comprehensiveness with 5 scoring between 86% and 88% agreement and one garnering 75% agreement.

On completion of the Delphi survey, the Expert Panel identified one supraordinate competency for each domain along with subcompetencies delineated for that domain (see Table 3 for an example). This was done in an effort to streamline and simplify each domain so that the fewest essential competencies could then be better integrated into current and future guidelines for nursing education. See Table 4 for examples of how the essential competencies for each domain were leveled across undergraduate, graduate, and psychiatric nurse practitioner categories.

Implications

Education

The trauma and resilience competencies for nursing education serve as a guideline of minimal expectations for nurses' self-care and patient care for two levels of nursing education: (1) undergraduate and (2) graduate. In addition, competencies for the specialty of psychiatric nurse practitioner programs were developed. The proposed competencies reflect essential knowledge, skills, and attitudes foundational for each of these levels and specialty of nursing education. The graduate level builds on the

Table 4. Leveling of Competencies.

Domain	Undergraduate	Graduate	Psychiatric nurse practitioner
Self-resilience	Demonstrate participation in and maintenance of self-care, managing stress, and supportive relationships with others. K, S	Develop and utilize a repertoire of resilience skills for oneself. K, S	Maintain a high degree of self-awareness through engaging in self-reflective practices by seeking ongoing consultation, supervision and/or individual psychotherapy. K, S, A
Resilience	Incorporate a strength-based approach in working with patients, families, and communities affected by trauma. K, A	Facilitate the development of resilience skills for individuals, families, and communities. S	Teach patients self-regulation skills such as dialectical behavior therapy, grounding, somatic skills, and mindfulness to enhance resilience. K, S
Knowledge	Explain the effects of adverse childhood experiences on risk-related morbidity and mortality. K	Describe the physical and psychological complexities of trauma, including the impact of trauma on developmental milestones. K	Demonstrate knowledge of the current literature on trauma and critically evaluate research on the science and theory of trauma treatment. K
Assessment	Assess patients by asking if they have experienced adverse experiences, e.g., neglect, substance use in a caregiver, physical or sexual abuse, and how that has affected their health. K, S	Conduct a trauma-informed history and assessment on every patient. K, S	Demonstrate the ability to tailor a comprehensive trauma assessment based on patient's history, attachment style, dissociation, avoidance, triggers, current resources, and skills. S
Diagnosis	Identify nursing diagnoses for those who have experienced trauma. K, S	Diagnose unresolved trauma and co-occurring mental health problems as appropriate to nursing roles. K, S	Diagnose trauma-related disorders and co-occurring psychiatric disorders. K
Interventions	Apply best practices in providing holistic care to individuals and families with a history of trauma. A, S	Provide trauma-informed developmentally appropriate education to patients regarding the connection between their symptoms and trauma history. K, S	Conduct evidence-based psychotherapy for trauma and co-occurring conditions. K, S
Evaluation	Involve the client with a history of trauma in evaluating progress toward measurable individualized goals. K, S	Measure patient change in trauma symptoms and resilience utilizing established tools. K, S	Evaluate treatment progress and attainment of patient's identified goals. S
Ethics/culture/policy	Advocate for the patient/family/community with a history of trauma. A	Educate others on how to change systems of care to a trauma-informed model. K, S	Engage in political advocacy to effect change for vulnerable populations who are victims of trauma. S

Note. K = Knowledge; S = skill; A= attitude.

undergraduate competencies and the psychiatric nurse practitioner level builds further on the graduate-level nursing competencies. These competencies should be integrated in core curriculum for all levels of nursing education and can work in tandem with other core competencies such as the Essentials of Psychiatric Mental Health Nursing in the BSN Curriculum (2007-2008), Psychiatric-Mental Health: Scope & Standards of Practice (2000), NONPF PMHNP (2003), and the revised Nurse Practitioner Competencies (2013), and the Community/Public Health Nursing Competencies (Quad Council Coalition Competency Review Task Force, 2018). Foli and Thompson (2019) state that the AACN Essentials of Baccalaureate Education has a conceptual link with the delivery of compassionate, safe trauma care and present sample trauma-informed care content for each existing Essential. They note that trauma knowledge needs to be infused in all areas of nursing.

The Trauma and Resilience Competencies will be sent to major stakeholder nursing organizations for endorsement; that is, for philosophical agreement with the intent and content of the competencies. Dissemination of the competencies will initially be through presentations and publications. However, it is hoped that funding can be procured to distribute to nursing faculty in the United States through seminars and educational workshops. Preliminary

faculty resources have been identified and content to support each competency have been developed and included. Copyright for the competencies has been obtained and they are available online at ACEs Connections which is an online social media platform to connect those using trauma-informed/resilience-building practices. Access at https://www.acesconnection.com/blog/trauma-and-resilience-competencies-for-nursing-education. In addition, the competencies will be published in Wheeler (in press).

These competencies reflect the first step, that is, identifying the content needed for resilience and trauma-informed and trauma-specific care. The next step involves developing strategies for optimal teaching and learning. Although these competencies provide content, unique pedagogical concerns have been identified relating to teaching clinicians about trauma (Cook & Newman, 2014). These include issues relating to boundaries, dependency and disempowerment dynamics, concerns about disclosure, and emotional dysregulation. It is essential for nurses to develop self-care plans and resilience skills for themselves to enhance their ability to work with complex, vulnerable, trauma-exposed patients. A comprehensive, reflective, and culturally sensitive curriculum that is developmentally informed and appropriately leveled to professional education should include both summative and formative evaluations.

Practice

The Trauma and Resilience Competencies are not created as a standard of practice but as a guide for nursing programs' curriculum development. Standards of practice have legal and regulatory implications while this document reflects a guideline for nursing curricula that describes minimal entry-level skills for nursing practice at three levels of practice, undergraduate, graduate, and for the psychiatric mental health nurse practitioner specialty. Other specialties such as neonatal nurses, midwives, family nurse practitioners, and other roles are invited to develop and build on these foundational competencies.

These competencies serve as a compass for a broad scope of practice when caring for those with trauma. In addition, these competencies provide clarity for students regarding their role and expectations for benchmarks for excellence in practice. Nurses who provide care in both inpatient and outpatient settings in diverse roles may vary; thus, practice depends on the setting, patient populations, and regional needs. These competencies are foundational and functional depending on the site and the population served. However, given the ubiquity and consequences of trauma and the need for resilience for nurses and the patients they serve, these competencies may also serve as universal precautions for nursing practice. This is consistent with researchers in trauma who suggest that integrating trauma-informed care into health-care systems and for all patients is responsive and supports optimum care and would help to prevent retraumatization (Elliott, Bjelajac, Fallot, Markoff, & Glover Reed, 2005; Muskett, 2013).

Standards of practice for trauma practice and care will continue to evolve. For example, screening for adverse childhood experiences needs to be buffered in any assessment. Asking sensitive questions requires a plan for proper follow-up and requires resources for referral and treatment. Questions have been raised regarding whether it is justified to screen for conditions when proper treatment cannot be provided (Finkelhor, 2018). Another practice problem in trauma care involves whether there should be a long-term period of stabilization for those with complex trauma (De Jongh et al., 2016). These and other practice issues need to be further researched to establish benchmarks for excellence. The Competencies reflect current practice with the recognition that review and revision of these competencies will be ongoing as new knowledge is generated.

Research

The Trauma and Resilience Competencies for Nursing Education will assist organizations and educators to identify outcomes that improve patient care. Measuring performance based on these competencies contributes to researchable questions that will increase understanding of complex clinical questions about trauma. These outcomes then provide a benchmark for practice excellence and an evidence base for care demonstrating how nurses make a difference in patient outcomes. This will then provide further guidance for research priorities and funding.

Tools are needed to measure student mastery of these competencies. Delineating behaviors or indicators for meeting each Competency are an essential next step toward proficiency in trauma care as an entry-level provider. Proficiency in trauma care will demonstrate how trauma-informed and trauma-specific care makes a difference in patient outcomes, and thus, reflects accountability to the nursing profession and society.

Conclusions

Judith Herman (1997) notes in her seminal book, *Trauma and Recovery*, that advances in trauma education and treatment can only occur when the implicit bias that blinds us from acknowledging the evil that exists in the world, is made explicit. Recognizing trauma in oneself and others requires one to experience their own vulnerability and obliges one to act. This is a significant

paradigm change that reflects a society that is conscious, transparent, open, and respectful of reality. Peplau (1965) noted that social forces precede areas of specialization in response to public and societal needs and increased specialty information. Given the increasing awareness and research on trauma and its consequences on health and the tumultuous events that have converged to lift professional blinders, a new era of care has emerged. The Trauma and Resilience Competencies for Nursing Education provide a compass toward that change and herald a practice responsive to individual and societal needs. Recognizing and overcoming barriers to care for trauma survivors benefits nurses, but most of all alleviates suffering and promotes health and resilience for those individuals, groups, and communities who have suffered trauma.

Author Roles

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