TRAUMA-INFORMED COUNSELLING AND MENTAL HEALTH: IMPLICATIONS FOR COUNSELLING

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Abstract
Trauma is an inevitable truth of life, preventable, but sometimes wholly unavoidable, as it occurs with or without any early signs. Trauma-informed is to understand the involvement and impact of violence and victimisation in the lives of most clients of mental health, substance abuse, and other services. It is also to apply that understanding in providing services and designing service systems to accommodate trauma survivors' requirements and vulnerabilities and facilitate their participation in treatment. As professionals, counsellors will always encounter a client in trauma at some point. For this reason, counsellors have to possess a basic knowledge of trauma-informed theory and intervention, on how to recognise and assess symptoms of trauma. Therefore, this paper provides an overview of trauma, mental health, trauma-informed counselling and how each has emerged as a counselling speciality in the last few years. Trauma, Trauma-informed counselling, and mental health were defined for the readers, and the principles and elements of the trauma-informed theory were provided. This paper further explained the difference between trauma-informed counselling and trauma-specific interventions. It briefly reviewed trauma history prevalence among consumers of mental health services and described the development of a trauma-informed perspective on mental health. Mental health in Nigeria was reviewed, followed by efforts of leading organisations in the counselling field to increase training opportunities in trauma-informed counselling. An overview of Psychological First Aid (PFA) was provided, and trauma counselling theories were reviewed. The paper concludes with a discussion on vicarious traumatisation, counsellor self-care and its implication on the counselling profession.

Keywords: Mental health, trauma and trauma-informed counselling

Introduction

The concept of trauma has existed for centuries, but trauma counselling has only emerged as a speciality in the counselling field within the last few years. Trauma describes almost any stressor experienced by a person (Kee, Ashina & Hsin, 2020). Trauma refers to an individual's emotional

response to an event supposed to be physically or emotionally hurtful. The American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (2013) lists traumatic distress like exposure to serious injury, actual or threatened death or sexual aggression in one (or more) of the following ways:

- witnessing the event(s) as it (they) happened to others,
- learning that the traumatic event(s) occurred to a family member or a friend,
- directly experiencing the traumatic event,
- experiencing repeated or severe exposure to aversive facts of the traumatic event(s).

The traumatic event has "lasting negative effects on an individual's mental, physical, social, and spiritual well-being". Although trauma outcomes can be extreme, they can also involve going through physiological and psychological responses (Levers, 2012). According to Cohen and Mannarino (2015), traumatic experience correlates with amplified risks of mental health and medical challenges, such as Post Traumatic Stress Disorder (PTSD), anxiety, drug abuse, depression, and suicide ideation. In addition, the experience of trauma can affect many areas of well-being and development and affect one's sense of safety, trust, and confidence.

Trauma-informed counselling begins with an accurate understanding of trauma and its impacts and benefits on recovery through an intentional and active focus on creating safety, trust, clarity, connection and inclusion. Trauma-informed counselling supports pro-social skill development related to self-regulation and self-calming. It is usually achieved through attuned ways at all levels of support and care across all settings, including in specialised treatment services (Lewin, 2015). Counsellors are among the central professionals that help prevent challenges and assist clients in upholding a constructive mentality, aside from psychiatrists and medical practitioners. *Counselling* is an important alternative that could help to improve an individual's emotional and mental health. Besides, counselling could offer guidelines so that an individual would realise the importance of maintaining a healthy mentality as is congruent with the objective of the World Health Organisation (WHO). A skilled counsellor should be able to support victims of traumatic experiences, salvage their emotional strength and improve mobility. However, not every counsellor possesses the competency and expertise in mental health and trauma, particularly in recognising the symptoms of mental disorders and diagnosing and treating clients with mental disorders and trauma. There are cases whereby counsellors fail to diagnose accurately because of inadequate knowledge of mental illness or well-being, mental disorder, mental health or trauma.

A report published by the Department of Health and Human Services (2017) stressed the importance of enhancing mental health strategies because traumatic stress could adversely affect public health. Nevertheless, there is still a shortage in training on trauma and stress after the trauma within the graduates' counsellor education program (Layne, 2014). Therefore, it is essential to include the mechanism of basic trauma information and the trauma-aspects of medical reasoning skills within the counsellor education programme so that a counsellor would be able to work in various mental health settings and assist the traumatised victims. However, Nigeria, as in most African countries, has not taken a significant lead on the research opportunity in this area (Lalor, 2010) to bring Africa's prevalence rate of 34% to the barest minimum, if not complete eradication.

Types of Trauma

a. **Acute Trauma**: This trauma involves a single experience perceived as threatening to a child's sense of physical or emotional safety (Terr, 2010). Typically, acute trauma is a sudden or unexpected trauma that is a different event of a limited nature. Examples of acute Trauma include a motor vehicle accident or a natural disaster. Distress after the experience of a traumatic event is common, but with time and appropriate social support, most children will return to normal functioning (O'Neill, 2010).

b. **Complex Trauma**: This trauma involves chronic, repeated exposure to one or more adverse experiences. Complex traumatic events are often severe and may be interpersonal, such as neglect or child abuse (Van der Kolk, 2014). Children who live in extreme poverty or dysfunctional and chaotic home environments, exhibit complex trauma symptoms. Studies on trauma suggest that children are at greater risk for poor physical and mental health outcomes with increased and repeated exposure to adverse experiences, such as those experienced with complex trauma (Afifi, 2016).

Trauma-Informed Education

Trauma-informed education involves school policies and practises grounded in (a) the realisation of the prevalence and impact of trauma, (b) the recognition of the signs and symptoms of trauma exposure in children and youth, (c) an appropriate response to students' needs guided by evidence-based practice, and (d) avoidance of re-traumatisation of the students (Substance and Mental Health Services Administration, SAMHSA, 2014). The term trauma-informed is often used interchangeably with trauma-sensitive. Both refer to understanding the prevalence and potential impact of trauma and the need to respond in safe and supportive ways.

Symptoms of Trauma and Post Traumatic Stress Disorder (PTSD)

Recognising possible indicators of PTSD is an integral part of crisis counselling, because it may be an antecedent to some crises, such as substance abuse, or an aftereffect of others, such as sexual assault (Duarte, 2017). PTSD frequently presents a grim diagnosis, such as depression or substance use, and symptoms often get overlooked when the focus is placed on the personal or interpersonal distress resulting from the PTSD. Clients presenting trauma symptoms, may seek treatment after an identifiable traumatic event such as a disaster, illness, or assault. Counsellors may also encounter situations where the trauma presentation is less evident, and past traumatic experiences contribute to current difficulties.

For the response to be considered, Buffalo (2019) states that following a traumatic stressor, an individual must experience symptoms in four clusters: avoidance, intrusion, alterations in arousal and activity and negative alterations in cognition and mood. Intrusion refers to re-experiencing the event through flashback, spontaneous memories, or nightmares of the traumatic event. Avoidance is marked by a persistent evasion of reminders of the event. Negative alterations refer to the range of negative emotions, beliefs, and cognitions (guilt, shame, anger) an individual may develop due to the traumatic event. Finally, alterations in arousal are marked by hypervigilance, aggressive or self-destructive behaviours, and sleep disturbances. These symptoms may cause significant impairment in an individual's functioning and last for at least one month.

Trauma assessment is mostly done through a structured clinical interview; however, counsellors

may find it helpful to use additional assessment tools to understand and treat many potential trauma responses. It is also essential for counsellors to recognise trauma symptoms to make accurate referrals in the action phase when necessary. Counsellors should recognise when working outside of their competence that they may risk doing more harm because of an ill-informed approach.

Importance of Trauma-informed Counselling

Regardless of the event or circumstance that brings an individual to the attention of a mental health practitioner, the client's trauma history is rarely explored or conceptualised as determinative in presenting problems. Furthermore, addressing such histories may not be viewed as critical to successful treatment in many mental health settings. Most individuals seeking mental health or other services are never screened, assessed, or treated for their traumatic experiences. As Fallot and Harris (2011) have noted, "Systems serve survivors of a childhood trauma without treating them for the consequences of that trauma; more significantly, systems serve individuals without even being aware of the trauma. This lack of awareness can result in:

- a failure to understand the presenting issues and their context fully.
- a failure to treat or make appropriate (trauma-specific) referrals; and
- re-traumatisation of patients with standard clinical procedures or inadvertent triggering events may slow patient progress, reduce openness to treatment, or derail therapy altogether.

Elements of a Trauma-Informed Department or Organization

Becoming trauma-informed has implications for the practitioner and the setting or system in which care is provided. Becoming a trauma-informed Organisation or Department at a systems-level necessitates multi-level changes across many domains. All aspects of services and programs need to be organised with an awareness of trauma, its impact, its self-perpetuating nature, and familiarity with the multiple and complex paths to healing and recovery. Administrative support for integrating knowledge of trauma and violence into all aspects of an organisation's functioning is essential. This support includes (where appropriate) explicit mention of the issue in mission and policy statements and administrative resolve to ensure the availability of resources for disseminating information.

Additionally, a review of institutional policies and procedures to improve sensitivity to the potential for re-traumatisation of patients should be in place. Finally, education and training in basic information about trauma are necessary for all staff, even in settings where there is administrative support for clinicians to receive specialised trauma training and supervision. In other words, Olusolami, Abiodun, Agatha and Angela (2020) noted that "To provide trauma-informed services, all staff of an organisation, from the receptionist to the direct care workers to the board of directors, must understand how violence impacts the lives of the people being served. To ensure that every interaction is consistent with the recovery process and reduces the possibility of re-traumatisation," Universal screening of all patients for trauma histories is also fundamental to a trauma-informed organisation. Even in settings where trauma-specific services are not available, a thorough trauma history screening can increase practitioner awareness of issues that may need consideration in treatment planning. Screening can also increase the client's knowledge of the potential impact that trauma has had on his or her life and the importance of addressing these issues in treatment.

Principles of Trauma-informed Practice

In addition to organisational features that reflect and implement a trauma-informed approach to

counselling, Fallot and Harris (2011) have identified five principles to guide practice: safety, trustworthiness, choice, collaboration, and empowerment.

i. **Safety**: The treatment setting and care providers must ensure physical and emotional safety. The assurance of safety is a necessary precondition to any practical therapeutic work with trauma survivors. An atmosphere respectful of survivors' need for safety, respect, and acceptance is fundamental for building trust and therapeutic engagement. Considerations may include the locations (including parking) of service settings and times when services are offered. Also, the availability of security personnel, whether doors are left open or locked, the appearance of the waiting and consultation rooms, and whether staff are trained to recognise patient discomfort and are trauma-sensitive in interactions. In inpatient settings, additional consideration should be given to physically separating male and female patients. In addition, making safe and comfortable timeout spaces available; respecting patients' privacy and personal modesty (concerning bathing, sleeping, and using the bathroom) is paramount. Training staff appropriately in de-escalation strategies, keeping patients informed of ward rules, procedures, and expectations, and having specific policies on reporting abuse are also necessary measures to put in place. furthermore, helping the patient identify emotional triggers and calming strategies that can reinstate feelings of control.

ii. **Trustworthiness**: Due to the emotional challenges that many trauma survivors go through in their past relationships, trust in the therapist and the therapeutic relationship is crucial. The ladder to help restructure confidence and trust includes efforts to understand and accomplish what is necessary for the client to feel safe, including respecting their emotional limits and not pressuring clients to disclose. By making clients' responsibilities and tasks clear, explaining procedures and tests, and addressing confusions and ambiguities, the clinician can also enhance the client's feelings of safety and trust. Respectful and consistent informed consent and strict confidentiality are essential to maintain appropriate and respectful professional boundaries.

iii. **Choice:** Emphasising and encouraging client's choice and control in the treatment, where possible, is essential and may include choices for clients over aspects of the services they receive (e.g., type of intervention, time of day, gender of clinician). A clear explanation of clients' rights and responsibilities is also necessary.

iv. **Empowerment**: Emphasising strengths and resilience and exploring coping strategies and sources of personal strength that have been used in the past are empowering. By recognising the clients' abilities and skills to their experience, the therapist can help the client organise these resources to cope with their challenges. A focus on wellness rather than illness is vital and empowering. Additionally, educating clients about trauma and how their past experiences may be contributing to their current circumstances and reactions can help clients gain insight into how to be more effective in anticipating and managing their responses. Furthermore, clients need to be encouraged to construct a practical sense of hope about the future and the skills to maximise future successes.

v. **Collaboration**: Trauma-informed practise involves practitioner-client collaboration and the

sharing of power. The collaboration experience is best given adequate attention in an atmosphere where the client is treated as the expert. The practitioner and client work with each other rather than the more traditional treatment approach of things being done to or for the client. To achieve this, the client must have a significant role in planning and evaluating the services he or she receives. In addition, clients' preferences should be heard and honoured where possible in goal setting and mounting treatment priorities.

These principles can work systemically so that counsellors and support staff operate in a trauma-informed setting as well, reaping the benefits of a work setting that is safe, trustworthy, collaborative, and empowering. It is a place where counsellors can exercise choice and some measure of control in their dealings with each other and the administration.

Mental Health

Mental health is the state of an individual's psychological and emotional well-being. Good mental health promotes healthy functioning (thinking, feeling, and behaviour) and significantly influences overall health, as poor mental health can contribute to mental and physical illness. In addition, mental health can be positively or negatively impacted by life experiences, e.g., trauma and adversity, relationships, school environment, and physical health (Buffalo, 2019). According to the World Health Organisation (WHO), mental health is more than just the lack of mental disorders or disabilities. It is a vital part of health - a condition of total physical, mental and social well-being and not just the absence of infirmity or disease.

Multiple social, psychological, and biological factors determine a person's mental health. For example, violence, emotional instability, and persistent socio-economic pressures/hardships are recognised risks to mental health. A mental health challenge is also associated with social exclusion, stressful work conditions, rapid social change, gender discrimination, unhealthy lifestyle, physical ill-health, and human rights violations. Mental disorders account for a vast worldwide weight of illness that is not adequately estimated nor appreciated. Each year, about 30% of the global population is affected by a mental disorder, and over two-thirds of those affected do not receive the care they need (Buffalo, 2019). It is anticipated that by 2020, widespread mental disorders such as depression, anxiety, and substance abuse-related disorders, will affect more people than complications from accidents, AIDS, heart disease, and wars collectively (Buffalo, 2019). This result is an astonishing statistic and poses serious questions about why mental health challenges are not given adequate attention as they currently receive.

In the past, it was not an uncommon sight to see naked or half-clothed individuals roaming the streets of cities in Nigeria. Referred to as lunatics, they lived on and ate off the streets. No one knew how they got to be that way, but the consensus was that their condition was incurable, and so they were sentenced to a life of roaming the streets until the day they died or disappeared. Sadly, this is the face of mental illness most Nigerians see, and this forms people's perception of what mental illness is. Nonetheless, mental disorders comprise a broad range of problems with different symptoms. They are by and large characterised by some mixture of behaviour, emotions, irregular thoughts, and interaction with others. Examples of mental disorders include addictive behaviours, anxiety disorders, depression, eating disorders, and schizophrenia. People generally have mental health concerns from time to time. However, a mental health issue becomes a mental illness when constant signs and symptoms change the ability to function and cause recurrent stress. It is not possible to tell

whether someone is developing a mental health problem reliably; however, if such signs appear in a short space of time, they may offer clues. Unfortunately, the awareness of mental health disorders in Nigeria is, at best, fieeting. The level of awareness of the Nigerian public on mental health issues is also understandably poor, and the misconceptions regarding mental health have continued to fiourish. Poor knowledge of the mental illness, its causes and its characteristics among Nigerians have been a significant hurdle to improving mental health in Nigeria.

Mental Health System in Nigeria

The World Health Organization report of 2006 on assessing the mental health system in Nigeria gave a general overview. It revealed that there is a considerable overlook of mental health issues in Nigeria. The report dissected the 1991 mental health strategy document in Nigeria, formulated to deal with mental health illnesses and other related issues. It reported that no revision had taken place since its formulation, and no formal assessment of how much it has been implemented has been conducted. The main stances of the report were based on a survey conducted in six States in Nigeria, each representing the six geo-political zones of the country. Investigation in these states revealed that though a list of essential medicines exists, they are not always available at the health centres. In addition, no particular office exists in the Health Ministry at any level for mental health issues, and only four percent of the government's budget on health is earmarked for mental health.

Interestingly, all of the seven mental health facilities studied are government-owned. No provision for children and adolescents is set aside in all these facilities. Many admissions to community-based inpatient Psychiatric Units and mental hospitals are involuntary, but there are no extant laws to regulate admission policies and protect patients' rights. Ninety-five per cent of psychiatrists in the surveyed areas, work only for government-administered mental health facilities, and five per cent work only for Non-Governmental Organisations (NGOs), for-profit mental health facilities and private practice. Though physicians are co-ordinators of the Primary Care Centres located within local government areas, such centres are run by non-physicians. Physicians in Public Health Centres (PHCs) can prescribe psychotropic medications without restrictions. Non-physicians working at primary care centres can sometimes attend to patients but only in emergencies.

Furthermore, family and patient associations focusing on mental health issues do not exist in the surveyed areas (and possibly in the entire country). The NGOs conduct surveys in areas not generally involved in individual activities, such as counselling, housing, or support groups. Furthermore, nobody is to oversee public education and co-ordinate or create awareness through campaigns on mental health challenges. There are no formal structures or provisions for interaction between primary healthcare staff and mental health providers. Also, reporting information on mental health is neither systematic nor formal.

Trauma-informed and mental health

To be “trauma-informed” is to understand how violence and victimisation are figured in people's lives, substance abuse, and other services. Applying this understanding in designing service systems and providing services to meet the needs of persons who have experienced trauma and facilitating client participation in treatment is crucial in mental health (Samsiah, Mohammed & Nurul, 2017). This shift in perspective and practise, implies a significant variation in how mental health patients are cared for by serving professionals and the policies of management and conduct of support staff. A trauma-informed method for care approaches trauma as a past event and an influential one that may

be causal to the client's current state or conditions. To be trauma-informed is to understand clients in a welcoming manner and their symptoms in the context of their life experiences and cultures, with an appreciation that some symptoms may represent efforts at coping.

Mental Health Consumer and Institutional Support

As documentation of the prevalence of early trauma accumulated, there were also concurrent and widespread calls for improvements in mental health care delivery by ex-patients and groups that represent them (e.g., National Coalition for Mental Health Recovery). Durate (2017) "The consumer/survivor/ex-patient displeasure with the obtainable mental health system is not a rejection of the need for help, but rather a disapproval of what is passing for help." The drive for the trauma-informed counselling pressure group was also boosted by the leadership of the Substance and Mental Health Services Administration (SAMHSA). SAMHSA, among other efforts, implemented a large-scale research programme on Women, Co-occurring Disorders and Violence Study (1998/2003) and supported the founding of the National Centre for Trauma-Informed Counselling and the National Child Traumatic Stress Network. Around the same time, the publication of Harris and Fallot's Using Trauma Theory to Design Service Systems clarified the conceptualisation of trauma-informed counselling and provided the needed vocabulary, rationale, and plan for implementing this type of counselling. During the same period, the final report of the President's New Freedom Commission on Mental Health called for a fundamental transformation in the country's approach to mental health care. It recommended that the Department of Health and Human Services (through the National Institutes of Health) embark on a sustained programme of research examining, in part, the consequences of trauma on the mental health of at-risk populations, such as children, women, and the victims of violent crime. The factors accumulating to trauma prevalence data, institutional leadership and improvement, clarification of conceptual frameworks, peoples' needs, demands and support led to an appreciation of the fundamental change in mental health delivery and trauma-informed therapy.

Efforts to Make Mental Health Settings More Trauma-Informed

Calls to make trauma assessments routine and to provide specialised trauma-related services in mental health settings have increased over the past decade, as has the groundswell of support for implementing trauma-informed treatment protocols. According to Kee, Ashina, and Hsin-ya Tang (2020), "Although childhood trauma experienced by individuals may be core to their condition and central to their healing, the treatment of adults within public health settings has seldom been addressed as a key factor." Demands for reducing or eliminating potentially traumatising or re-traumatising mental health practises have been heard for even longer, and in some cases, practical actions have been taken. In one instance, the drive to reduce the use of child and adolescent in-patient fetters and shelter (R/S) issued from findings that the rates of these practises in 1999 and 2000 were 56 times higher for children and adolescents than they were for adults in that state. This alarming statistic, growing national apprehension about such practices, and mounting knowledge of the trauma history rates among these youth prompted the development and performance of State-wide R/S (reduction strategy). Examination of comparable 3-month periods before and after the interventions revealed considerable reductions in total R/S episodes (per 1000 patient-days) and hours: episodes decreased by 65.9% in child units, 37.7% in adolescent units, and 67% in mixed (child and adolescent) units, with hours per episode decreasing by 31% for adolescents, 19% for children, and 16.7% for mixed units. Notably, and contrary to initial concerns, the use of involuntary medication decreased markedly, as did injuries to staff and patients. Findings have also been

reported in other mental health systems.

Theoretical Framework

Trauma Theory

Trauma Theory states that "traumatisation occurs when internal and external resources are inadequate to cope with an external threat" (Van der Kolk, 2014). The way we think, learn, feel, remember, and cope with the world is affected by traumatic experiences that fragment our brain by reducing the capacity for the right and left hemispheres to communicate and function together and inhibit brain development. Buffalo (2019) suggested that the American Psychiatric Association plans to introduce complex Trauma as Developmental Trauma Disorder in the next edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). The DSM-V is to capture childhood trauma and the symptoms experienced by individuals exposed to repeated trauma. The complexity of trauma involves vulnerability and risk, the nature of the stressor, the immediate responses, and post-trauma responses (Bloom & Harrison, 2011). Childhood trauma is more likely to produce long-lasting and more negative effects than adult trauma since the child's brain is still developing (Bloom & Harrison, 2011). However, the nature and severity of the trauma experience must be considered (Bloom & Harrison, 2011). Individuals exposed to trauma, especially chronic trauma, are likely to develop hyperarousal and a chronic condition of an acute fight or flight response due to unnaturally high levels of epinephrine, cortisol, and beta-endorphins (Bloom & Harrison, 2011). Trauma survivors often experience symptoms of PTSD, which result in activation of the alarm response, with symptoms representing hypervigilance versus appropriate prediction of future trauma and avoidance and re-enactment of trauma versus adaptation and survival (Bloom & Harrison, 2011).

All these actions were because humans have a unique capacity to experience emotional pain. Therefore, experiences can be traumatic to humans because they are emotionally painful or involve the threat of emotional pain. In other words, emotional and physical pain could produce considerable fear. In such cases, the negative outcome is related to the individual's psychological meaning of the event. An example of an event that might be traumatic because it is emotionally painful is sudden abandonment by a loved one. For example, if a woman comes home one day and finds that her spouse has left her without warning, the overwhelming feelings of helplessness and fear about surviving life emotionally would strongly react negatively to the event.

In some cases, the psychological pain of a traumatic event involves damage or threat of damage to an individual's psychic integrity or sense of self. An example of this type of adverse event would be an experience of sexual assault in which the victim did not expect to experience physical injury or pain. For example, a woman might be raped by a man on a date and be traumatised by the experience, even if she believed she was not in physical danger during the experience. In addition, such an experience might damage her sense of self-worth, because of the shame of being guilty over any responsibility she feels for what happened or anguish over her inability to protect herself from a very harmful and unwanted experience.

The essential emotional experience in events involving a threat to psychic integrity or sense of self is the feeling of not being able to protect one's self-image internally. In these events, the event's meaning gives it a negative valence.

Trauma-Informed Counselling (TIC)

Trauma-Informed Care (TIC) is informed service delivery. It is not designed to treat specific symptoms or symptoms of trauma, but rather to "provide services appropriate to the special needs of trauma survivors" (Harris & Fallot, 2011). According to Bloom and Harrison (2011), to halt the progression of maladaptive trauma response and counteract the effects of trauma. Service providers must recognise the fight or flight response. Also, hyperarousal of client minimises physiological hyperarousal and reduces physical and emotional stress threats. In addition, there should be an increase in safety and restore trust in the client. The principles of TIC include understanding trauma and its impact, promoting safety, ensuring cultural competence, supporting consumer control, choice, and autonomy, sharing power and governance, integrating care, allowing relationships that promote healing, and believing that recovery is possible. There are five requirements for creating a trauma-informed system: administrative commitment to change and a universal screening tool throughout the organisation. Training and education for all organisation staff about trauma and its long-lasting effects, adopting hiring practises that favour employees who are sensitive to probable trauma history of the clientele. There should be a review of policies and procedures to ensure that they are designed actively to avoid unintentional re-traumatisation of individuals (Harris & Fallot, 2011). According to the National Center on Family Homelessness (2011), a trauma-informed environment views symptoms and problems as part of coping mechanisms to deal with trauma. As a result, consumers have elegantly created adaptations to ensure their needs are met.

The Daily Work of Counsellors and the Counselling Profession

Regardless of the setting, counsellors are likely to encounter a client in crisis (Durate, 2017). Most clients in a crisis state experience acute interpersonal problems in their social environment, chronic mental challenges, or a combination (Choundhury, 2020). More often, counsel encounters a client experiencing a combination of the two, a divorcee battling chronic depression or a trauma survivor battling addiction. In addition, counsellors working in agencies are likely to encounter clients living with chronic mental illness who may have a primary psychiatric diagnosis and other situational factors such as homelessness and poor social support.

Psychological First Aid (PFA)

Psychological First Aid has become the essential approach clinicians use when responding to crises such as trauma. This approach is similar to Maslow's hierarchy of needs, in which physical needs and safety are addressed before emotional stabilisation. The nature of the time-sensitive crisis work approach is not meant to be curative. Instead, it is meant to relieve the challenge faced until further action can be taken. PFA is a non-intrusive method that offers practical assistance and stabilisation. PFA is not meant to serve as a theory or intervention model. It is instead the basics of intervention for trauma. Although PFA is presented step-by-step, crises are chaotic and often do not occur in a linear format (James, 2018). Assessment is a continuous and ongoing process when working with a trauma client.

The first three steps of PFA are focused on observing, attending and understanding the client's problem (James, 2018). In the first step, counsellors use their core listening skills to define and understand the problem from the client's perspective. In the next step, counsellors assess the client's safety and work to minimise physical and psychological dangers. The third step involves providing emotional, instrumental, or informational support. The type of support depends on the client's needs, however, this is when the counsellor shows the client that they are valued and supported. The final

three steps of PFA are focused on taking action. In the fourth step, the counsellor and client examine appropriate choices available to the client. The amount of input from the client depends on his or her level of distress. The counsellor and client should examine social supports, coping mechanisms, or behaviours the client can engage in to get through the crisis and positive and constructive thinking patterns to help reduce stress and anxiety. The fifth step in PFA involves making plans. The counsellor and client identify additional people and referral sources that can be contacted for immediate support and develop concrete actions the client can do at the moment. This step is central to the client's self-help and rescue management. The final step involves obtaining a commitment from the client. This step is straight to the point, and the objective is to have the client entrust to one or more behaviour(s) that will assist in restoring them to their pre-crisis condition.

Counsellor Self-Care

Trauma-informed counselling is challenging work, and counsellor self-care is an important and essential aspect of Myer (1992) (Tamuno-Opubo, Edeh, Adeniyi, & Edisemi, (2021). When working with people who have gone through intense psychic trauma or with clients in crisis, counsellors are also at risk of experiencing Vicarious Traumatisation (VT) or stress resulting from working with clients who have been traumatised or are suffering (Levers, 2012). Counsellors may be at risk of experiencing symptoms similar to their clients. One way to mitigate the chances of experiencing VT is to seek out supportive and regular supervision (Olusolami, Abiodun, Agatha & Angela, 2020). Experiences in supervision often reflect experiences in the counselling relationship, and ongoing supervision may assist practitioners in recognising when they may be experiencing symptoms of Vicarious Traumatisation.

Counsellors must take the time to promote their emotional, mental, physical, and spiritual well-being. Self-care is a time for reflection, healing, and growth. Without it, the effectiveness of crisis and trauma work may be diminished. Counsellors cannot effectively assist clients without attending to their own emotional needs. When they engage in self-care, they can remain present and fully attend to the client's needs. Counsellors' self-care can also assist clients in developing resiliency. While crises and trauma can be painful experiences for both the counsellor and the client, working through them provides an opportunity for the traumatised persons to recognise their strength and ability for growth.

Implications for Professional Counselling

In the light of the preceding, trauma-informed counselling is not only prevalent in Nigeria but the risk factors and consequences are also empirically evident. The following are, therefore, implications for counselling practice in Nigeria:

1. This paper provides counsellors with information that can help create awareness for everyone they find around them.
2. The paper also reveals an area in which counsellors can harness their capacity-trauma counselling. This will assist counsellors in providing the proper intervention for trauma victims. This can be achieved by ensuring that the trainee-counsellor curriculum in universities covers such sensitive issues.
3. This study helps to see the need for family health and school counsellors to train adolescents within their field of influence on how to be assertive.

Conclusion

To be trauma-informed is to understand the connection and impact of violence and victimisation in the lives of most clients of mental health, substance abuse, and other services. It is also to apply that understanding in designing service systems and providing services to help trauma survivors' requirements and vulnerabilities and facilitate their participation in treatment. This shift in perspective and practise, implies essential changes in mental health settings and providing care, particularly in recognising that symptoms may reflect coping efforts and the potential for inadvertent client traumatisation in practise settings. Trauma-informed counselling is not a treatment per se; it is an approach that starts with the premise that practitioners do no (more) harm and proceeds with sensitivity to the specific issues that arise in the context of trauma and broader client-centred principles of practice. Some have described the trauma-informed perspective as a paradigm shift. This perspective represents a change in the framework for understanding clients and the context of their presenting complaints. Given the prevalence of traumatic experiences, especially those endured during development, and their longstanding effects on clients' lives, the trauma-informed perspective offers a compelling and humane organising principle for conceptualising and addressing many of the problems and challenges facing those seeking mental health and other services.

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