Trauma-Informed Supervision

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Clinical Supervision

• Signature pedagogical method of the mental health fields
  – Roots in psychoanalytic training methods
  – Strongly emphasized by Professional Counselors & Counseling Psychology

• Supervisor Roles
  – Normative
  – Formative
  – Restorative
Supervision Needs

- Formative: concerns psychoeducation and the development of skills
- Normative: “quality control” – monitoring the practice of a clinician/mental health professional
- Restorative: the support element of supervision
Restorative Needs of Supervisees

- Providing social and mental health services requires **emotional labor**
  - Requires providers take a particular social & emotional stance with clients
  - Literally adopt a certain physical posture, facial expressions and verbal tone
  - In most social services this includes the provider intellectually and emotionally experience the world through the clients subjectivity – empathy
  - Supervisees need a space to process, make sense and develop coping strategies for the work
Risks of Emotional Labor

• Burnout
  – Depersonalization/detachment
  – Emotional exhaustion
  – Decreased sense of personal accomplishment

• Vicarious trauma
  – PTSD-like symptoms
  – Disrupted schemas

• Re-triggering of prior trauma exposure
Burnout
Definitions

Maslach and Jackson (1981) define burnout as

- a syndrome characterized by slow onset emotional exhaustion, depersonalization, and reduced feelings of accomplishment that affects individuals in the helping professions

- A prolonged response to chronic emotional and interpersonal stressors on the job which consists of three components:
  - Exhaustion- a form of "energy depletion".
  - depersonalization (defined as : disengagement or detachment from the world around you)
  - diminished feelings of self-efficacy in the workplace.
What does emotional exhaustion look like or sound like to supervisors? My supervisee...

- Has mentioned changing careers
- Seems depressed
- Seems drained and fatigued
- Seems frustrated by his job
- Seems to be at the end of her rope
How does burnout happen?

- Therapists take on too much
- Feeling unappreciated
- Feeling helpless to change things
Some signs of burnout include...

- Losing interest and meaning in your work
- Distancing from others
- Increasing irritability
- Reduced productivity
- Feeling trapped and unable to do anything about it
- Cynicism, fatigue, feeling drained
- Feeling “oppressed” by the system at work
Taking steps to prevent burnout is the best way to avoid it

- Practice good stress management on a daily basis
- Know the warning signs for burnout
- Have management strategies in place should warning signs appear
Vicarious Traumatization
Burnout vs. VT

• Burnout is the cumulative effect of work stress
  – It does no include specific symptoms of VT as will be described
  – It is not, necessarily, a byproduct of working with traumatized clients
  – Burnout can happen to any type of human services worker
  – VT is exclusive to those who work with clients with trauma histories
  – VT is often viewed as a more severe and specific extension of burnout
Vicarious Traumatization

• VT – McCann & Pearlman
  – Infection metaphor
  – Emotional labor is the most basic level of risk
  – VT is more severe than general effects of emotional labor alone or burnout and occurs in cases where the client has experienced trauma and is sharing that experience with the provider, with which the provider is empathizing
  – Interaction with providers personal trauma history
Vicarious Traumatization

• “transformation in the inner experience of the therapist that comes about as a result of empathic engagement with the clients’ trauma material” (Saakvitne, 2002, pg. 31)

• May be similar to symptoms of PTSD, with extreme fear, withdrawal, and disturbed feelings of security (Pross, 2006)
  – Schema alteration (Dill, 2007)
Vicarious Traumatization Symptoms

- Emotional distancing
- Reduced empathy
- Intellectualizing
- Or...overidentification & mutual dependence
- Social isolation
- Denial of client’s trauma
- Hypervigilance
- Avoidance of cues
Vicarious Trauma Can Affect Our Job Performance

- Increased staff conflict
- Poor communication
- Avoidance of working with traumatized clients/job responsibilities
- Worried about not doing enough
- Over-involved in details/perfectionism
- Low motivation

- Increased errors/decrease in quality of work
- Feeling trapped
- ↓ feelings of satisfaction and personal accomplishment
- Hopelessness associated with work/clients
- Numbness to clients’ trauma stories
Personality Factors

• Risk factors:
  – Reservation and nervousness in social interaction
  – Therapist’s own personal history
  – Self-sacrificing defense style
    • May employ such techniques as rescue attempts, boundary violations, or controlling behaviors
  – Years of experience
  – Gender
    • Several studies have highlighted females as more susceptible (Edwards et al, 2006)
    • But, in the context of therapy for sexual offenders, male therapists may overidentify with offenders and may thus feel a high level of guilt or shame (Moulden & Firestone, 2007)
Personality Factors

• Protective factors:
  – Personal support system
  – Access supervision and maintain self-care
  – Education/training in the poverty cycle, recidivism rates, abuse and maltreatment statistics, and case studies can provide people with concrete evidence that organizational and societal responsibility play critical roles.
  – Strong trauma stewardship (Lipsky and Burk, 2009)
    • “caring for, tending to, and responsibly guiding other beings who are struggling, but at the same time, not internalizing others’ struggles or assume them as our own”
Organizational Contributions to VT

- Large caseloads
- High % of clients with trauma/PTSD
- Lack of clinical/personal support at work
- Insufficient supervision
- Absence of peer support and supervision
- Few resources to refer clients for additional services
- Professional isolation
- Cultural clash between clients and agency
- Lack of work resources to complete a job
Helpers At-Risk for Vicarious Trauma

• Routes to VT
  – Client
    • Clients are not toxic, rather the work provides fertile ground for parallel process
  – Environment
    • Service settings where provider safety cannot be guaranteed
  – Population
    • Nature of population can lead to chronic exposure to vicarious trauma, e.g. child welfare, war veterans, mass tragedy, etc.
Helpers At-Risk for Vicarious Trauma

• Individual risk factors for VT
  – New therapists and those new to working with trauma
  – Those with a personal trauma history
    • Exhaustion, compassion fatigue and over-identification
  – Helpers with immature or maladaptive coping styles
    • Emotional distancing, cynicism, depersonalization, emotional numbing, callousness, objectification of clients, self-sacrificing
    • Active coping, humor, seek emotional support, planning = lower VT
  – Those with shy/withdrawn & neurotic personality traits
  – Interaction of gender and work context
Helpers At-Risk for Vicarious Trauma

- Environmental risk factors
  - Environmental safety
  - High VT exposure
  - Lack of job resources
    - Job strain – imbalance between job control and demands
      - Job demands high VT exposure but insufficient resources
        employees experience disempowerment and distress
      - Key job resource – trauma-specific training and trauma-informed supervision
Mitigating VT

• Batson and colleagues observed that providers who think about how “they” would feel in the client’s shoes vs. those who think about how “the client” feels are at higher risk for VT.
  – Focusing on the client’s experience promotes compassion
  – Focusing on how we would feel in their shoes promotes VT

• Supervision & VT
  – Target supervisee growth in the specific area of coping with working with trauma clients
  – Means placing focus on the provider occasionally
  – Encouraging or mandating counselor seek own treatment
Trauma-Informed Supervision
But even with the need for trauma informed supervision, Sexton (1999) found that only 53 percent of trauma therapists received any form of trauma related supervision.
Rationale for Trauma-Informed Supervision

• Increasing demand to practice in a specialized manner
• Increasing demand to practice in an evidence-based and accountable manner
• Human services in general requires emotional labor which creates unique strains
• Increasing recognition of need for trauma-focused services
• Human services work with traumatized clients poses risks of vicarious trauma
• Need for supervisors that are
  – Versed in principles of trauma intervention
  – Skilled in shaping both supervisees technical skills in responding to trauma as well as self-care skills
Trauma Interventions

• Increasing emphasis on development of trauma-specific models of intervention
  – Therapies
    • Trauma-Focused Cognitive Behavioral Treatment
    • Integrative Treatment of Complex Trauma (John Briere)
  – Systemic strategies
    • Trauma Informed Care

• Training in such approaches may or may not include skills at managing the emotional labor & vicarious trauma inherent in the work
Supervision Competencies

• Training in clinical supervision
  – Most masters level human services professionals have no formal coursework in supervision.
  – In Alabama LPC’s have to demonstrate advanced education in supervision to be come supervising counselors
  – Almost no attention given to the specific issue of supervising trauma work
Specialized Supervision

• As accountability movement in health and social services continues to gain steam, evidence-based practice demands are shaping supervision practice.

• Supervisors increasingly required to be specialized themselves.
  – e.g. - addictions providers needs supervisors with addictions counseling competencies as well as general supervision competencies.
Research Support for the Need for TiS

• Trauma experiences are relatively common in both client and helper populations *(Meuser et al., 2004; Pearlman & Maclan, 1995)*

• Clients with trauma exposure at higher risk of receiving iatrogenic care *(McCarthy, 1997)*

• Helpers working with trauma at risk for VT *(Pearlman & Maclan, 1995)*

• Supervision in this context meets 2 basic functions
  – Enhance client care
  – Assist helpers with managing their emotional labor
Trauma in Client Populations

• Meuser et al. (1998, 2004)
  – 90% of population served in mental health system have trauma exposure, & most experiencing multiple events

• Lipshitz et al. (1999)
  – Adolescent inpatient unit – 93% had trauma history, 32% met criteria for PTSD

• Triffleman et al. (1995)
  – 77% of male veterans in inpatient substance abuse treatment report severe childhood trauma
Trauma in General Populations

• Adverse Childhood Experiences study
  – Study of those seeking weight loss
  – Successful patients dropping out of program
  – Common feature of dropouts was history of childhood trauma (Stevens, 2012)
  – Catalyst for the ACE Study (CDC, 2012)
    • 17,000 patients, mostly white, college-educated
    • Childhood trauma exposure rate of 63.9%
    • Later studies found similar rates of 60% of children witnessed one or more victimizations in past year (Finkelhor et al., 2009)

• Human services workers will encounter trauma
Traumatized Helpers

- Evidence those entering helping professions have elevated levels of trauma exposure.
- Higher percentage of sexual abuse survivors among therapists (Elliot & Guy, 1993; Follette, Polusny, & Milbeck, 1994; Schauben & Frazier, 1995).
  - Pearlman & Maclan (1995) 60% of helpers had personal trauma history
    - However comparable to general population rate of 63% in ACE Study
- Must manage both their personal trauma history and make meaning of personal and various trauma AND aid client in recovering from their trauma exposure.
A Model of Trauma-Informed Supervision

• TIS Core Competencies
  – General supervisory competence
    • Knowledge of...
      – services they are supervising
      – supervision models, methods and research
      – models of supervisee development
      – evaluation & feedback methods
      – cultural diversity and its impact on supervisee performance and behaviors
      – Contextual knowledge about supervision practice
  • Skills
    – Supervision techniques
    – Supervisory alliance skills
    – Managing multiple roles
    – Providing formative and summative feedback
Trauma-Specific Knowledge

• Can be a good general supervisor, but not a competent Trauma-Informed supervisor
• How trauma effects development and human functioning
• Needs of traumatized populations
• Nature and process of retraumatization
• Trauma-specific services
TIS Core Activities

• Overcome stigma of addressing personal factors among supervisees
• Assessing helper’s risk for VT symptoms
• Identifying VT risk factors
• Identifying VT symptoms in supervisees
• Provide trauma education
• Provide administrative and ethical guidance
• Provision of supportive atmosphere to process reactions to trauma work
• Advocacy
  – Organizational processes and policies, professional development and employee benefits, increased social support on the job
Supervisory Role

• **Strong supervisory alliance**
  - Being able to open up about intense emotions that may arise

• **It is important for supervisors to be mindful of the signs of vicarious traumatization in supervisees.**
  - First sign – emotional dysregulation (Azar, 2000)
    • The supervisee may become combative or overly obliging with the supervisor, avoid taking responsibility for a problem, or begin to come late to arranged meetings.
  - Hesitancy to discuss details of a case
  - Overidentification with clients (Etherington, 2000)
Organizational/Structural Role

• Therapists’ relationships with their supervisors have implications for the extent to which they perceive that the organization is fair and just (Knudsen, Ducharme, and Roman, 2008)

• Agencies
  – Reduce or balance caseloads
  – Offer additional supervision/personal therapy for mental health professionals and supervisors
  – Encourage self-care, like vacation and sick leave
Vignette

• Take the following vignette regarding VT
• Break up into small groups and outline a plan for supervision action to
  – Ensure effective provision of service to the client
  – Ensure effective amelioration of VT reactions of the provider
  – Take into account the TIS principles which include advocate for the provider at the organizational level.
Ethics & TiS

• Client welfare
• Providers experiencing VT, burnout are less competent
• Use of harmful practices: The use of interventions that are not trauma-sensitive can be iatrogenic
• Advocacy
  – Need to advocate at the systemic level for reforms that reduce incident of VT and promote intervention with VT
• Supervision competence
Trauma work requires trauma informed supervisors who understand traumatology, have general supervision competencies and specific trauma supervision competencies that center on shaping effective trauma treatment techniques and assessing and intervening with provider vicarious trauma.
Self-Care
Self-Care Skills for Therapists

- Increase self-awareness of possible vicarious traumatization
- Encourage help-seeking
- Normalize clinical experience
- Engage in self-care skills and self-soothing activities
- Engage social supports
- Mobilize organizational supports to prevent and address vicarious traumatization
Supervisors should . . .

• Be proactive in recognizing and accepting vicarious traumatization and job-related stressors.

• Monitor caseload

• Promote education and training about vicarious trauma burnout

• Educate about boundary issues between clients and helpers in order to reduce this source of stress.

• Provide education about stress inoculation
Care for Caregivers

• Supervisors oversee a broad range of clients
  – Thus high exposure to traumatic details
  – Administrative demands – discussing potential suicide risks, child abuse, neglect, and maltreatment cases, and assigning difficult cases to supervisees who may already feel overburdened

• Silver, Poulin, and Manning (1997) found that supervisors had lower rates of job satisfaction when compared to their front-line counterparts
  – Due to extensive exposure to a stressful work environment and more years in the field

• Self-care/boundaries
  – Good sleep hygiene, physical wellness, promoting self-awareness, and fostering close relationships

• Using humor as a way of combatting stress
• Seeking personal therapy or supervision may also be necessary
Vignette

• Take the following vignette regarding VT

• Outline a plan for supervision action to:
  – Ensure effective provision of service to the client
  – Ensure effective amelioration of VT reactions of the provider
  – Take into account the TIS principles which include advocating for the provider at the organizational level
A female worker, Jane, has been with your agency for 10 months and began work on a family preservation case about 3 months ago. The case involves a 15 year old female with severe Type 1 Diabetes who lives with her mother. Though it was never reported, the mother reports that Father is not involved because the child reported to mother details indicating that Father was molesting her when she was 3. Mother filed for a divorce and the father has expressed no interest in parenting responsibilities, often including missing child support payments. Mother doubts that the child now remembers the sexual abuse by her father. Mother reports feeling overwhelmed regarding parenting the child on her own, that she doesn’t listen or follow medical advice. The child has been in and out of the ER multiple times due to dangerous and dramatic swings in her blood sugar. When a hospital social worker heard the child’s reports that mother was often gone for days at a time at casinos, leaving little food in the house, and sometimes returning drunk, the social worker reported these items to the child abuse hotline.

Jane seems like an ideal match for this case. She is young, energetic, and has been successfully managing Type 1 diabetes since childhood as well, making her more knowledgeable about juvenile diabetes than most of the other staff. Because it is a family preservation case, Jane has been going to the home once a week. The child has reported that she and her mother get into arguments regarding food, insulin, and medical orders, sometimes leading to both being violent with each other. She has been staying longer than you would expect for other family preservation case home visits. The worker explains that she feels this time has been helpful, as the family has been able to successfully comply with the family safety plan regarding no violence toward one another.

Two weeks ago, Jane’s pager went off due to emergency. Her 15 year old diabetic client had called her in an emergency, reporting that she was scared because her mother wasn’t home and her blood sugar felt “funny”. She reported blurring vision. Jane counseled her to call 911 for help, but unsure if she would be coherent to do this, she also went to the home. When Jane arrived at the home, the child was unconscious. The worker dialed 911 and the child has since become medically stable but is remaining hospitalized due to a dangerous infection in her left toe that may require partial amputation. Since this event, you notice that Jane contributes markedly less in group staffing. She seems less efficient in her work in general. Her family support worker reports that she seems distant, not her usual bubbly, talkative self and that the two rarely discuss the details of their cases anymore unless it is a minimum task requirement. She seems jumpy, less motivated, and her comments are consistently more negative than before. Her paperwork has been late over the last 2 weeks as well, though not to the point of negatively impacting her cases. Her home visits with other clients have also grown shorter.
• What personal, client, and agency factors do you see as salient to this worker’s current status?

• If you were her supervisor, what would you do?

• What factors of the worker’s case seem similar to what you would expect from others in her job position?

• What organizational changes might you advocate for, as the supervisor, to assist with this staff and other staff’s similar difficulties?
Thank you!

Any additional questions or comments should be addressed to Dr. James “Tres” Stefurak – jstefurak@southalabama.edu