

Traumatology: An International Journal

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Online First Publication, June 16, 2014. <http://dx.doi.org/10.1037/h0099835>

CITATION

Berger, R., & Quiros, L. (2014, June 16). Supervision for Trauma-Informed Practice. *Traumatology: An International Journal*. Advance online publication.

<http://dx.doi.org/10.1037/h0099835>

Supervision for Trauma-Informed Practice

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To become trauma-informed, a system of care must demonstrate an understanding of the complexity of trauma and recognition of it as both interpersonal and sociopolitical. Although awareness of the need to enhance systems of care to become trauma-informed has been growing in recent years, even when trauma is not the main focus of service, training of all professional, administrative, and secretarial staff is essential to transform an agency to become trauma-informed. One vehicle for training the professional staff is supervision designed to enhance the knowledge and skills of practitioners who provide services to clients who have experience trauma. This article discusses how the principles and strategies of supervision can be adapted and applied to foster the professional and personal growth of practitioners and enhance their mastery of trauma-informed care. Supervision of trauma-informed care shares with other types of supervision the major components of educational, support, and administrative guidance and oversight. However, because constant interaction with traumatized clients may have negative effects on practitioners, some elements of trauma-informed practice supervision require special attention. The article has 3 parts. First, we discuss the goals, nature, and educational, supportive, and administrative functions of supervision in the healing professions. We then review basic assumptions of trauma-informed practice, specifically, safety, trustworthiness, choice, collaboration, and empowerment. Third, we identify personal and agency-related challenges and risks to practitioners in learning and executing trauma work and analyze the protective function of supervision in addressing these challenges. We present principles for effective supervision that enhance the ability of practitioners to provide trauma-informed services and decrease their risks for vicarious traumatization (i.e., trauma reactions caused by interaction with those directly exposed to traumatic events). Finally, we describe an illustrative case example and suggest directions for future research.

Keywords: trauma-informed practice, supervision, mental health, healing professions, vicarious traumatization

Awareness of the need to enhance systems of care to become more trauma-informed, even when trauma is not the main focus of service, has been growing in recent years (Quiros & Berger, 2013). A critical condition for developing a trauma-informed system of care (i.e., agencies and other care providing setting) is that all staff members, including professionals, secretaries, and administrators, have a comprehensive understanding of the effects and complexity of trauma, its potential behavioral manifestations, and principles for addressing the needs of traumatized clients (Jennings, 2004). Thus, training is essential in the process of transforming an agency to become trauma-informed.

To become trauma-informed, a system of care must demonstrate understanding and recognition of trauma as both interpersonal *and* sociopolitical. Efforts to articulate the meaning of trauma-“informedness” on a direct practice level vary in their breadth and focus. For example, Levers, Ventura, and Bledsoe (2012) have stated that “Providing adequate information about the pervasiveness of the psychological and neurological effects of trauma to

program staff is essential if employees are expected to begin to conceptualize the range of possible responses by their clients to activating stimuli” (p. 495). Others (Quiros & Berger, 2013) have offered a definition that includes the sociopolitical complexity of trauma, an aspect that broadens the scope of trauma practice. This complexity includes awareness of the intersectionality of race, class, and gender, and underscores that consideration of such is essential for the creation of systems of care that are truly trauma-informed. Finally, a system of care that is trauma-informed is aligned with the mission of social justice, in that structural and environmental conditions are considered when assessing trauma, and therefore failure to effectively adopt trauma-informed care as an integral aspect of the culture and practice of the service-providing setting may potentially put service programs out of synch with professional commitment to social justice of social workers, counselors, psychologists, and other helping practitioners.

Diverse vehicles serve to bring about the relevant transformation of systems of care, including lectures, seminars, training, and group and individual supervision. For our purposes, we have focused on supervision as a crucial means in helping program staff comprehend and work with the complexity of trauma and its after effects.

Supervision has traditionally been considered a central component of professional practice (Joubert, Hocking, & Hampson, 2013) and as the method of choice for helping novice in healing

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professions acquire the knowledge and skills necessary for effective and high level professional performance (Kadushin & Harkness, 2002; Shulman, 2010). While no systematic evidence to support it could be identified, anecdotal reports from students and supervisors suggests that in recent years, driven by pressure from managed care, as many agencies are struggling to minimize time allocated to activities that do not generate revenues, supervision has been compromised and became to be seen as a luxury rather than a necessity for maintaining high standards of service.

The current article discusses how the principles and strategies of supervision can be adapted and applied to foster the professional and personal growth of supervisees and enhance their mastery of trauma informed practice. To this end the article includes three parts. First, supervision in the helping professions is discussed; second, challenges and issues relative to trauma informed practice are reviewed; finally, strategies for the use of supervision to enhance the competence of practitioners in providing trauma informed services are discussed and illustrated by means of a case example.

Supervision in Helping Professions

Supervision has long been used in healing disciplines as a main channel through which knowledge, values, and skills are transmitted from experienced practitioners to students and beginning practitioners (Kadushin & Harkness, 2002; Shulman, 2010). Ideally, supervision is a reflective process that provides a physical and emotional safe space and opportunity to examine the clinical work of the practitioner with the goals to enhance personal and professional growth, shape competence, and promote a high level of services (Bledsoe, 2012; C. S. Cohen, 2004). To this end, supervision offers practitioners the chance to debrief and explore alternative perspectives and to reach a conclusion on the best line of action in particular client situations (Joubert et al., 2013). Parallel to practice, to allow such debriefing and exploration, the supervisory relationship must become a safe space where supervisees feel they can freely speak their minds and do so in a trusting environment (Miller, 2001). Typically, the supervisor, who is a senior professional, guides, offers feedback, models, oversees, coaches, and evaluates the process through which the less experienced or novice practitioner acquires the necessary knowledge and skills and evaluates the latter's performance within a physically and emotionally safe space where ethical and professional boundaries are maintained (Quiros, Kay, & Montijo, 2013).

The importance of supervision as a way to enhance practitioners' expertise has been recognized by licensing bodies such as the National Association of Social Workers (NASW), the American Mental Health Counselors Association (2010), and the American Psychological Association (2010), which require supervision to be routinely available for practitioners. For example, social workers are expected to be routinely supervised during the first 5 years of their professional experience and on an "as-needed, self-determined basis" afterward (NASW Standards, 2008); similar expectations exist in other human service professions. Supervision's crucial role in enhancing practitioners' ability to reflect critically, learn, and evaluate their levels of stress has been supported by research (Joubert et al., 2013).

The supervisory role includes three types of functions—educational, supportive, and administrative. The educational function

focuses on teaching the supervisee about relevant population groups (e.g., children with special needs and their families, cancer patients), challenges typical of the specific setting and context (e.g., hospital, school, mental health clinic), models of practice and strategies for intervention (e.g., solution focused, cognitive-behavioral), and the linking to theoretical frameworks. The supportive aspect of supervision refers to the provision of emotional support to help the supervisee cope with work-related challenges and stresses, identify personal issues that may impede the ability to provide effective services to clients and offer strategies for addressing them. The administrative function includes advising the supervisee about agency's policies and monitoring her or his adherence to them, delegating assignments, and evaluating practitioners' performance (Hopkins & Austin, 2004; Kadushin & Harkness, 2002; Shulman, 2010).

Effective supervision to enhance mastery of practitioners is provided either individually or in group and is informed by diverse models. For example, Kitchiner, Phillips, Roberts, and Bisson (2007) used a brief training supervision with a group of mental health professionals in trauma focused cognitive-behavioral therapy as a strategy to overcome the scarcity of well prepared trauma informed practitioners. Evaluations demonstrated a significant decrease in trauma related symptoms in clients served by the trainees supporting the potential of a group clinical supervision model to offer a cost-effective strategy for preparing service providers for trauma-informed practice.

Trauma-Informed Practice

Trauma-informed practice has both individual and organizational aspects. Its basic assumptions are safety, trustworthiness, choice, collaboration, and empowerment (Quiros & Berger, 2013; Harris & Fallot, 2001). As noted throughout the trauma literature, physical and emotional safety are the foundation for all therapeutic work (Najavits, 2002). This means creating a physical environment that generates a sense of safety including the minutest details, such as type of furniture and the office location. The environment must not only *be* safe but also *feel* safe. Achieving safety requires providing adequate information about the pervasiveness of the psychological and neurological effects of trauma, and about the extent to which practices and settings ensure and reinforce the physical and emotional safety of consumers.

According to Harris & Fallot (2001), trustworthiness, that is, maintaining clear and appropriate boundaries, honoring confidentiality policies, clarity, consistency, and predictability are keys to creating a trauma-informed system of care. On a direct practice level, contracting with clients around issues of confidentiality in the beginning of individual or group sessions is one way of creating trustworthiness. However, appropriate boundaries, clarity, and consistency vary by culture; thus gestures, language, and actions that promote trustworthiness in one culture may achieve the opposite reaction in another. Hence, it is important that the agency provide training in cultural awareness, and use individuals who are informed about the norms of clients' culture of origin to advise on the type of conditions that enhance trustworthiness in that particular culture.

A trauma-informed environment also values choice, that is, consumers are to have some control over and independence of preference relative to their recovery and be offered an array of

services. For example, in one residential substance abuse treatment facility, group members participating in a 12-week group cycle were given a choice about the order of topics. The degree to which the availability of choice is helpful depends on the specific individual and circumstances. For some, especially women from traditionally male-dominant cultural backgrounds, the need to make choices may become an additional stressor.

The principle of collaboration means sharing of power, allowing clients to play an active role in their treatment, and having providers acknowledge the expertise that clients bring to the treatment process. This means building a helping relationship where the worker's knowledge and wisdom are not privileged over those of the client. Rather, alternative strategies, in which the skills and knowledge of both the professional and client can be heard, become paramount. Each learns from the other's experience and multiple realities are honored (Daniel & Quiros, 2010).

Finally, Harris & Fallo (2001) has discussed empowerment as maximizing consumer skill building and allowing clients to be involved in the planning, operating, and evaluating of services. This can take the form of providing clients with resources, building on their strengths, and engaging them in interventions that ensure their voices are heard and taken seriously. For example, including clients in the process of deciding group topics, having clients name their experiences instead of subjecting them to naming that is controlled by an institution, testimony to the trauma (to the degree that proving this testimony does not put the client in a position of feeling shame and guilt, e.g., for being raped and thus no longer pure), and moving beyond the diagnosis to name their experiences. For instance, Kacen (2002) invited battered women to title their life story, thus making them active participants in constructing the realities of their life affected by traumatic exposure. In a similar fashion, Craine Berth (2012), who conducted a qualitative study of recurrent episodes of homelessness in single mothers, involved interviewees as coresearchers in analyzing their own narratives. Ultimately, the helping relationship fosters a partnership among the women seeking services and the service providers.

Principles of Supervision for Trauma-Informed Practice

Specific challenges and risks to practitioners in learning and executing trauma work (or trauma-informed practice) may include personal attitudes and resistance as well as agency mission and absence of appropriate policies and resources. With a few exceptions (Ben-Porat & Itzhaky, 2011; Kassam-Adams, 1995; Wood, 2011), theoretical and empirical literature has argued that supervision is a critical strategy in helping practitioners to address such challenges and to prevent, mitigate, and heal vicarious trauma (Bell, Kulkarni, & Dalton, 2003; M. Cohen & Gaglin, 2005; Pulido, 2007; Sexton, 1999). Ongoing supervision has been recognized as a major protective factor because it can serve as a buffer against vicarious trauma, that is, trauma reactions triggered in clinicians as a result of working with traumatized clients (Yassen, 1995), which suggests that in trauma practice supervision should be mandatory rather than "on an as-needed basis." Trauma-informed supervision combines knowledge about trauma and supervision, and focuses on the characteristics of the interrelationship between the trauma, the practitioner, the helping relationship, and the context in which the work is offered (Etherington, 2009).

Compatible with the functions of supervision identified above, supervision for trauma-informed practice may include transferring theoretical, empirical evidence and clinical knowledge through teaching, training, and overseeing clinical judgments (educational function); assessing supervisees' vulnerabilities and resilience relative to trauma content based on their own experiences; helping them address job-related stress and challenges, and exercise self-care (supportive function) and delegation of a balanced trauma-related caseload; and guiding the implementation of agency's trauma policy (administrative function).

Parallel to the principles that guide trauma-informed direct practice, safety, trustworthiness, choice, collaboration, and empowerment should be exercised in supervision for trauma-informed practice. Safety begins with an assessment of the environment and self-assessment of the supervisor. Because the environment needs to feel safe at all levels, office décor, physical set up, and sitting arrangements within the space where supervision takes place as well as the procedures involved (i.e., consistent times and days for supervision) should be a preparatory function of supervision. Environments that reflect acceptance and predictability in scheduling contribute to supervisees' feeling comfortable to share work-related challenges and stresses and to identify personal issues that may impede the ability to provide effective services. Specifically, a strong supervisory working alliance plays a critical role in creating a space that feels physically and emotionally safe, and enhances trust and communication. When supervisees experience a stronger working alliance with their primary supervisors and feel safe enough to share trauma-related reactions and receive feedback, vulnerability to vicarious traumatization decreases and, consequently, the quality of services to clients is anticipated to improve (Bober & Regehr, 2006; Bordin, 1983; Hunter & Schofield, 2006; Pearlman & Mac Ian, 1995; Shulman, 2010; Toren, 2008; Tsui, 2005). Consistent with the principles of trauma-informed practice, this relationship must be built on trust, which is based on the supervisor establishing clear boundaries and expectations, listening without judgment, assisting supervisees with reflecting on their practice, giving feedback about their performance in a noncritical fashion, and remaining present (Quiros et al., 2013).

Choice is the third hallmark of trauma-informed supervision. It includes allowing the supervisee to play an active role in the type of intervention used. Choice coincides with collaboration as the supervisor works with the supervisee to choose the best possible intervention. This is a mutual relationship in which the knowledge and wisdom of the supervisor are not privileged over that of the supervisee. Rather, alternative strategies, in which the skills and knowledge of both professionals can be shared, become paramount. Each learns from the other's experience and multiple realities are honored (Daniel & Quiros, 2010).

Finally, empowerment includes providing learning opportunities so that supervisees can practice skills on their own, while being monitored. Supervisees may also feel empowered by validation and consistent feedback not only on challenges but on successes as well. For example, in one agency, supervisees were told to come to supervision with a list of successes, in addition to challenges.

It has been documented that supportive supervision is a predictor of lower levels of vicarious trauma in workers who served survivors of family violence (Choi, 2009). To enhance the sup-

portive nature of supervision in the context of trauma work, it has been recommended that, if possible, supervision and evaluation be separate because concerns of negative evaluations may prevent practitioners from revealing responses that may be indicative of vicarious trauma. Because supervisees are in vulnerable positions, creating safety in this helping relationship is key to facilitating changes in practice behaviors.

Within this relational context, the focus of supervision for trauma practice is twofold. Supervisees' performance in trauma work is monitored through the lenses of worker's stress reactions that puts clients at risk while manifestations of compassion fatigue or vicarious traumatization puts practitioners at risk. However, the two are connected, as stated by Hesse (2002):

For therapists, organizations, and institutions, the key to successfully working with trauma victims is understanding secondary trauma and the risks associated with hearing traumatic material and finding ways to process and cope with it. Addressing secondary or vicarious trauma is, without a doubt, in the best interests of the recipients of our services—our clients. (p. 308)

Relative to the protection of traumatized clients, some interventions used in trauma practice, such as gradual exposure or flooding, may cause more damage than help if done without very careful attention to "how much is too much." The efficacy of these interventions has been supported by research (Berger, in press). However, supervision is required to secure against compromising a client's sense of safety and creating the risk of retraumatization. While it is the supervisor's role to monitor the type and amount of interventions by the supervisee, when such monitoring is executed as a *collaborative* effort of supervisor and supervisee, the latter is *empowered* and is forced to exercise self reflection.

Considering protection of the practitioner, one role of the supervisor is to be cognizant of the potential for vicarious traumatization when assigning tasks and clients to maximize a balance in the severity, number, and types of trauma in clients for each worker, while considering length of experience, history of personal trauma, and professional performance with traumatized clients. A meta-analysis (K. Cohen & Collens, 2013) of research that examined possible negative effects on workers serving traumatized clients showed the prevalence of sadness, anger, fear, helplessness, powerlessness, somatic reactions (e.g., numbness, nausea, tiredness), detachment, and decreased personal and professional functioning. It is the responsibility of the supervisor to assess the existence of such reactions in the supervisee, and, if manifested, to offer strategies for addressing them and to make referrals for help if needed.

In addition, supervisors should educate supervisees about vicarious trauma and guide them in managing workload (e.g., pacing and sequencing clients), refrain from "crowding" all severely traumatized clients in a row on the same day, taking breaks for respite, and using cognitive strategies to separate work from personal life (how not to take home one's clients and how to "tune out" work-related thoughts). The effectiveness of educating and guiding the practitioner relies on creating a trauma-informed environment, because practitioners may be more receptive if the principles of trauma-informed care are put in place.

Another supervisory role is to check with supervisees to ensure, without being intrusive, that they are psychologically and emotionally well, to provide psychoeducation about vicarious trauma,

and to encourage practitioners to exercise evidence-informed strategies for self-care, such as recreational activities, using supportive relationships of family, friends, and peers, and following healthy personal habits. Research has indicated that even practitioners who were aware of and believed in the usefulness of recommended strategies for self-care did not dedicate the time necessary to engage in self-care activities (Bober & Regehr, 2006), suggesting the critical role of supervisors in enhancing the translation of knowledge into action.

To be able to provide the most effective guidance to supervisees, supervisors must be educated about vicarious trauma symptoms, including those that seem subtle in practitioners, in general, and in those serving specific populations, in particular (Bledsoe, 2012; Pearlman & Saakvitne, 1995). They may include overinvolvement with clients or excessive preoccupation with their issues, interpersonal withdrawal from the relationships with the client or with the supervisor, and failure to exercise self-care. Because some of the issues related to vicarious trauma may be played out and manifested in the supervisor-supervisee relationship via parallel process, it is imperative that the supervisor be aware of his or her own tendencies to become a rescuer of the supervisee and to develop a sense of grandiosity just like the supervisee tries to do for the client.

There is a fine line between providing professional supervision and providing therapy, and although it is beyond the role of the supervisor to explore and help the supervisee address his or her personal traumatic experience, there needs to be some references to it in supervision. What type of traumatic events practitioners encounter and how they address them may affect the way in which they approach their traumatized clients. For example, a supervisee who shares a client's traumatic experience may try to avoid discussing the experience because the client's issues bring back painful memories and reactivate the practitioner's own trauma reactions. This may compromise the practitioner's ability to help the client. In another example, the practitioner might also assume that the coping skills that helped him or her heal, may be equally appropriate for the client. The goals in these instances are twofold: (a) to provide the emotional safety for the practitioner so that the work that needs to be done with the client will not be compromised and (b) to continually emphasize self-reflective practice. Addressing countertransference and transference issues in an emotionally safe manner allows for both personal and professional growth within the supervisor-supervisee relationship.

A Case Example

Working in a residential substance abuse treatment center, where the majority of clients had histories of trauma and sometimes multiple traumas, allowed a supervisor to model what trauma-informed systems of care and practice would look like (Savage, Quiros, Dodd, & Bonavota, 2007). The agency received a grant from the Substance Abuse and Mental Health Services Administration whereby "trauma-informed" group and individual interventions were offered to the clients. Using the group intervention *Seeking Safety: Cognitive-Behavioral Therapy for PTSD and Substance Abuse Treatment* (Najavits, 2002), the two facilitators of these groups worked with clients on building safe coping skills to address their traumas. Because of the anticipated intensity of the work, it was required that the facilitators, both of whom

were licensed mental health providers, participate regularly in weekly individual and joint supervision. Supervision took place in a quiet and private office where interruptions were minimal. In addition, supervisors maintained an open-door policy. When the supervisors' schedules did not allow for unanticipated interruptions, a time to check in and talk in person or on the telephone was scheduled. The clinicians attended supervision prepared with an agenda of both personal and professional challenges and successes. They also kept personal journals to process their feelings and to record times when they felt overwhelmed by the emotional intensity of the work. The journals were an empowering tool giving voice to their experiences as facilitators and as women with unique life histories. The verbal and nonverbal messages to these clinicians from their supervisor was that they each brought to the helping relationship distinctive skills, which could not be taught and which made their tool box unique. It was also reiterated during the supervisory sessions that, when feeling challenged, it might help to connect the personal with the professional. For example, resistance to explore or probe a client may be caused by the clinician struggling with a similar issue. The supervisor modeled acceptance, respect, empathy, and maintained a balance between praise and accountability (Najavits, 2002).

In one instance, the practitioner shared that she was overidentifying with one client. She found herself "giving advice" in the individual sessions rather than active listening and guiding. She shared that she could relate to the woman she was working with in that she, too, turned to alcohol during a time in her childhood and adolescence when she witnessed domestic violence between her parents. In the safe confines of supervision, she shared that alcohol was a way to cope with a tumultuous time in her life. In this instance, the supervisor provided both education and support by working collaboratively with her to link her past alcohol and drug use to the trauma she was experiencing at the time, while also pointing out that the same coping skills that had worked for her may not work for the client and, furthermore, that it takes time to develop compassion and link trauma with alcohol abuse. Although the clinician's experience made for a deeper connection with her client(s), because she could use herself and her experiences as a frame of reference, she learned (a) that this could be done without sharing her own story and (b) the importance of active listening and guiding. In addition, the clinician was reminded by the supervisor that she must be realistic about resources available to the client and work within the confines of the agency, which may be limiting and very different from her personal experience.

In this particular facility, the supervision was provided to the clinicians by facilitators who were trauma-informed, as illustrated before; thus, it minimized the risk of vicarious traumatization and maintained the sustainability of the intervention.

Summary and Conclusions

While conceptual, empirical, and clinical aspects of supervision and trauma-informed practice were discussed individually, issues related to their intersection were not. Because of the unique challenges and risks for vicarious traumatization in practitioners who provide psychosocial and mental health services, whose professional tasks expose them consistently and intensively to traumatized clients, we advocate that supervision be mandatory. Supervision for trauma-informed practice shares with supervision for

other types of practice the major components of educational, support, and administrative guidance and overseeing. However, because of the potential effects of the constant friction with trauma on the practitioner and, consequently, on the services that they provide to clients, some elements require special attention in supervision for trauma-informed practice. Specifically, the establishment of the supervisory context as a safe place, cultivating trust of the supervisee in the supervisor, allowing the supervisee the freedom of choice, and making the supervision a collaborative and empowering process. Studies have documented the importance of specialized supervision that addresses the complexity of trauma and its potential effects on practitioners and eventually clients. However, no systematic evaluation of best supervisory policies and strategies has been conducted. Thus, our recommendations are based on our anecdotal, though extensive, experience as consultants and providers of supervision for trauma-informed practice. Future research should focus on examining empirically the efficacy of diverse models of supervision for trauma-informed practice for practitioners and their clients, what works for whom, and what outcomes are associated with different supervision modalities.

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Received December 31, 2013

Revision received January 22, 2014

Accepted February 9, 2014 ■