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Trauma-informed supervision: Historical antecedents, current practice, and future directions

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ABSTRACT
In this article, the author traces the development of the current emphasis on trauma-informed practice and care in behavioral and mental health treatment. Using the discrimination model of clinical supervision, the author then discusses the application of trauma-informed principles to supervision. Relevant research is cited, and case examples are employed to illustrate critical roles, responsibilities, and tasks. Challenges and future directions also are identified.

KEYWORDS
Clinical supervision; trauma-informed supervision; trauma-informed practice

Over the past decade, increased attention has been devoted to articulating the nature and implications of trauma-informed care in mental health and related fields. Trauma-informed care is not "trauma therapy." The focus of treatment is not necessarily on the trauma and its aftermath. Trauma-informed practitioners are attuned to the multifaceted treatment needs of their clients and recognize the connection between present-day challenges and past trauma. Trauma-informed practice must address the differing contexts in which clients' trauma may surface. On the one hand, some clients seek assistance to address their responses to a traumatic experience, such as surviving a plane crash or natural or human-made disaster. In contrast, many clients seek, or are required to seek, treatment for current problems in living that reflect and stem from past trauma. Research suggests that it is this second scenario that is most common among clients seeking mental health services (Berthelot, Godbout, Hebert, Goulet, & Bergeron, 2014; Saunders & Adams, 2014). Trauma-informed practice also requires that clinicians recognize the impact that their work has on them personally and professionally, and be proactive in caring for themselves.

There is a notable dearth of literature available to guide supervisors in providing supervision that is sensitive to the implications that clients' histories of trauma have for them *and* those with whom they work. This special issue of *The Clinical Supervisor* begins to fill this gap. It is our hope that the articles in this special issue lead to increased emphasis on and inquiry into

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the nature and provision of knowledgeable supervision to those engaged—directly and indirectly—in trauma work.

In this introductory article, the author traces the evolution in thinking about and understanding of trauma and its effects. Based upon contemporary research and theory, the nature of trauma-informed practice (TIP) and trauma-informed care (TIC) are then explained. The suggested nature of trauma-informed supervision (TIS) is then discussed.

In the articles that follow, invited authors describe trauma-informed supervision in a variety of contexts. Trauma-informed care and supervision is necessary in any practice setting, including services to children and adolescents. In this special issue, we have focused primarily on treatment with adults. Although the core concepts, considerations, and competencies identified in this special issue are relevant with any client population, there also are significant differences.

Understanding trauma: A 40-year evolution

The past 40 years have seen an explosion in theoretical and empirical interest in trauma and its impact on those exposed to it and, more recently, the clinicians who work with trauma survivors.

Emphasis on precipitating events

In early literature, authors focused on the effects that potentially traumatic events had on individuals exposed to them, such as veterans of the Vietnam War and children exposed to interpersonal victimization, particularly sexual abuse (Courtois & Gold, 2009). Events such as the bombing of the federal building in Oklahoma City in 1995, the terrorist attacks in the United States in 2001, and the destruction from Hurricane Katrina in 2005 required researchers and clinicians alike to broaden their focus to include the traumatic impact of natural and human-induced disasters (Van Der Kolk, 2007). More recently, attention has been focused on the traumatic impact of socio-political occurrences, including civil wars, genocide, human trafficking, and community violence (Cook, Simiola, Ellis, & Thompson, 2017; Courtois & Gold, 2009; Wolf, Green, Nochajski, Mendel, & Kusmaul, 2014).

Emphasis on the effects of trauma

Throughout the 1980s and 1990s, attention turned to identifying common sequelae of trauma exposure. Numerous social, psychiatric, psychological, behavioral, and physical problems were identified. These included substance abuse, suicide and suicidal ideation, eating disorders, self-injury, chronic pain, and psychiatric conditions such as borderline personality disorder,

depression, post-traumatic stress disorder (PTSD), somatization disorders, and dissociative identity disorder (Brown, Schrag, & Trimble, 2005; Garno, Goldberg, Ramirez, & Ritzler, 2005; Mulvihill, 2005; Randolph & Reddy, 2006). Childhood trauma survivors, in particular, were found to be at greater risk of subsequent victimization in the form of intimate partner violence and rape (Arata & Lindman, 2002; Yehuda, Halligan, & Grossman, 2001).

During this same 20-year period, a different line of inquiry focused on changes in cognitive schema. Researchers found that exposure to trauma often results in the belief that the world is unsafe and unpredictable, leading to a sense of powerlessness and reduced feelings of self-efficacy (Currier, Holland, & Malott, 2015; Jeavons, Greenwood, & Horne, 2000; Park, Mills, & Edmondson, 2012; Samuelson, Bartel, Valadez, & Jordan, 2017; Smith, Abeyta, Hughes, & Jones, 2015). Researchers observed that survivors of childhood trauma struggled with additional distortions in thinking about the self, characterized by feelings of worthlessness, and about others, in the form of mistrust (Cloitre, Miranda, & Stovall-McClough, 2005; Giesen-Bloo & Arntz, 2005; Ponce, Williams, & Allen, 2004; Smith, Davis, & Fricker-Elhai, 2004).

Risk and protective factors and post-traumatic/adversarial growth

Constructivist self-development theorists, including Lisa McCann, Karen Saakvitne, and Laurie Pearlman, were at the forefront of articulating the changes in cognition that resulted from trauma exposure. They argued that trauma was a uniquely individual experience (McCann & Pearlman, 1990a). The same event could produce very different responses in those who experienced it: "Constructivist self-development theory… emphasizes the importance of the individual as an active agent in creating and construing his or her reality" (McCann & Pearlman, 1990a, pp. 5–6).

The recognition that the experience of trauma is unique to the individual led to efforts to identify factors that either placed an individual at greater risk of being traumatized or minimized the impact that a stressful event had on the individual. Theorists and researchers alike also recognized that an individual's unique response to a stressful event reflected sociocultural influences and environmental context (Adams & Boscarino, 2005; Adeola & Picou, 2014; Elliott & Urquiza, 2006; Katerndahl, Burge, Kellogg, & Parra, 2005).

A particularly powerful factor found to be important is social support at the individual and community levels (Carlson et al., 2016; Evans, Steel, & DiLillo, 2013; Sattler, Boyd, & Kirsch, 2014; Smith, Felix, Benight, & Jones, 2017). Social support is important both at the time of exposure to trauma and long-term as the individual struggles with its after-effects (Sippel, Pietrzak, Charney, Mayes, & Southwick, 2015). This factor is multidimensional and includes validation and understanding, acceptance, affirmation, and

availability of appropriate resources. The absence of support, which can consist of blame and/or accusation, continued exposure to the traumatic experience, and the lack of acknowledgment of the impact of the event, places the survivor at greater risk of being traumatized.

Prior emotional functioning is another factor that may either intensify or mitigate the impact of a stressful event (Carlson et al., 2016; Glad, Hafstad, Jensen, & Dyb, 2017; Lanctôt & Guay, 2014; Nickerson, Bryant, Rosebrock, & Litz, 2014). Individuals with preexisting mental health problems are at greater risk of being traumatized. Emotional, psychological, and psychiatric problems are common sequelae of trauma; researchers have suggested that these conditions may have preceded the exposure, or at least have been exacerbated by it.

The focus on risk and protective factors has been complemented by efforts to ascertain the ways in which individuals can grow and benefit from exposure to trauma. When individuals can identify positive aspects of their traumatic experience, they are likely to experience fewer negative long-term consequences (Burton, Cooper, Feeny, & Zoellner, 2015; Linley & Joseph, 2004; McLaughlin & Lambert, 2017; Poole, Dobson, & Pusch, 2017; Zalta et al., 2016).

Researchers have found that traumatized individuals may benefit in several ways; most notably, a reordering of priorities, an enhanced or new sense of spirituality, a deeper appreciation for life and for loved ones, and increased feelings of empathy and concern for others (Bonanno, 2004; Grasso et al., 2012; Mancini, Littleton, & Grills, 2016; Taormina, 2015). Adversarial growth also can lead to enhanced feelings of self-efficacy: "What doesn't kill you makes you stronger" (McMillen, 1999, p. 459). It does appear that survivors of interpersonal victimization in childhood, particularly sexual abuse, have a harder time identifying positive changes (Domhardt, Münzer, Fegert, & Goldbeck, 2015; Ulloa, Guzman, Salazar, & Cala, 2016).

Trauma and neurobiology

A more recent advancement in the understanding of trauma is a recognition of the neurobiological changes that result from exposure (Del Río-Casanova, González, Páramo, Van Dijkea, & Brenlla, 2016; Nemeroff & Binder, 2014; Sperry, 2016; Wilkinson, 2017). Biochemical changes in the developing brain have been found to interfere with the brain's ability to process trauma and affect the body's stress response systems. Delima and Vimpani (2011) explained, "The behaviours resulting from chronic stress include poor self-regulation, increased impulsive behaviours, and emotional responses such as high levels of experienced anxiety, aggression and suicidal tendencies and, in some, a learned helplessness from the constant impairment of self-regulation" (p. 45). Therefore, the long-term emotional, psychological, and cognitive

effects of trauma often reflect maladaptive brain processes related to stress regulation.

Trauma and mental health disorders

The relationship between trauma exposure and later mental health issues was formally recognized in 1980 when the American Psychiatric Association's (APA) third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) included two new diagnostic categories, Post-Traumatic Stress Disorder (PTSD) and Dissociative Disorder (DD) (Courtois & Gold, 2009). Trauma was assumed to occur in response to a specific event that was outside of the range of "usual human experience" (APA, 1980, p. 236). The definition of and requirements for PTSD, the most widely applied diagnosis for trauma-exposed individuals, have been refined over the years in response to ongoing research and the resulting refinement in thinking. In the most recent, fifth, edition of the *DSM* (APA, 2013), a new diagnostic category, Trauma and Stressor-Related and Dissociative Disorders, includes several specific disorders like PTSD and DD.

From the outset, controversy has surrounded the use of the PTSD diagnosis in cases of trauma exposure (McNally, 2009; Rosen & Lilienfeld, 2008). Even with the recent reconceptualization of stress disorders, no single diagnosis adequately accounts for the individual's unique interpretation of her or his exposure to trauma. Neurobiological changes and the changes in cognitive schema that typically accompany trauma exposure also are not adequately reflected (Wheeler, 2007).

Indirect trauma

A more recent line of inquiry has been focused on the impact that working with survivors of trauma, particularly interpersonal victimization, has on those engaged in the work. Imprecision in the use of terms to describe the effects of working with survivors has led to some confusion in the literature (Knight, 2015). Research substantiates three distinct but interrelated manifestations: vicarious trauma, secondary traumatic stress, and compassion fatigue. Theorists and researchers have agreed that indirect trauma is an inevitable consequence of working with survivors of trauma. Emphasis is placed on the practitioner being proactive in mitigating and managing its effects rather than prevention. Indirect trauma is different from burnout and countertransference, although it may lead to one or both phenomena (Berzoff & Kita, 2010; Pearlman & Saakvitne, 1995; Salston & Figley, 2003).

Secondary traumatic stress refers to a cluster of symptoms that mirror indicators of PTSD, analogous to those experienced by trauma survivors themselves. Manifestations include persistent, intrusive thoughts and images

of clients, hypervigilance, reexperiencing the client's trauma in recollections and dreams, and hyperarousal (Bride, 2004). In response to these reactions, clinicians may adopt distancing strategies such as denial, detachment, emotional insulation, and disbelief. The *DSM*-V(APA, 2013) expanded the PTSD diagnosis to include this form of trauma.

The term vicarious trauma is often used to refer to the full range of professionals' reactions. In fact, it refers to a very specific manifestation, changes in cognitive schema, analogous to the distortions in thinking first noted by constructivist self-development theorists among individuals exposed to trauma. Like their clients, practitioners develop a worldview characterized by suspicion, pessimism, and powerlessness (Cunningham, 2004; McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995; Van Deusen & Way, 2006).

Compassion fatigue is not unique to working with trauma survivors, but it is particularly common among individuals who work with this population (Adams, Boscarino, & Figley, 2006; Berzoff & Kita, 2010; Figley, 1995). Listening to survivors' stories of trauma, coupled with witnessing the distress firsthand, can result in an inability to empathize with clients, particularly in those cases where the individual is difficult to engage or displays hostility toward the clinician.

Analogous to the study of direct exposure to trauma, researchers have sought to identify risk and protective factors. The risk of indirect trauma appears to be higher among professionals who have less education, are newer to their jobs, and have the most and least experience working with trauma survivors (Harr & Moore, 2011; Molnar et al., 2017). Findings regarding the influence of a personal history of trauma are mixed. There is some evidence that therapists who experienced childhood trauma are at higher risk of experiencing indirect trauma (Nelson-Gardell & Harris, 2003). It is unclear whether exposure to other forms of trauma predisposes therapists to indirect trauma, since empirical inquiry has been narrowly focused on the impact of childhood victimization.

An organizational climate that validates and normalizes workers' reactions mitigates the risk, while a climate that is perceived as unsupportive increases it (Brockhouse, Msetfi, Cohen, & Joseph, 2011; Dombo & Blome, 2016). Authors have agreed that proactive self-care is essential to managing the effects of indirect trauma (Bober & Regehr, 2006; Layne et al., 2011). Lower risk is associated with organizational and supervisory environments that promote self-care activities and convey to staff that mediating the impact of indirect trauma is an organizational responsibility as much as an individual one (Hensel, Ruiz, Finney, & Dewa, 2015; Sprang, Ross, Miller, Blackshear, & Ascienzo, 2017).

Analogous to the evolution in thinking regarding direct trauma exposure, the positive aspects of indirect trauma have been examined. "Vicarious

resilience" or "vicarious posttraumatic growth" has been observed among therapists working in a variety of practice contexts (Barrington & Shakespeare-Finch, 2013; Cosden, Sanford, Koch, & Lepore, 2016; Frey, Beesley, Abbott, & Kendrick, 2017; Molnar et al., 2017). Positive outcomes include enhanced appreciation for one's advantages in life, a reordering of personal goals and priorities, increased sense of professional competence and resourcefulness, and heightened capacity for compassion and empathy. For those therapists with a history of trauma exposure, affirmation of their strengths and resilience also has been observed (Killian, Hernandez-Wolfe, Engstrom, & Gangsei, 2017).

Trauma-informed practice and care

The evolution in thinking about and the understanding of trauma and the impact on its victims has resulted in an appreciation for the role that this phenomenon plays in the lives of many of the individuals seeking or required to seek treatment. Studies of clinical populations consistently have demonstrated that adults with histories of childhood trauma are overrepresented among those seeking or required to seek treatment in mental health, substance abuse, forensic, domestic violence, child welfare, homeless, and sexual assault settings (Álvarez et al., 2011; Larsson et al., 2013; Rossiter et al., 2015). Furthermore, epidemiological studies have revealed that most adults have been exposed to at least one event that could be characterized as traumatic (Beristianos, Maguen, Neylan, & Byers, 2016; Courtois & Gold, 2009; Gillikin et al., 2016; McCall-Hosenfeld, Mukherjee, & Lehman, 2014). The increasing frequency of natural disasters, the escalation of terrorist attacks and gun and community violence, and ongoing wars underscore the requirement that practitioners be well-versed in understanding the needs of victims and survivors (Gil, 2015; Glad et al., 2017; Helpman, Besser, & Neria, 2015).

The terms *trauma-informed practice* and *trauma-informed care* began to appear in the mental health literature in 2001. Since that time, the nature of this approach has been refined and clarified. The underlying assumption is that "any person seeking services or support might be a trauma survivor…. [Treatment must] recognize, understand, and counter the sequelae of trauma to facilitate recovery" (Goodman et al., 2016, p. 748). The underlying assumption is that "any person seeking services or support might be a trauma survivor…. [Treatment must] recognize, understand, and counter the sequelae of trauma to facilitate recovery" (Goodman et al., 2016, p. 748).

The terms *practice* and *care* often are used interchangeably. However, it is more accurate to use the term practice when referring to the individual clinician and care when referring to an organizational approach to treating trauma survivors. Theorists and researchers have noted that trauma-

informed practice cannot occur without organizational support in the form of assignment of caseloads, provision of supervision, and allocation of resources to manage indirect trauma (Bassuk, Unick, Paquette, & Richard, 2017; Conover, Sharp, & Salerno, 2015).

Trauma-informed practice

Authors (Berger & Quiros, 2016; Conover et al., 2015; Goodman et al., 2016) have agreed that trauma-informed practice must adhere to five principles: safety, trust, collaboration, choice, and empowerment. These principles reflect the considerable body of research that has documented the short- and long-term effects of trauma exposure. They also represent "the direct opposite conditions of persons who have experienced traumatic events. That is, the safety and experience of freedom and empowerment of those who have experienced trauma was compromised, leading to a distrust of others" (Hales, Kusmaul, & Nochajski, 2017, p. 318).

Trauma-informed practice also must avoid retraumatizing clients and, in cases of interpersonal victimization like childhood abuse, re-creating maladaptive social interactions in the therapeutic relationship. The ways in which these five principles are manifested will vary depending upon practice context. Survivors of human-made and natural disasters will often seek or be offered treatment at the time of the event. Intervention at this point is likely to be more crisis-oriented (Breckenridge & James, 2010; Courtois & Gold, 2009). Intervention in these cases may be more accurately referred to as trauma *specific* or *focused*. The intent is to help survivors make meaning of the traumatic event and develop ways of coping and managing the immediate emotional, behavioral, physiological, and cognitive effects (Gray & Litz, 2005). An additional—and important—focus is preventing or mitigating the long-term effects associated with exposure to trauma (Briere & Scott, 2014; Lopez Levers, Ventura, & Bledsoe, 2012; Manderscheid, 2009).

In contrast, many individuals seek or are required to seek services for current problems in living that stem from past trauma (Jones & Cureton, 2014; Knight, 2009). Most of the available literature on trauma-informed practice focuses on this context and these individuals. Intervention often emphasizes the resolution of the present-day difficulties, due to survivors' sense of urgency, a scarcity of resources, and narrowly defined agency focus. The trauma-informed clinician understands the "the ways in which current problems can be understood in the context of past victimization" (Knight, 2015, p. 26). The clinician also "recognizes the implications that being a survivor [of past victimization] have for the client's ability to enter into a working alliance… given core beliefs characterized by hostility towards others" (Knight, 2015, p. 26).

Safety

Survivors often experience the world—and, in many cases, other people—as unsafe. Creating a safe environment is multifaceted and includes both the physical and interpersonal environments. "The environment must not only *be* safe but also *feel* safe" (Berger & Quiros, 2014, p. 297). The location of furniture in the clinician's office can either promote safety or reinforce its absence. Clients should, for example, be able to avoid sitting with their backs to a door, window, or other potential source of anxiety. Furniture should be comfortable, and colors should be soothing. Privacy also must be ensured. The clinician creates a safe interpersonal environment by, among other things, normalizing and validating client reactions, displaying an understanding of the impact of trauma, and conveying empathy, understanding, and genuineness.

Trust

The elements that contribute to safety also contribute to trust. Harris and Fallot (2001), who were the first to write about trauma-informed practice and care, noted that trust also develops when the therapist maintains clear and appropriate boundaries, protects confidentiality to the extent that is possible (and informs clients when this is not possible), and interacts with the client in ways that are consistent, predictable, and transparent. Trustworthiness also depends upon cultural awareness, since cultural norms and traditions influence how individuals experience, interpret, and respond to traumatic exposure (Berger & Quiros, 2014; Mattar, 2011). Fostering trust in survivors of trauma requires clinicians to directly address and explain any mandates that might govern their interactions with clients (Becker-Blease, 2017; Knight, 2015).

Although not as widely discussed, trust also includes helping clients develop trust in themselves. Since survivors often feel overwhelmed by their reactions and believe their emotions are unmanageable, the clinician must create a therapeutic environment wherein clients learn to both express *and contain* feelings. This reduces the possibility that intervention will be retraumatizing (Knight, 2015).

Choice

Because feelings of powerlessness are prevalent among survivors of trauma, it is important that, to the extent possible, they have some degree of choice in deciding upon methods and modes of intervention. This leads to a need for the clinician to be schooled in a range of culturally relevant strategies and techniques and willing to employ those that respond to clients' stated needs. The clinician also adheres to principles of informed consent, advising clients of the advantages, disadvantages, and purpose of various courses of action.

Collaboration

Collaborative efforts between therapist and client reinforce the principles of choice and empowerment. "Clients [are encouraged] to play an active role in their treatment and providers acknowledge the expertise that clients bring to the treatment process" (Berger & Quiros, 2014, p. 298). A collaborative approach to treatment requires cultural competence and reinforces the notion that clients are the experts in their lives (Breckenridge & James, 2010; Mattar, 2011).

Empowerment

Adherence to the principles of choice and collaboration facilitate client empowerment, a particularly important therapeutic outcome, given the powerlessness that many trauma survivors experience. To the extent possible, clients should have an influential role in "planning, operating, and evaluating services" (Berger & Quiros, 2014, p. 298). The principle applies to an individual client's own course of treatment as well as to soliciting that client's input into the overall provision of services to clients in general. Empowerment also requires the clinician to introduce strategies that assist the trauma survivor in managing feelings and present-day challenges associated with their experience (Knight, 2015).

Status of trauma-informed practice

The findings of several studies have indicated that trauma-informed practice remains an ideal, rather than a reality, in many practice settings, even those that are widely viewed as and known for treating trauma survivors (Cook et al., 2017; Courtois & Gold, 2009; Layne et al., 2011; Mattar, 2011). It appears that opportunities are available to educate professionals and professionals-to-be about trauma and trauma-*specific* interventions (Smith, Hyman, Andres-Hyman, Ruiz, & Davidson, 2016; Valinejad, 2015; Zaleski, Johnson, & Klein, 2016). However, preparing clinicians to engage in trauma-*informed* practice, generally, is lacking (Berger & Quiros, 2016; Courtois & Gold, 2009).

Trauma-informed care

Numerous efforts have been undertaken to infuse trauma-informed care (TIC) into virtually all behavioral and mental health settings. However, TIC remains limited or nonexistent in many practice contexts (Becker-Blease, 2017; Bloom, 2010; Branson, Baetz, Horwitz, & Hoagwood, 2017). The reasons for this vary, but include limited financial resources, a lack of appreciation for the role that trauma plays in clients' lives, and an understanding of TIC and its principles. TIC is an "organizational change process that is structured around the presumption that everyone in the agency (from clients through agency management) may have been directly or

indirectly exposed to trauma within their lifetime" (Wolf et al., 2014, p. 111). Trauma-informed care is guided by the same five principles that define practice; the additional consideration is that they apply both to clients and staff.

Safety

Considerations associated with the agency's exterior and interior appearance that promote safety for staff and clients include assessing the need for open versus locked doors and barred versus unbarred windows, comfortable and pleasant waiting areas, options for anonymity, and guaranteed privacy. Safety for clients requires organizational staff to be respectful, pleasant, and sensitive to signs of client distress.

Trust

An organizational climate and leadership that promotes respect among staff, clarifies expectations for performance, rewards excellence and supports employees' efforts to improve upon their work, and protects staff from external threats to job security and satisfaction (such as budget cuts, negative media attention, litigation) enhances trust among staff. Safety and trust among staff is engendered when self-care is not only promoted but provided and the existence of indirect trauma is normalized and validated (Bloom, 2010). Trauma-informed care also requires that organizations adhere to guidelines regarding the distribution of cases and the size of caseloads to prevent burnout and limit indirect trauma.

Collaboration, choice, and empowerment

Trauma-informed care means that staff are encouraged to provide input into policies that impact them and their clients. Like the clients who are served, agency personnel must believe they have a voice. At all levels within an organization, employees also must understand the needs of trauma-exposed clients, as well their own vulnerability to indirect trauma (Wolf et al., 2014).

Status of trauma-informed care

There appears to be consensus regarding what trauma-informed care should look like (Bassuk et al., 2017). However, the evidence suggests that, like trauma-informed practice, the implementation of TIC in most mental, behavioral, and physical health settings is limited (Branson et al., 2017; Conover et al., 2015; Lang, Campbell, Shanley, Crusto, & Connell, 2016; Wolf et al., 2014). Even in settings that provide trauma-*focused* services to clients, organizational policies and culture typically are not operating from a trauma-informed perspective (Bassuk et al., 2017).

Where it has been implemented, TIC has been found to enhance staff and client empowerment and client satisfaction with treatment services and reduce

manifestations of indirect trauma (Sullivan, Goodman, Virden, Strom, & Ramirez, 2017). In contrast, lack of adherence to the principles of TIC, particularly trust and safety, has been found to be associated with higher rates of indirect trauma among staff, lower rates of vicarious resilience, and reduced overall quality of services to clients (Elliott, Bjclajac, Fallot, Markoff, & Reed, 2005; Frey et al., 2017).

Trauma-informed supervision

An essential element of trauma-informed care is trauma-informed supervision. It is only when therapists have knowledgeable and supportive supervision that they can operate from a trauma-informed perspective. The basic requisites of trauma-informed supervision include knowledge of trauma and its effects on clients, indirect trauma, core skills of clinical supervision, and core precepts of trauma-informed practice and care. Trauma-informed supervision requires the same five elements that comprise trauma-informed practice and care (Berger & Quiros, 2016).

A primary challenge to providing trauma-informed supervision is the lack of understanding among many clinical supervisors of the nature of trauma and its effects on victims, and a lack of familiarity with the principles of trauma-informed practice and care (Berger & Quiros, 2016; Courtois & Gold, 2009; Mattar, 2011). A second challenge reflects a common problem in the provision of clinical supervision generally. In many instances, the supervisor may have little or no training in or preparation for this role (Gray, Ladany, Walker, & Ancis, 2001; Mehr, Ladany, & Caskie, 2015). Furthermore, administrative responsibilities associated with both the clinician and supervisor roles often restrict the amount of time that can be devoted to supervisees' clinical practice (Knight, 2013; Sommer, 2008). Research findings continue to demonstrate that the topics that clinicians most need to discuss in supervision are the very topics that they avoid bringing up (Best et al., 2014; Mehr et al., 2015; Petrila, Fireman, Fitzpatrick, Hodas, & Taussig, 2015). In the case of therapists working with trauma survivors, this is likely to include manifestations of indirect trauma (Etherington, 2009; Furlonger & Taylor, 2013).

Although models of clinical supervision have proliferated over the past quarter-century, integration of trauma-informed principles is lacking, particularly when it comes to understanding how to address therapists' reactions to working with trauma survivors, a critical task of trauma-informed supervision (Bober & Regehr, 2006; Hernández, Engstrom, & Gangsei, 2010; Joubert, Hocking, & Hampson, 2013). When too much attention is paid to supervisees' reactions, it may take the form of quasi-therapy, which leads to boundary violations, distracts from supervisees' need for guidance, and undermines their self-efficacy (Berger & Quiros, 2016). When the clinician's reactions are ignored or minimized, this may intensify—rather than mitigate—the impact

of indirect trauma (Yourman, 2003). The following example reveals the deleterious effects of an uninformed response to manifestations of indirect trauma.

> Monica works in an outpatient substance abuse treatment program for women. Her primary purpose is to assist clients in remaining sober and address any challenges to their sobriety that may surface. She meets with her supervisor, Victor, monthly for supervision. Monica recently began working with Meghan, age 30, who has been using drugs and alcohol since she was 13. Meghan has been sober for one month. In their most recent weekly session, she disclosed to Monica that her father had molested her throughout her childhood. Starting at age 13, he began to "pimp her out" to his friends in exchange for money to support his own addiction to heroin. Meghan described violent and sadistic sexual and physical abuse and reported that her father often photographed the abuse and posted the photos to pornographic websites.

In her last supervisory session with Victor, Monica began to cry as she described Meghan's abuse; she also expressed her desire to "castrate" Meghan's father and her other perpetrators. Victor acknowledged Monica's feelings, but questioned if she was getting "triggered" by something in her own personal history. Monica replied, "I don't think so. Nothing comes to mind, at least." Victor then suggested that her "intense" affective response "strongly suggests" that she was experiencing countertransference. He gently suggested that she consider going into therapy to address her "unresolved issues," since as her supervisor it would be "inappropriate" for them to discuss this in supervision.

Victor's reaction to Monica revealed his lack of knowledge about the impact that her work had on her. Rather than normalizing and validating her responses to her client's victimization, he framed them as abnormal. Monica acknowledged that Victor's comments left her feeling confused and guilty. She was unable to identify something in her past that might have triggered her reaction, so she did not pursue therapy. But she continued to question why she had reacted so strongly and "inappropriately" to Meghan's disclosures. This supervision scenario was described in a workshop the author was conducting on trauma-informed practice. As Monica was discussing her experience, numerous attendees acknowledged similar experiences in which manifestations of indirect trauma were either ignored or misinterpreted.

Integrating trauma-informed principles into the discrimination model of clinical supervision

Bernard's discrimination model of supervision is one of the more widely known, investigated, and utilized perspectives on supervision (Bernard & Goodyear, 2014). The supervisor helps supervisees "move from relatively passive learners to those who take an active role in enhancing their

knowledge" (Knight, 2017, p. 3). The model readily lends itself to incorporating a trauma-informed lens. When the three discrimination model roles (i.e., teacher, counselor, consultant) are considered in a trauma-informed context, supervisory mistakes such as the one just described are avoided, and supervisees receive the guidance, education, and support they need.

In the teaching role, the supervisor assumes primary responsibility for supervisees' learning. This role is critical in those cases where supervisees are trainees, inexperienced, or encounter a clinical situation with which they are unfamiliar. The consultant role is appropriate when supervisees are more knowledgeable and confident in their abilities. The supervisor helps supervisees think more critically and analytically about their work. The counselor role remains constant throughout the supervisory relationship and fosters supervisees' understanding of and ability to manage their personal feelings and reactions as these surface in their work with clients. The intent is not to provide therapy. Rather, it is to help supervisees examine their reactions to clients and their work so as to minimize the potential for disruption in the therapeutic relationship.

Safety

Safety in trauma-informed supervision mirrors that which should exist in the therapeutic relationship. A supervisory alliance in which the following factors are present facilitates safety:

(1) Supervisees feel accepted and understood;
(2) the boundaries and expectations are clear; and
(3) supervisees are encouraged to take an active role in their learning and engage in honest and open discussion.

These requirements suggest the importance of the supervisor attending to the relational aspects of the supervisory relationship (Berger & Quiros, 2016).

Trauma-informed supervision normalizes supervisees' experiences and accommodates supervisees' unique learning needs and reactions to and understanding of their clients who are trauma survivors. Consistent with trauma survivors, supervisees will experience their work differently based upon personal and background characteristics and professional training and experience (Berger & Quiros, 2014; West, 2010). In describing what constitutes a safe place for supervisees working with trauma survivors, one supervisor in Berger and Quiros's (2016) study noted the need to "[create] an oasis within the chaos… [balance] being very attentive, gentle, supportive, and nurturing, while also nudging workers to challenge themselves, hold them accountable, and yet create a safe place to struggle toward professional growth" (p. 149).

The three roles associated with the discrimination model (Bernard & Goodyear, 2014) are relevant for this aspect of trauma-informed supervision. Supervisors should assist clinicians in minimizing the impact of their work and be proactive in taking care of themselves. As both teacher and consultant, the supervisor helps supervisees understand their reactions to their work. This knowledge normalizes and validates manifestations of indirect trauma which, in turn, makes these reactions easier to manage. Together, supervisee and supervisor work to identify strategies that minimize the impact of indirect trauma and allow the supervisee to engage in self-care.

The counseling role also may come into play as supervisors help therapists understand the source of countertransference and develop strategies to manage it. Indirect trauma is not countertransference, but these reactions are often co-occurring and can reinforce one another (McCann & Pearlman, 1990). In Berger and Quiros's study (2016), supervisors of clinicians who worked with trauma survivors noted the importance of "modeling vulnerability and process[ing] [supervisees'] own encounters with trauma" (p. 151) as a way of helping supervisees contain the pain that their work triggered. The supervisor's willingness to model transparency and vulnerability is essential for assisting supervisees in acknowledging and managing countertransference and indirect trauma.

Supervisors should consider routinely engaging in an "affective tuning in" in each supervisory session (Etherington, 2000). "Supervisees can be asked to reflect on any changes in their response to specific clients or to their work in general, since indirect trauma [and countertransference] vary in response to changing circumstances in supervisees' personal and professional lives" (Knight, 2013, p. 232). The use of a check-in normalizes supervisees' personal reactions and encourages them to be proactive around self-care and managing indirect trauma and countertransference.

Trust

As noted, trust and safety are interdependent. Trust is fostered when the supervisee views the supervisor as knowledgeable about trauma and its impact on survivors and therapists. This knowledge includes educating supervisees on appropriate intervention techniques and approaches. Of even greater importance is helping supervisees see how "the way [their clients] relate to the world and see themselves in context with the world around them has been significantly shifted by the traumatic events in their lives" (respondent quoted in Berger & Quiros, 2016, p. 150). As teacher and/or consultant, the supervisor helps supervisees understand clients' core beliefs about self and others and appreciate how these beliefs influence their ability to engage in a therapeutic relationship. The supervisor also will need to assist supervisees in seeing manifestations of transference when these

surface in the therapeutic relationship and understand how to use these dynamics to deepen the alliance and enhance clients' insight.

Bernard and Goodyear's (2014) teaching role takes on added significance in those practice contexts in which trauma survivors are seen for current problems in living, since many clinicians remain unfamiliar with the nature and effects of trauma exposure. In settings in which clients' present-day problems take precedence, clinicians may overlook or ignore signs and symptoms of underlying trauma, believing that their role prohibits exploration of the trauma (Knight, 2009). The supervisor helps supervisees understand that when they help clients better manage present-day challenges, this conforms to the trauma-informed principle of empowerment.

> James works in a mental health program that helps individuals leaving inpatient psychiatric facilities transition back into their local communities. He is young, 25, and a recent graduate of a master's program in counseling. His work typically is short-term, no more than eight sessions, and is focused primarily on helping clients secure resources that facilitate a successful transition into the community.

James recently began working with Al, a 42-year-old Army veteran. In their third session, James intended to discuss the various housing options available to Al. However, Al began to talk about his combat experiences, describing in detail how several of his friends and a commanding officer whom he respected were "blown apart" by an improvised explosive device. Al cried as he talked about being covered with "blood and guts" and also expressed a great deal of rage at the perpetrators and a desire to "cut them to shreds."

In his next supervision session with Elaine, James recounted his response to Al's disclosure. He expressed his shock at what Al had experienced, and told Elaine that he has said to the client, "This have must have been horrible for you. You must have been horrified, sick, disgusted, devastated. I can't even think of the words to describe what it must have been like." The following exchange with Elaine then occurred:

James: After he [Al] finished telling me all this, I was speechless. I felt helpless and totally unprepared to help him. I said the first thing that came out of my mouth. I wasn't even thinking. I know, I was inappropriate.

Elaine: At that moment, not thinking, but reacting spontaneously was a *good* thing. Al needed validation that what he had endured was indeed horrific, and you provided him with that.

James: But he needs so much more. He needs help with what happened to him and what he saw and experienced. And I can't help him. I'm only there to get him into community housing.

Elaine: You are right, sort of. But remember, you also need to find other resources in the community, like counseling, to support his move to community housing. In the meantime, you obviously created a safe

place for him to disclose what happened to him in Afghanistan. He has developed enough trust in you to share this very deep and painful "secret."

James: Okay. But I'm not a therapist, I'm just a rehabilitation counselor.

Elaine: True, but how you responded to Al reassures him about how others will respond in the future. Your understanding and compassion lets him know that his reactions have merit and hopefully provide him with the courage he needs to make a connection with a therapist.

James: I just felt so unprepared, so out of my element.

Elaine: You did exactly what you needed to do. You listened and provided empathy. But, it sounds like you didn't encourage him to go into greater detail about what happened?

James: [Nods]

Elaine: That's exactly the right thing to do. Stripping away his defenses at this point would not be helpful to him and would undermine his stability and ability to go back to the community. Make sense?

James: Yes, actually it does. I never thought about my job this way.

Elaine: Good. Now, let me ask you something. How was it for you—how were you feeling, what was your reaction—as Al told you about his friends being blown up in front of him?

Even though her organization did not operate from a trauma-informed orientation, Elaine had gone through training in trauma-informed practice and she had many years of experience working with trauma survivors. In contrast, James had no such training and was quite inexperienced. Elaine adopted the teaching role and helped James understand how he could simultaneously work within his role as a case manager helping clients successfully transition into community housing and appropriately respond to clients with trauma histories. Elaine also utilized the counselor role when she normalized potential manifestations of indirect trauma by asking James about his reactions to Al's disclosures.

One area that often requires the supervisor's input is how to manage mandatory reporting requirements when the trauma involves interpersonal victimization (Knight, 2013). Mandatory reporting is presumed to contradict the trauma-informed practice principle of client empowerment. Clinicians often are ambivalent about adhering to the mandate, fearing the impact that their report will have on the therapeutic relationship (Pietrantonio et al., 2013). The supervisor may need to help supervisees understand how they can meet their legal obligations in a way that still provides clients with some measure of control (Henderson, 2013). Clinicians are required to report their adult clients' victimization as a child, but clients are not required to cooperate with authorities following the report. Therefore, the practitioner can encourage clients to disclose as little or as much information as they want when meeting with

appropriate authorities (Daniluk & Haverkamp, 1993; Melton, 2005). Clinicians also can encourage clients to file a report themselves.

Trust also is established in the supervisory relationship when the supervisor addresses supervisees' affective reactions but clarifies and maintains appropriate boundaries. This approach reflects the appropriate use of the counselor role, limiting the possibility that the supervisory relationship will take on aspects of a therapeutic one (Bride & Jones, 2006). The supervisor's exploration of supervisees' personal reactions is intentional and designed to enhance self-awareness. Walker (2004) observed that the supervisor must be cognizant of the potential for retraumatization if there is too much focus on clients and their disclosures. An affective check-in centers on the *supervisees'* reactions, not the client's trauma. As the supervision session between James and Elaine continued, she engaged in a check-in, which was both liberating and validating:

James: [In response to Elaine's question about the impact of Al's disclosures] I'm not sure. I mean, it was sort of upsetting. But, I know that I need to not let my clients get to me.

Elaine: Where in the world did you learn that? [Laughs] Of *course* you are going to be affected by your clients! You're human. I suspect that hearing Al's story, thinking about or visualizing what he went through, must be upsetting?

James: Oh gosh, *yes*! It was so upsetting to me. I think almost more than what he shared with me, it was seeing this big, hulking, tattooed guy crying. I keep thinking about him, and about what he had to go through. Honestly, I've always wondered why we went to war over there, and now more than ever, I think it's wrong. It pisses me off.

Elaine: I'm so glad you could tell me this. If you are going to be there for your clients, you have to take care of yourself. That means being open with yourself—and with me—about your reactions. I'm not here to judge and I'm not playing therapist. I don't want to take that on. [Laughs] It's normal to think about your clients when they tell you the sorts of things Al shared. To worry about them. And we often start to see our world differently when we listen to our clients. Perhaps we can take a bit of time to talk about ways that you can take care of yourself?

Elaine made appropriate use of the counselor role as she encouraged James to discuss his reactions to his client and clarified the purpose of this discussion. The teacher and consultant roles also came in to play as she normalized James's reactions and urged him to consider ways he could take care of himself to minimize the impact that his work has on him.

Choice, collaboration, and empowerment

Inexperienced supervisees may need more guidance and instruction as they transition into trauma-informed practitioners, underscoring the teacher role. However, the trauma-informed supervisor recognizes and conveys to supervisees that "[their relationship] is a mutual one in which the knowledge and wisdom of the supervisor are not privileged over that of the supervisee…. Each learns from the other's experience and multiple realities are honored" (Berger & Quiros, 2014, p. 298). Trauma-informed supervisors must be able to balance the teaching role—in which they take on more of the role of the expert—with that of a consultant who fosters autonomy, independence, and empowerment.

An approach to supervision that has relevance for trauma-informed supervision was first described by Fontes (1995) and referred to as "sharevision." In this approach, supervisors create a more egalitarian relationship with supervisees; this in turn promotes more open and honest discussion. The concept of sharevision is consistent with relational approaches to supervision, which emphasize the attention that both parties pay to their relationship (Peled-Avram, 2017). This more egalitarian approach lessens the power differential between supervisor and supervisee that can impede honest discussion, particularly around the clinician's affective responses. As the previous example reveals, even though James is an inexperienced beginning clinician, Elaine treats him with respect, which is empowering to him.

An egalitarian approach is especially helpful when manifestations of parallel process surface in the supervisory relationship (Miehls, 2010). The existence of parallel process is acknowledged in the supervision literature, and it is presumed to be the result of supervisees reenacting in supervision a problematic dynamic from their practice (Goren, 2013). Therefore, when supervisees are helped to understand their reactions to their supervisor, they are learning more about their clients' reactions to them (Schamess, 2012).

Relational theorists have argued that parallel process may reflect transference on the part of *both* supervisee and supervisor (Miller & Twomey, 1999; Virtue & Fouché, 2009). Therefore, supervisors must promote and encourage honest discussion with their supervisees about their relationship. Miehls (2010) noted, "Supervision can be most helpful when supervisors and supervisees engage in an ongoing dialogue that explores difficulties and/or mutual transferences that occur during supervision" (p. 372). The discrimination model (Bernard & Goodyear, 2014) roles of teacher, consultant, and counselor will be instrumental in facilitating this sort of supervisory climate.

Supervisors often find themselves caught in the middle between organizational demands and their responsibilities to their supervisees and to their agency's clients (Knight, 2013). This challenge is particularly likely to occur in settings that do not adhere to a trauma-informed orientation (Becker-Blease, 2017). As supervisors acknowledge these reactions directly and

actively seek to manage them, they are modeling how the supervisee can address countertransference in the therapeutic relationship.

In a workshop on trauma-informed practice led by the author, a participant, Maria, described an encounter she had with her supervisor, Tim. Maria worked in an outpatient mental health clinic. Most of her clients had a history of trauma exposure, typically childhood victimization. Maria reported the following:

> I met with my supervisor to discuss something that happened in a session I had with one of my clients, Nathan. Nathan had a long history of substance abuse and also was diagnosed with bi-polar disorder. I had been meeting with him for about two months, and we were making progress. He started trusting me, and had started to disclose his history of sexual abuse. We [her agency] had suspected he was a survivor, but so far there had been nothing in his record. I have worked with a lot of survivors, but not many men. In thinking back on it, I think that because he was a guy, his abuse just hit me harder. Not sure why, but it did. There were multiple perpetrators—a father, uncle, older siblings—the father forced them to sodomize Nathan. That probably also was why his case hit me so hard.

In supervision, I started to talk about the case. I don't usually get into too much detail with my cases because Tim doesn't really have a lot of time and is in a hurry. I started to describe what Nathan had told me about his abuse, and Tim sort of waved his hand at me, and said something like, "Okay, okay, so he was sexually abused. I get it. What is your question?" I couldn't believe it! He was so dismissive of me and Nathan. I made up some BS, and told him I'd handle it on my own. I know he knew I was angry, but he didn't say anything. But the next time we met for supervision, which was, like, two weeks later, he told me if I had an issue with him, I should tell him. But the way he said it, I could tell that wasn't a good idea. And in that supervision session, I could tell that he was pissed off at me. No way was I going to tell him how I felt!

As the author and seminar participants processed this exchange, it became clear to all, including Maria, that her supervisor's response to her presentation of Nathan's case triggered in her a great deal of anger at Tim's dismissive attitude and intensified her reactions to Nathan's abusers. Rather than using her reaction to deepen Maria's understanding of her and Nathan's feelings, Tim cut short the discussion, leaving Maria even angrier and feeling confused and isolated. Although it was unclear what may have triggered Tim's reactions and response, Maria speculated that he was extremely overworked and probably "burned out." Tim carried a small caseload himself, and Maria speculated that maybe he just could not handle hearing about someone else's cases.

In any supervisory relationship, interpersonal issues may surface that require attention. Given the power differential between supervisors and supervisees, it is the supervisor's responsibility to address these issues when

they surface (Goren, 2013; Miehls, 2010). From relational and trauma-informed perspectives, bringing up relational challenges deepens the supervisory relationship and models what clinicians also must do in their practice when transference occurs (Becker-Blease, 2017; Miehls, 2010).

The supervisory relationship also is a place where posttraumatic and adversarial growth can be promoted (Brockhouse et al., 2011). This underscores the importance of the consultant role. A supervisory alliance that fosters choice, collaboration, and empowerment is one that, by definition, encourages the supervisee's growth. Research findings suggest that the supervisor should make a concerted effort to assist supervisees in identifying the ways in which they have grown—both personally and professionally—from their work (Killian et al., 2017). The supervisor can, for example, ask that supervisees come to supervision prepared to talk not only about their challenges, but also their successes and indicators of growth (Berger & Quiros, 2014). Encouraging this discussion in supervision also has the advantage of modeling for clinicians the conversations they should have in their therapeutic encounters with clients.

Challenges and future directions

An obvious challenge is the ongoing need to educate providers of mental health services at all levels about the nature and principles of trauma-informed practice and care. This education must include identifying strategies and techniques of intervention that are consistent with a trauma-informed orientation. The trauma literature is vast, but it remains somewhat bifurcated. There is abundant literature on the need for a trauma-informed orientation and what this means. But the intervention literature—which also is extensive—focuses primarily on trauma-*focused* interventions for trauma survivors.

Most clinicians practice in settings in which clients present for treatment with a current problem in living rather than a desire or intent to address underlying trauma. It is these settings that are most in need of a trauma-informed orientation. It also is in these practice contexts where specific practice guidelines and intervention strategies—beyond the five principles of trauma-informed practice—must be more clearly articulated. Future efforts must be directed toward merging the trauma-informed literature with the practice literature that outlines intervention strategies appropriate for both trauma-focused and trauma-informed settings.

In terms of supervision, three challenges are evident, in addition to those mentioned at the outset of the discussion of trauma-informed supervision. First, in many if not most settings, supervisors serve as a teacher, consultant, and counselor to their supervisees as well as an evaluator of their work. The supervisor's evaluative responsibilities may inhibit supervisees' willingness and ability

to openly discuss challenges they face in their work or share with the supervisor observations about their working relationship. Authors have suggested that the evaluative function of supervision be separated from the clinical function (Mehr et al., 2015). For example, the supervisor could hold evaluative supervision meetings at a different time and context from those devoted to supervisees' clinical practice. Another option is to place responsibility for clinical supervision in the hands of individuals who do not have any associated administrative responsibilities for the supervisees (Heckman-Stone, 2004).

These two options require resources that may not be readily available. Therefore, it is noteworthy that the results of several studies have suggested that, when supervisors display genuineness and transparency, encourage supervisee feedback, clarify expectations associated with their clinical and administrative responsibilities, and create a supervisory climate characterized by mutual respect, the negative impact of their dual responsibilities is minimized (Kreider, 2014; Tromski-Klingshirn & Davis, 2007; Walsh, Gillespie, Greer, & Eanes, 2003). Each of these characteristics is inherent in trauma-informed supervision.

Second, trauma-informed supervision can only occur in an organizational context that is trauma-informed (Bassuk et al., 2017; Wolf et al., 2014). Trauma-informed supervision must be consistently available and ongoing. In many settings, more seasoned clinicians—who may be assigned the more challenging cases, including trauma survivors—receive little to no clinical supervision. Furthermore, trauma-informed supervisors must have access to the same sort of informed support and guidance as their supervisees. The requirements of trauma-informed care depend upon resources that may not be readily available.

Third, the trauma-informed literature assumes that trauma survivors are seen within an organizational context. In fact, many therapists who work with trauma survivors practice autonomously. The challenges associated with preparing individuals and agencies for trauma-informed practice and care are mirrored—and in fact amplified—in private practice settings. The application of trauma-informed practice and care in peer supervision has yet to be addressed.

Given the centrality of supervision to trauma-informed practice, far greater attention must be directed toward articulating specific supervisory techniques that are consistent with the principles of trust, safety, collaboration, control, and empowerment, but also account for the financial realities and the administrative responsibilities of the supervisor.

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