Journal of Counselor Preparation and Supervision

Volume 14 | Number 4 Article 12

2021

Supervision Strategies to Facilitate Vicarious Post Traumatic Growth Among Trauma Counselors

Jennifer D. Deaton
University of North Carolina at Greensboro, jddeaton@uncg.edu

Brooke Wymer
Clemson University, bcwymer@gmail.com

Ryan G. Carlson
University of South Carolina, carlsorg@mailbox.sc.edu

Follow this and additional works at: https://digitalcommons.sacredheart.edu/jcps

Part of the Counselor Education Commons

Recommended Citation

Deaton, J. D., Wymer, B., & Carlson, R. G. (2021). Supervision Strategies to Facilitate Vicarious Post Traumatic Growth Among Trauma Counselors. *Journal of Counselor Preparation and Supervision, 14*(4). Retrieved from https://digitalcommons.sacredheart.edu/jcps/vol14/iss4/12

This Article is brought to you for free and open access by DigitalCommons@SHU. It has been accepted for inclusion in Journal of Counselor Preparation and Supervision by an authorized editor of DigitalCommons@SHU. For more information, please contact ferribyp@sacredheart.edu, lysobeyb@sacredheart.edu.

Supervision Strategies to Facilitate Vicarious Post Traumatic Growth Among Trauma Counselors

Abstract

Counselors working with clients who have experienced trauma may encounter a range of indirect trauma responses (i.e., vicarious trauma, compassion fatigue, and/or secondary traumatic stress). Alternatively, counselors may experience positive affects such as living life more fully, treating others differently, or becoming more emotionally expressive in their relationships due to indirect trauma exposure. The latter experience is called vicarious post traumatic growth and has implications for more positive counselor functioning and better client outcomes. In this article, we review four enabling factors of vicarious post traumatic growth to provide supervision strategies to address indirect trauma; meaning making, social interests, social support, and empathy. Following, we offer a retrospective case analysis to demonstrate these strategies to facilitate vicarious post traumatic growth and implication considerations.

Keywords

supervision, vicarious trauma, vicarious post traumatic growth, supervision strategies, trauma counselors

Author's Notes

Correspondence concerning this article should be addressed to Jennifer D. Deaton, Counseling and Educational Development Department, University of North Carolina at Greensboro. Email: jddeaton@uncg.edu. Other authors' contact information are as follows; Brooke Wymer, Department of Education and Human Development, Clemson University. Email: bellis5@clemson.edu. Phone: 803.719.6103 and Ryan Carlson, Department of Educational Studies, University of South Carolina. Email: carlsorg@mailbox.sc.edu. Phone: 803-777-2889.

This article is available in Journal of Counselor Preparation and Supervision: https://digitalcommons.sacredheart.edu/jcps/vol14/iss4/12

Supervision Strategies to Facilitate Vicarious Posttraumatic Growth Among Trauma Counselors

Counselors working with clients who have experienced trauma may develop indirect trauma (Knight, 2018) responses such as vicarious trauma (McCann & Pearlman, 1990), compassion fatigue (Figley, 1995), or secondary traumatic stress (Canfield, 2005). The peer-reviewed literature contains considerable variability in the definition of these terms (Baird & Kracen, 2006). Vicarious trauma (VT) is defined as a shift in the clinician's cognitive schemas when exposed indirectly to trauma (McCann & Pearlman, 1990). Specifically, VT may cause disruption in the clinicians' views of the world, safety, self, and others (Pearlman & Saakitne, 1995; McLean et al., 2003). Compassion fatigue is associated with helping professionals experiencing desensitization, numbing, and decreased empathetic response due to frequent exposure to client suffering and/or indirect trauma exposure (Berzoff & Kita, 2010; Figley, 1995). Symptoms of secondary traumatic stress manifest similarly to posttraumatic stress disorder and include hypervigilance, avoidance, intrusion, as well as associated emotional distress (Ludick & Figley, 2017; Stamm, 1995). While these constructs differ in presentation, all three indicate a need for supervision and inquiry into the potential adverse effects of trauma work on the counselor. For the remainder of the article, we will utilize the term indirect trauma, as described by Knight (2018), to include VT, compassion fatigue, and secondary traumatic stress associated with working with client trauma.

Trauma counselors are at substantial risk for indirect trauma (Ludick & Figley, 2017; Stamm, 1995). Approximately 18% of general mental health workers identify secondary traumatic stress symptoms that potentially meet criteria for posttraumatic stress disorder (Meldrum, King, & Spooner, 2002). Moreover, sexual trauma counselors, counselors with a higher number of trauma

cases on their overall caseload (Schauben & Frazier, 1995; Pearlman & Mac, 1995), and counselors with a personal history of trauma (Ludick & Figley, 2017; Williams et al., 2012) report more indirect trauma than other speciality areas.

Working with clients who have experienced trauma is complex. Counselors working with clients who have trauma may engage in a process of reconstructing conceptualizations of themselves, others, and the world in an attempt to reduce indirect trauma (Brockhouse et al., 2011; Cohen & Collens, 2013; Triplett et al., 2012). This reconstruction produces not only positive emotions, but a cognitive shift towards self-actualization (Cohen & Collens, 2013). This cognitive shift and reconceptualization (Brockhouse et al., 2011; Cohen & Collens, 2013) is called vicarious posttraumatic growth (VPTG: Arnold et al., 2005). Over 70% of trauma counselors report living life more fully, treating others with greater kindness, or becoming more expressive emotionally within their personal lives as a result of their work with trauma. However, there remains a lack of supervision strategies to facilitate an intentional cognitive shift from indirect trauma towards VPTG among counselors (Knight, 2018).

Previously, scholars (Knight, 2018; Lonn & Haiyasoso, 2016) have conceptualized supervision strategies for addressing indirect trauma, however, none have addressed strategies rooted in facilitating VPTG. The purpose of this article is to draw from existing VPTG research and synthesize strategies to support facilitation of VPTG among counselors experiencing indirect trauma. In this article, we will (a) review four enabling factors of vicarious posttraumatic growth, (b) present strategies for facilitating VPTG among counselors experiencing indirect trauma, (c) outline strategies with a retrospective case analysis, and (d) discuss implication considerations.

Vicarious Posttraumatic Growth

Vicarious posttraumatic growth is the experience of growth as a result of working with

clients who have experienced trauma (Arnold et al., 2005). Growth may include changes in one's view of self and worldview, changes in interpersonal relationships (Bartoskova, 2017), spirtuality (Arnold et al., 2005), establishing meaningful work (Brockhouse et al., 2011), and finding ways to process the trauma work (Bartoskova, 2017). Previously, scholars (Bartoskova, 2017; Brockhouse et al., 2011) have attributed VPTG to social learning theory (Bandura, 1997). The counselor obtains the learned behavior of growth from their environment by observing the client's battle and survival during the therapeutic process (Bartoskova, 2017). Cohen and Collens (2013), alternatively, described an initial shock that occurs when hearing trauma the client has endured and their capabilities to overcome, which serves as the catalyst for VPTG. Within both theories, the process of VPTG begins after an initial distress caused by indirect trauma exposure to which the counselor must reconstruct their beliefs. It is the attempt to engage in reconstruction that reduces the symptoms of indirect trauma (Brockhouse et al., 2011).

Scholars consistently compare VPTG to the client experience of growth (i.e., posttraumatic growth) contributing to confusion within peer-reviewed literature. For example, trauma counselors have identified experiences of VPTG such as (a) noticing growth of self, (b) making a difference, and (c) finding their own ways to process the trauma work (Bartoskova, 2017). These themes are similar but contextually different than those found among primary trauma clients in Tedeschi and Calhoun's (1996) earlier work. Tedeschi and Calhoun (1996) developed three categories of posttraumatic growth from the client perspective: (a) self-perception, (b) changes in interpersonal relationships, and (c) changes in life philosophy. Individuals who experience trauma often report changes in how they perceive their abilities to face difficulty, a willingness to be more emotionally expressive in their relationships, and recognition of meaning amidst the aftermath that result in changes within their life philosophy (Tedeschi & Calhoun, 1996). Counselors experiencing VPTG

are finding their own ways to process the trauma work just as the client may find personal strength in self-perception. The counselor may also experience a sense of making a difference just as the client would experience the potential for new possibilities. Counselors, however, sustain a sense of invulnerability as they are not the personal victim. Further, a client may experience one traumatic experience while a counselor experiences chronic, cumulative indirect trauma exposure (Abel, Walker, Samios, & Morozow, 2014).

Across disciplines, researchers have identified several enabling factors of VPTG: social support, self-care, empathy, coherence (Brockhouse et al., 2011; Linley & Joseph, 2007; Mairean, 2016), social interest, and making meaning of the trauma work (Linley & Joseph, 2007). There are two externalized enabling factors to consider; (a) social support and (b) self-care (Brockhouse, et al., 2011; Mairean, 2016). For the client, social support plays a significant role in the adjustment to trauma exposure (Zhao, Wu, & Xu, 2013) as a way of coping with emotional distress and making meaning after trauma (Tedeschi & Calhoun, 1996). Similarly, social support serves as an enabling factor to VPTG among clinicians and helping professionals experiencing indirect trauma as a means of managing the emotional responses of the work (de Boer et al., 2014; Linley & Joseph, 2007). Self-care is not only critical to wellness and the therapeutic work, but an essential component to managing the emotional responses when working with client trauma (Lawson, 2007; Smith et al., 2007). Moreover, self-care that includes social interests fosters meaning making and meaning of life (Adler, 1998) to overcome distress and facilitate VPTG. Both social support and self-care include positive social interactions that may help counselors reduce indirect trauma and increase VPTG (Mairean, 2016).

Meaning making and empathy are two internalized processes that enable VPTG (Brockhouse et al., 2011; Linley & Joseph, 2007). A counselor’s ability to facilitate client

empowerment is a rewarding experience. Counselors gain their own sense of empowerment and validation of trauma work through the facilitation of the client's healing (Ling, Hunter, & Maple, 2014) permitting VPTG by being a part of the client's change (Bartoskova, 2017). Empathy is the ability to engage in placing oneself vicariously in another's shoes with openness and acceptance (Hojat, 2007). Empathic individuals are able to adjust the psychological distance between themselves and the client to enrich the empathic engagement by having more flexible schemas. Thus, challenging personal schemas to allow for the experience of growth following a personal impact of indirect trauma (Brockhouse et al., 2011).

Strategies for Facilitating VPTG During Supervision

When supervisors work with counselors experiencing indirect trauma, it is essential to address emotional responses of working with clients' trauma history (Knight, 2018; Berger &Quiros, 2016). However, supervisors must find a balance between not engaging in the dual role of counselor for the supervisee (ACA, 2014) while at the same time ensuring they are not ignoring, minimizing, or overlooking the counselor's indirect trauma responses in supervision (Knight, 2018). While counselors' indirect trauma responses may present like countertransference, Knight clarifies that these are different phenomena, but that indirect trauma could lead to countertransference. In order to address indirect trauma, the supervisor must monitor both the verbal and nonverbal clues of indirect trauma: (a) changes in the counselors' behavior, (b) signs of emotional exhaustion, (c) withdrawal, (d) distress, and (e) the inability to engage in self-care activities (Etherington, 2000). Currenlty, peer-reivewed supervision literature does not include clear strategies for supervisors to facilitate VPTG within trauma-informed supervision. However, based on enabling VPTG factors, we present the following supervision strategies in order to support facilitating VPTG during supervision.

Engaging Emotional Support within the Supervisory Relationship

As previously mentioned, social support is a VPTG factor by providing a means for managing emotional responses to trauma work (Linley & Joseph, 2007). This management comes from the opportunity for disclosure provided in social interactions. Therefore, having emotional support to discuss distress within the work environment is a catalyst for VPTG and aids managing strong emotions associated with the trauma exposure (Duffy et al., 2014).

Trauma-informed supervision requires a safe and validating supervisory relationship (Jordan, 2018) and therefore should cultivate an environment in which open and unedited dialogue can occur to allow for both positive and negative reactions to the clients' trauma narratives. Beginning at the organizational level, a community agency culture that normalizes and validates the counselors' reaction to the trauma narrative mitigates indirect trauma. However, a perceived unsupportive environment and lack of organizational support do not facilitate VPTG (Brockhouse, et al., 2011; Dombo & Blome, 2016). These environments may lead to counselor burnout (Newell & MacNeil, 2010), lower retention (Middleton & Potter, 2015), and to ineffective work with clients (Sprang, Craig, & Clark, 2011). Emotional support in the supervisory relationship includes the supervisor directly addressing the counselors' indirect trauma (Sommer & Cox, 2005).

The supervisor could engage the counselor to disclose personal feelings from client's trauma narratives that cannot be discussed outside of supervision. The first strategy to elicit disclosure in supervision is a supervisor may prompt the counselor to write down details of the client's trauma that stood out to them on a sheet of paper. Next, create two additional columns for the counselor to write down their initial thoughts of those details in one column and the counselor's feelings towards those details. The supervisor may then utilize this strategy to process the counselor's emotional response to the client's trauma narrative. The supervisor would then

normalize and validate the counselor's responses, as well as assist the supervisee in resolving the narrative. This resolution could include processing ways to manage responses, make meaning of the experience, and affirm the counselor's competency and purpose in trauma work. This strategy can be used on one individual case or on a cumulation of details across cases to allow for the counselor to address their feelings of the case head on.

A second strategy to engage emotional support is to offer open door hours in which the counselor has accessibility to the supervisor in order to "debrief" the narrative received from the client. This can be offered similarly to office hours provided in an educational setting or can be structured at the beginning or end of the supervision session. Comparable to relational supervision theories (Peled-Avram, 2017), this allows for the counselor to receive the supervisor's immediate reactions to the trauma narrative while the supervisor addresses the counselor's immediate feelings. Other scholars have noted strategies in trauma-informed supervision that may offer emotional support such as facilitating peer support within group supervision, facilitating conversations around beginning counselors' experiences within their role as trauma counselors (Lonn & Haiyasoso, 2016), or an affective check in to address counselors' personal feelings prior to addressing interventions and case conceptualization (Etherington, 2000). Jordan (2018) further recommends exploring the counselor's trauma genogram to understand the depth in which working with clients who have experienced trauma may trigger the counselor.

Identify a Self-Care Plan to Include Social Interests and Meaning Making

Providing mental health services can be physically, psychologically, and emotionally exhausting among professionals due to various demands (Lenz, Oliver, & Sannganjanavanich, 2014). Additionally, a counselor's ability to build a therapeutic relationship is hindered when a counselor is unable to facilitate a lifestyle that encourages optimum wellness (Lawson, 2007;

Smith et al., 2007). Indirect trauma can negatively influence a counselor's sense of purpose and meaning in life (Solomon, 2004). Scholars have previously inferred a counselor is able to cope with stress and trauma more effectively when they are able to identify purpose and meaning in life (Bartoskova, 2017). Moreover, supervision which emphasizes self-care safeguards against indirect trauma facilitates VPTG (Absassary & Goodrich, 2014).

Utilizing supervision to create a self-care plan that includes engaging in social interests and meaning making enables VPTG. A supervisor may facilitate this by outlining a weekly self-care plan that can be facilitated in supervision or in the workplace. One strategy to promote social interests in self-care includes encouraging counselor-led self-care initiatives within the organization such as office book clubs, social gatherings, and peer-led exercise clubs. This allows the counselors to engage in self-care, cultivate a supportive culture, and promote counselor ownership of their protective strategies. Further, this positions the counselor to prioritize self-care over the care the counselor provides to their clients (Jordan, 2018). Promoting self-care activities within the organizational or supervisory environment lowers the risk associated with indirect trauma while simultaneously conveying to the staff the investment and responsibility of clinicians' care (Hensel, Ruiz, Finney, & Dewa, 2015; Sprang, Ross, Miller, Blackshear, & Ascienzo, 2017). Self-care should not only be encouraged by supervisors, but structured within scheduling so that counselors may have time allocated for self-care (Sommer & Cox, 2005). For example, when possible, a counselor should be given control of their schedule to balance their trauma cases throughout the week supporting a practice of structured self-care. The counselor may schedule their trauma cases for the beginning of the week and non-trauma cases towards the end of the week, schedule trauma cases for certain parts of the day or sporadically throughout the day, and build in short breaks between trauma cases to engage in grounding activities. When a counselor is

proactive about self-care, indirect trauma can be managed more effectively (Bober & Regehr, 2006; Layne et al., 2011; Knight, 2013). Further, promoting counselors' ownership of their protective strategies enables the counselor to facilitate their own wellness initiatives as a part of their overall practice. Jordan (2018) adds trauma-informed supervisors should focus on increasing the counselor's awareness of their own needs and boundaries to balance and prioritize accordingly. Lastly, a supervisor should follow up weekly on the counselor's self-care plan, address any barriers or challenges in the plan, and aid the counselor in creating time and space for their social interests.

Other scholars have suggested mental health agencies incorporate practices to mitigate indirect trauma such as reducing caseloads, increasing paid leave, and engaging in non-direct aspects of the trauma work such as case management or advocacy work (Chrestman, 1999; Kassam-Adams, 1999; Rosenbloom et al., 1999; Rudolph & Stamm, 1999; Schauben & Frazier, 1995; Trippany et al., 2004). However, the demands of the agency often preceed these strategies leaving self-care to be neglected. Therefore, supervisors may elect to utilize supervision time to incorporate self-care practices for immediate needs and reduce indirect trauma. Examples include yoga, meditation, expressive arts, mindfulness or Qi gong to increase awareness, mental clarity, and centeredness (Christopher, et al., 2006; Schure, Christopher, & Christopher, 2008).

Facilitate Meaning Making within Clinical Work

Counselors often report experiencing a change in worldview as a result of working with trauma clients leading to both a re-evaluation of life priorities and VPTG (Bartoskova, 2017). Therefore, counselors making meaning of clinical work is critical in facilitating VPTG (Linley & Joseph, 2007). Moreover, scholars argue indirect trauma is a necessary element of working with trauma in order to understand the positives of the work (Abassary & Goodrich, 2014) and facilitate VPTG (Author, 2020). Thus, addressing the potential negative impact of trauma

work in supervision provides a necessary avenue to directly discuss the personal feelings of counselors experiencing indirect trauma (Sommer & Cox, 2005) and enable meaning making (Linley & Joseph, 2007). This can be done by reframing the counselor's clinical work (Lonn & Haiyasoso, 2015) and the implications of indirect trauma for a greater purpose.

One strategy for assisting counselors in meaning-making associated with trauma work may include offering journal prompts for counselors to reflect on between supervision sessions such as; (a) *Why did I choose this work?* (b) *What have I gained and/or learned from my clients?* (c) *What has changed in my life since becoming a counselor?* (d) *What are my strengths as a counselor?* (e) *How have I changed as a result of my work with clients?* Another strategy may include incorporating expressive arts within supervision to facilitate meaning-making. For example, a supervisor may ask the counselor to draw, collage, or construct who they are as a result of their work with trauma to foster meaning within their work.

Other strategies may include normalizing the difficulties associated indirect trauma, sharing experiences the supervisors themselves may have experienced (Knight, 2018), or highlighting progress the client has experienced as a result of the counselors' work (Pack, 2014). Further, a supervisor may emphasize the client's engagement in the therapeutic process and the strengths of the counselor. Lastly, a supervisor may encourage the counselor to elicit client feedback with open-ended questions at the close of each supervision session (Authors, 2014) to foster the meaning making of trauma work.

Assess Levels of Empathy for VPTG Facilitation

Being emotionally perceptive is a natural characteristic and necessary as a helping professional (Ling, Hunter, & Maple, 2014). Empathic individuals have the unique ability to make necessary adjustments based on the personal impact of indirect trauma (Brockhouse et al., 2011).

Highly empathic counselors, for instance, have the ability to adjust their relating-to-others schemas by decreasing the emotional distance between the client and the counselor, and therefore challenging personal schemas. A counselor may metaphorically apply the traumatic event to themselves and engage in the belief that counseling is making a foreseeable difference. This allows the counselor to reframe the adverse experiences of working with trauma into something that is concrete, manageable, and within the context of the work (Ling, Hunter & Maple, 2014; Linley & Joseph, 2007). Further, counselors with higher levels of empathy are associated with higher levels of growth (Brockhouse et al., 2011; Linley & Joseph, 2007).

Counselors working with clients who experience trauma, experience chronic and cumulative indirect trauma exposure themselves. Therefore, empathic stamina and engaging in self-reflection are essential for balance among indirect trauma exposure and empathic energy (Ling, Hunter, & Maple, 2014). Counselors can practice this balance by setting boundaries between the emotional demands of the narrative with their responsibilities in the therapeutic relationship. Finding this balance requires a process of continuous self-awareness to maintain wellbeing through supervision, peer support, professional development, or personal counseling. Linley and Joseph (2007) found counselors who engaged in supervision or personal counseling reported more positive psychological changes and less burnout. Moreover, personal counseling served as a protective factor against indirect trauma and a facilitator of growth.

Consequently, engaging in empathic interactions places counselors at risk for indirect trauma and compassion faigue (Figley, 2002). Therefore, supervision around empathy should support counselors with establishing and maintaining professional boundaries as well as developing a daily practice of emotional regulation and self-other awareness (Wagaman, Geiger, Shockley, & Segal, 2015). Professional boundaries may include internal strategies such as

separating oneself emotionally from the client, limiting self-disclosure, or practicing grounding techniques for emotional regulation. Other externalized strategies may include reducing indirect trauma exposure unrelated to work such as television, movies, or podcasts depicting similar trauma narratives. Assessing empathy can support both the counselor and supervisor to determine the flexibility within the counselor's schema and provide a foundation of information about the counselor and their susceptibility to indirect trauma. A supervisor may assess a counselor's empathy through direct observation or video recording to monitor the counselors' self-other awareness, empathy towards the trauma narrative, and clinical decision-making patterns (Wagaman, et al., 2015). Further, we recommend using empathy measures for objective and measureable information.

One tool for assessing a counselor's level of empathy is The Empathy Assessment Index (EAI). The EAI consists of four subscales measuring affective response (α = .84), self-other awareness (α = .70), perspective taking (α = .82), and emotional regulation (α = .72) through a 20 -item self-report assessment (Lietz et al., 2011). This information allows the counselor and the supervisor to use the EAI as a tool when addressing the personalization of the trauma by providing a comprehensive understanding of the areas in which empathy is the strongest for the counselor. Further, a supervisor may use the tool to process the strengths and limitations of the counselor's empathy and its impact on their work with clients. Another measure to consider is the Professional Quality of Life Scale (ProQOL; Stamm, 2010). The ProQOL separately measures compassion satisfaction (α =.87), burnout (α = .72), and compassion fatigue/secondary trauma (α = .80). A supervisor may elicit this measure to assess how much compassion satisfaction and secondary trauma the counselor is experiencing if significant emotional responses are observed (Stamm, 1999). Further, a supervisor may evaluate their work with the supervisee through the changes in

these measures. It should be noted the ProQOL is not a diagnositic tool however, high scores in burnout or secondary traumatic stress and low scores in compassion satisfaction should be evaluated further (Stamm, 2010). Lastly, supervisors should model empathic understanding of the counselor's experience to alleviate stress and facilitate VPTG (Abassary & Goodrich, 2014).

Retrospective Case Analysis

The following strategies were implemented with a supervisee in an education setting at a university-based clinic. Names have been changed for the purpose of this retrospective case analysis. Ashlee was a counseling intern receiving weekly supervision and working with child survivors of sexual trauma. Supervision often began with a weekly check-in at which the supervisor began to notice incongruence in the dialogue of the check-in with the presentation of Ashlee's demeanor. Ashlee was quiet, distant, and keeping closely to the facts of the case. When confronted about the incongruency, Ashlee began to open up about feeling overwhelmed with the stories that she was hearing. Ashlee described starting to experience nightmares around her clients' trauma narratives and becoming hypervigilant when at home alone or in public. Ashlee knew that she could not disclose client details to her peers, but also felt that weekly supervision was not quite meeting her needs in addressing these responses. Etherington (2000) described the importance of supervisor's engaging in this affective checking-in with counselors regarding the emotional impacts of trauma work and ensuring counselor's feelings are accepted, normalized, and addessed.

Before proposing a solution, the supervisor began to ask Ashlee more about the feelings that she was having towards the client narratives to assess for VT. Ashlee reported that when she was with her peers, she began to pay more attention and monitor children and their families surrounding them. Ashlee described being fearful that children may experience abuse without

others knowing. Additionally, she related having difficulty hearing friends make inappropriate jokes after hearing the stories that she had in her sessions.

Emotional Support

After hearing Ashlee's experience of being overwhelmed, the supervisor understood Ashlee needed an outlet in-between supervision sessions to disclose the trauma narratives. Ashlee and the supervisor set up drop-in, open door hours at the end of the day, two days a week for debriefing sessions throughout the week. This allowed Ashlee to be able to come in and discuss some of the harsher narratives and obtain emotional support during disclosure. In the debriefing sessions, Ashlee shared narratives from clients. The supervisor elicited emotional support by providing an authentic reaction to Ashlee's disclosures. The debriefings were directed toward Ashlee's personal processing of the information, leaving supervision to address her personalization of the trauma narrative. During formal supervision, the supervisor asked Ashlee directly how she was processing the client's session and what personal reactions she had.

Social Interests

The second strategy the supervisor implemented with Ashlee was to assess the utilization of her self-care plan and its effectiveness. Ashlee described her self-care as a part of her schedule. The self-care had quickly become additional work or tasks to complete; meeting a church group, meeting a running group, and service obligations. The supervisor began asking Ashlee where she finds passion and value outside of work. Ashlee shared she enjoyed volunteering with her church or painting at home but had not felt that she had the time to participate in her interests. Inquiring about Ashlee's social interests allowed the supervisor to support a self-care plan that would support establishing meaning in Ashlee's life and within her work.

Ashlee and the supervisor formally began to plan out her self-care to include activities that

made meaning in her life. Ashlee agreed that making plans to volunteer within her church initiatives gave her a greater meaning outside of her work which made her feel confident and prepared, but too much involvement felt like a second job. The supervisor and Ashlee worked together to prioritize the plan and adjust for fewer cases towards the end of the week, which left room for volunteering. Ashlee decided to leave work a few hours early on Fridays to spend a little time with her church's afterschool program or to simply take the time to create art for herself. This allowed Ashlee to have the allotted time at an organizational level while taking ownership of how she should best use that time. Further, Ashlee and her supervisor incorporated a schedule that placed her more difficult cases at the beginning of the week when she was the most focused and prepared.

Meaning Making

In subsequent supervision sessions, Ashlee often discussed her feelings around the inconsistencies with her clients when they would not attend sessions. The supervisor began to notice a personalization within the reflection. Through discussing the sessions further, the supervisor began to reframe the interventions Ashlee used to identify meaningful and small victories. For example, when Ashlee's client continued to be inconsistent towards their goals, the supervisor provided support supported by reminding Ashlee the client had maintained contact with Ashlee indicating the strength of the therapeutic relationship (Lonn & Haiyasoso, 2016).

Empathy

Lastly, the supervisor assessed Ashlee's empathic engagement with her clients through video observation. While Ashlee's empathy and compassion were true assets to her clinical work, they were particularly taxing on her well-being. Ashlee had not set a routine to balance her emotional well-being nor established a practice that would

incorporate immediate relief of indirect trauma. The supervisor provided a brief didactic on empathy and the need for self-care between clients. Collaboratively, Ashlee and the supervisor then incorporated strategies of immediate self-care and mindfulness through technology and online guided imagery resources to be used in-between sessions as needed

Over time, through observation and self-report, Ashlee reported a reduction in adverse responses. Ashlee and her supervisor began each session with addressing her symptoms directly to engage emotional support within the relationship and ended with brief mindfulness and guided imagery to practice strategies for immediate self-care. Each of these strategies became a weekly practice of her supervision in order to address indirect trauma and support the facilitation of VPTG. Lastly, Ashlee utilized the open door hours consistently, but reduced her need for the time as a her indirect trauma decreased and her positive responses increased.

Ethical Considerations

Ethical considerations for these strategies include maintaining the appropriate boundaries of the supervisor role as to not transition into a therapeutic role (Bernard & Goodyear, 2014; Knight, 2018). Misusing the supervisor role to enact as a counselor neglects the supervisee's needs for development and disrupts self-efficacy (Berger & Quiros, 2016; Bernard & Goodyear, 2014). However, should the counselor experience significant impairment as a result of indirect trauma, the supervisor is ultimately responsibility for the welfare of the client (ACA, 2014). Other ethical considerations when utilizing the strategies include the supervisor's responsibility to encourage and foster the supervisee's engagement through a multicultural lens and take into account the unique needs and preferences of the supervisee (Borders, 2014; Knight, 2018). The supervisor should engage emotional support within the supervisory relationship but encourage external social

support as it pertains to the counselor's support system and community. Additionally, meaning making should be supported and facilitated within the context of the counselor's culture such as spirituality, finding purpose, or fostering personal relationships. For example, finding existential meaning may be an internalized purpose or externalized such as familial responsibility or of a religious guidance.

Conclusion

Professional effectiveness and personal wellness may be sacrificed when the threshold of enduring and acclimating to stressors have been reached (Lenz, Oliver, & Sannganjanavanich, 2014). Candidly, no counselor is invulnerable to the difficulty of trauma work regardless of specialty. The primary aim of the presented strategies is to support supervisors in facilitating VPTG among counselors who self-report or exhibit signs of indirect trauma. Supervisors should engage with counselors in ways that allow disclosure of the trauma narrative in order to elicit emotional support rather than minimize the reactions to the trauma work. This can be done through debriefing sessions and open dialogue around the personal feelings of the client's trauma. Self-care that engages social interests and meaning making among supervisees can be supported by the supervisor by providing self-care opportunities in the organizational structure or allowing time during the work week for self-care. Facilitation of meaning making should also occur during supervision through reframing and providing insight to the counselor's meaningful work. Lastly, the supervisor may assess levels of empathy through observation or using an empathy measure in order to assess and address the counselor's emotional engagement with the client. In order to fulfill the ethical responsibility of the profession both as counselors, supervisors, and counselor educators, we must support the facilitation of VPTG when working with trauma.

References

Abassary, C. & Goodrich, K. M. (2014). Attending to crisis-based supervision for counselors: The care model of crisis-based supervision. *The Clinical Supervisor, 33*, 63-81. doi:10.1080/07325223.2014.918006

Abel, L., Walker, C., Samios, C., & Morozow, L. (2014). Vicarious posttraumatic growth: Predictors of growth and relationships with adjustment. *Traumatology: An International Journal, 20*(1), 9-18. doi: http://dx.doi.org/10.1037/h0099375

Adler, A. (1998). *Social interest: Adler's key to the meaning of life*. Oxford, England; Boston, MA: Oneworld Publications. (Original work published in 1938)

American Counseling Association, (2014). ACA code of ethics. https://www.counseling.org/knowledge-center.

Arnold, D., Calhoun, L.G., Tedeschi, R.G. & Cann, A. (2005). Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology, 45*(2), 239–263. doi: 10.177/0022167805274729

Baird, K., & Kracen, A. C. (2006) Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counselling Psychology Quarterly, 19*(2), 181-188. doi: 10.1080/09515070600811899

Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice Hall.

Bartoskova, L. (2017). How do trauma therapists experience the effects of their trauma work, and are there common factors leading to post-traumatic growth? *Counselling Psychology Review*, *32*(2), 30-45.

Berger, R., & Quiros, L. (2016). Best practices for training trauma-informed practitioners: Supervisors' voice. *Traumatology, 22,* 145-154. doi: 10.1037/trm0000076

Bernard, J. M. & Goodyear, R. K. (2014). *Fundamentals of clinical supervision* (5th ed.). New York, NY: Pearson

Berzoff, J., & Kita, E. (2010). Compassion fatigue and countertransference: Two different concepts. *Clinical Social Work Journal, 38*(3), 341-349. doi: 10.1007/s10615-010-027-8

Bober, T., & Regehr, C. (2006). Strategies for reducing secondary or vicarious trauma: Do they work? *Brief Treatment and Crisis Interventions, 6,* 1-9. doi: 10.1093/brief-treatment/mhj001

Borders, L. D. (2014). Best practices in clinical supervision: Another step in delineating effective supervision practice. *American Journal of Psychotherapy, 68*(2), 151-162. doi: 10.1176/appi.psychotherapy.2014.68.2.151

Brockhouse, R., Msetfi, R.M., Cohen, K. & Joseph, S. (2011). Vicarious exposure to trauma and growth in therapists: The moderating effects of sense of coherence, organizational support, and empathy. *Journal of Traumatic Stress, 24*(6), 735–742. doi: 10.1002/jts.20704

Canfield, J. (2005). Secondary traumatization, burnout, vicarious traumatization. *Smith College Studies in Social Work,* 75(2), 81-101. doi: 10.1300/J497v75n02_06

Chrestman, K. (1999). Secondary exposure to trauma and self-reported distress among therapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed.) (pp. 29–36). Lutherville, MD: Sidran Press.

Christopher, J. C., Christopher, S. E., Dunnagan, T., & Schure, M. (2006). Teaching self-care through mindfulness practices: The application of yoga, mediation, and qigoing to counseling training. *Journal of Humanistic Psychology, 46,* 494-509. doi: 10.1177/0022167806290215

Cohen, K., & Collens, P. (2013). The impact of trauma work on trauma workers: A metasynthesis on vicarious trauma and vicarious posttraumatic growth. *Psychological Trauma: Theory, Research, Practice, and Policy, 5*(6), 570-580. doi: http://dx.doi.org/10.1037/a0030388

Deaton, J. (2020). *Vicarious posttraumatic growth among helping professionals: Factor analysis and an investigation of construct validity* (Publication No. 27743330) [Doctoral dissertation, University of South Carolina]. ProQuest Dissertation Publishing.

de Boer, J., van Rikxoort, S., Bakker, A. B., & Smit, B. J. (2014). Critical incidents among intensive care unit nurses and their need for support: Explorative interviews. *Nursing in Critical Care, 19*(4), 166–174. Doi: https://doi.org/10.1111/nicc.12020

Dombo, E. A., & Blome, W. (2016). Vicarious trauma in child welfare workers: A study of organizational responses. *Journal of Public Child Welfare, 10,* 505-523. doi: 10.1080/15548732.20161206506

Duffy, E., Avalos, G., & Dowling, M. (2014). Secondary traumatic stress among emergency nurses: A cross-sectional study. *International Emergency Nursing*, 23(2), 53-58. doi: 10.1016/j.ienj.2014.05.001

Etherington, K. (2000). Supervising counsellors who work with survivors of childhood sexual abuse. *Counselling Psychology Quarterly, 13*, 377–389. doi: 10.1080/09515070110037975

Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York, NY: Brunner/Mazel.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology, 58*(11), 1433-1441. doi: 10.1002/jclp.10090

Haber, R., Carlson, R. G., & Braga, C. (2014). Use of an anecdotal client feedback note in family

therapy. *Family Process, 53,* 307-317. doi: 10.1111/famp.12070

Hensel, J. M., Ruiz, C., Finney, C., & Dewa, C. S. (2015). Meta-analysis of risk factors for secondary traumatic stress in therapeutic work with trauma victims. *Journal of Traumatic Stress, 28,* 83-91. doi: 10.1002/jts.21998

Hojat, M. (2007). *Empathy in patient care: Antecedents, development, measurement and outcomes.* New York, NY: Springer Science + Business Media.

Jordan, K. (2018). Trauma-informed counseling supervision: Something every counselor should know about. *Asian Pacific Journal of Counselling and Psychotherapy, 9*(2), 127-142. doi: 10.1080/21507686.2018.1450274

Kassam-Adams, N. (1999). The risks of treating sexual trauma: Stress and secondary trauma in psychotherapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed.) (pp. 37–48). Lutherville, MD: Sidran Press.

Knight, C. (2013). Indirect trauma: Implications for self-care, supervision, the organization, and the academic institution. *The Clinical Supervisor, 32,* 224-243. doi: 10.1080/07325223.2013.850139

Knight, C. (2018). Trauma-informed supervision: Historical antecedents, current practice, and future directions. *The Clinical Supervisor, 37*(1), 7-37. doi: 10.1080/07325223.2017.1413607

Lawson, G. (2007). Counselor wellness and impairment: A national survey. *Journal of Humanistic Counseling, Education, and Development, 46*, 20 – 34. doi: 10.1002/j. 2161-1939.2007.tb00023.x

Layne, C. M., Ippen, C., Strand, V., Stuber, M., Abramovitz, R., Reyes, G.,…Pynoos, R. (2011).

The core curriculum on childhood trauma: A tool for training a trauma-informed workforce. *Psychological Trauma: Theory, Research, Practice, and Policy, 3,* 243-252. doi: https://doi.org/10.1037/a0025039

Lenz, A. S., Oliver, M., & Sangganjanavanich, V. F. (2014). Perceptions of the wellness model of supervision among counseling interns. *The Clinical Supervisor*, *33*(1), 45.62. doi:10.1080/07325223.2014.905814

Lietz, C. A., Gerdes, K. E., Sun, F., Geiger, J. M., Wagaman, M. A., & Segal, E. A. (2011). The Empathy Assessment Index (EAI): A confirmatory factor analysis of a multidimensional model of empathy. *Journal of Society for Social Work and Research, 2*(2), 104-124. Doi 10.5243/jsswr.2011.6

Ling, J., Hunter, S. V., & Maple, M. (2014). Navigating the challenges of trauma counselling: How counsellors thrive and sustain their engagement. *Australian Social Work, 67*(2), 297-310. doi: 10.1080/0312407X.2013.897188

Linley, P.A. & Joseph, S. (2007). Therapy work and therapists' positive and negative well-being. *Journal of Social and Clinical Psychology,* *26*(3), 385–403. doi: 10.1521/jscp.2007.26.3.385

Lonn, M. R. & Haiyasoso, M. (2016). Helping counselors "stay in their chiar": Addressing vicarious trauma in supervision. *In Ideas and research you can use: VISTAS Online 2016.* Retrieved from https://www.counseling.org/docs/default-source/vistas/article_90_2016.pdf?sfvrsn=4

Ludick, M., & Figley, C. R. (2017). Toward a mechanism for secondary trauma induction and reduction: Reimagining a theory of secondary traumatic stress. *Traumatoloty, 23*(1), 112-123. http://dx.doi.org/10.1037/trm0000096

Mairean, C. (2016). Secondary traumatic stress and posttraumatic growth: Social support as a moderator. *The Social Science Journal, 53*, 14–21. doi: 10.1016/j.soscij.2015.11.007

McCann, I.L. & Pearlman, L.A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3,* 131–149.

McLean, S., Wade, T.D. & Encel, J.S. (2003). The contribution of therapist beliefs to psychological distress in therapists: An investigation of vicarious traumatization, burnout and symptoms of avoidance and intrusion. *Behavioral and Cognitive Psychotherapy, 31*, 417–428. doi: 10.1017/S135246580300403X

Meldrum, L., King, R., & Spooner, D. (2002). Secondary traumatic stress in case managers working in community mental health services. In C. R. Figley (Ed.), *Treating compassion fatigue* (pp. 85–106). New York: Brunner-Routledge. 70.

Middleton, J. S., & Potter, C. C. (2015). Relationship between vicarious traumatization and turnover among child welfare professionals. *Journal of Public Child Welfare, 9*(2), 195-216. doi: 10.1080/15548732.2015.1021987

Newell, J. M., & MacNeil, G. A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventative methods for clinicans and researchers. *Best Practice in Mental Health, 6*(2), 57-68.

Pack, M. (2014). Vicarious resilience: A multilayered model of stress and trauma. *Affilia, 29*(1), 18-29. doi: 10.1177/0886109913510088

Pearlman, L., & Mac, I. P. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26,*

558–565.

Pearlman, L., & Saakvitne, K. (1995). *Trauma and the therapist*. New York: Norton.

Peled-Avram, M. (2017). The role of relationship-oriented supervision and personal and work-related factors in the development of vicarious traumatization. *Clinical Social Work Journal, 45*(1), 2-32. doi: 10.1007/s10615-0151-0573-y

Rosenbloom, D., Pratt, A., & Pearlman, L. (1999). Helpers' responses to trauma work: Understanding and intervening in an organization. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed.) (pp. 65–79). Lutherville, MD: Sidran Press.

Rudolph, J. M., & Stamm, B. H. (1999). Maximizing human capital: Moderating secondary traumatic stress through administrative and policy action. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed.) (pp. 277–290). Lutherville, MD: Sidran Press.

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly, 19*, 49–64. doi: 10.1111/j.1471-6402.1995.tb00278.x

Schure, M. B., Christopher, J., & Christopher, S. (2008). Mind-body medicine and the art of self-care: Teaching mindfulness to counseling students though yoga, meditation, and Qigong. *Journal of Counseling and Development, 86,* 47-56. doi: 10.1002/j.1556-6678.2008.tb00625.x

Smith, H. L., Robinson III, E. H., & Young, M. E. (2007). The relationship among wellness, psychological distress, and social desirability of entering master's level counselor trainees. *Counselor Education and Supervision, 47*, 96–109. doi: 10.1002/j.1556-

6978.2007.tb00041.x

Solomon, J. L. (2004). Modes of thought and meaning making: The aftermath of trauma. *Journal of Humanistic Psychology, 44*(3), 299–319. http:// dx.doi.org/10.1177/0022167804266096

Sommer, C., & Cox, J. (2005). Elements of supervision in sexual violence counselors' narratives: A qualitative analysis. *Counselor Education and Supervision, 45*, 119–134. doi: 10.1002/j.1556-6978.2005.tb00135.x

Sprang, G., Craig, C., & Clark, J. (2011). Secondary traumatic stress and burnout in child welfare workers: A comparative analysis of occupational distress across professional groups. *Child Welfare, 90*(6), 149-168. doi: 10.1080/10615800903085818

Sprang, G., Ross, L., Miller, B. C., Blackshear, K., & Ascienzo, S. (2017). Psychometric properties of the secondary traumatic stress – Informed organizational assessment. *Traumatology, 23*(2), 15-171. doi: 10.1037/trm0000108

Stamm, B. H. (2010). *The concise ProQOL manual* (2nd ed.) Pocatello, ID: ProQOL.org.

Stamm, B. H. (1999). *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators* (2nd ed.). Lutherville, MD: Sidran Press.

Stamm, B. H. (Ed.). (1995). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. Baltimore, MD, US: The Sidran Press.

Tedeschi, R.G. & Calhoun, L.G. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9,* 455–471.

Triplett, K. N., Tedeschi, R. G., Cann, A. Calhoun, L.G. & Reeve, C. L. (2012). Posttrauamtic growth, meaning of life, and life satisfaction in response to trauma. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*(4), 400-410. doi: 10.1037/a0024204

Trippany, R. L., White Kress, V. E., & Wilcoxon, S. A. (2004). Preventing vicarious trauma: What

counselors should know when working with trauma survivors. *Journal of Counseling & Development, 82,* 31–37. doi: 10.1002/j.1556-6678.2004.tb00283.x

Wagaman, M. A., Geiger, J. M., Shockley, C., & Segal, E. A. (2015). The role of empathy in burnout, compassion satisfaction, and secondary traumatic stress among social workers. *Social Work, 60*(3), 201-2019. doi: 10.1093/sw/sw014

Williams, A. M., Helm, H. M., & Clemens, E. V. (2012). The effect of childhood trauma, personal wellness, supervisory working alliance, and organization factors on vicarious traumatization. *Journal of Mental Health Counseling, 34*(2), 133–153. doi:10.1037/trm0000024.

Zhao, C., Wu, Z., & Xu, J. (2013). The association between post-traumatic stress disorder symptoms and the quality of life among Wenchuan earthquake survivors: The role of social support as a moderator. *Quality of Life Research, 22*(4), 733–743. doi: 10.1007/s11136-012-0197-4