The Lived Experience of Trauma Counselor Supervisors

Nancy N. Fair

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THE LIVED EXPERIENCE OF TRAUMA COUNSELOR SUPERVISORS

A Dissertation
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In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By
Nancy N. Fair

August 2017
ABSTRACT

THE LIVED EXPERIENCE OF TRAUMA COUNSELOR SUPERVISORS

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Nancy N. Fair

August 2017

Dissertation supervised by Dr. Lisa Lopez Levers

Trauma is ubiquitous in our society, taking a costly toll on the physical and psychological well-being of individuals across all social strata, and creating an ever-increasing need for better understanding of how to help the victim survivors. The purpose of this current study addresses an aspect of that need for understanding by examining the lived experiences of clinicians who have learned about trauma and who are addressing trauma survivors’ needs by acting as supervisors for other clinicians. This qualitative, phenomenologically oriented study used van Manen’s (1990) four lived existentials, Bronfenbrenner’s (1979, 2005) bi- ecological model of human development, and existing trauma literature as its base. Historically, basic trauma education has not been provided to master’s or doctoral level students in counselor education programs. The rapidly expanding base of
trauma literature has referenced knowledgeable, competent supervision as a necessity for therapists working with traumatized clients, yet little has been written about those supervisors, how they are trained and educated, and their lived experience in the process of becoming competent trauma supervisors.

For this study, eight clinicians who have been supervising other clinicians who work with adult survivors of childhood sexual abuse were interviewed. The results were summarized into five themes that focused on the ubiquity of trauma, the “trial by fire” learning that was required to become knowledgeable, the rise to supervisory roles for which participants were sometimes unprepared, what they needed but didn’t get, and what they deem necessary to support them in their work. The author suggests ways in which the field of counselor education could be enhanced to better support supervisors in addressing the needs of their supervisees, and those of their traumatized clients.
DEDICATION

To my clients: You have taught me more about trauma, resilience, and healing than I ever imagined possible.
ACKNOWLEDGEMENTS

First and foremost, I want to thank my dissertation chair, Dr. Lisa Lopez Levers for her unwavering support for me in this endeavor. She held the hope for me when I couldn’t, and believed in me when I didn’t. Her ability to execute seemingly impossible feats of practical magic over the course of my journey continues to amaze me, and her dedication to the subject of trauma was much of the reason why I loved this program. Her writing, and the writing of other authors she recommended opened my eyes to aspects of philosophical thinking that enhance my work as a counselor. Her humor and insight have continued to support me, both as a student and as a person.

The members of my committee have earned my deepest thanks as well for helping me through this process. Dr. Matthew Walsh has inspired me by sharing his enthusiastic and warm support, and his brilliant dissertation as a model for what can be accomplished. Dr. Gibbs Kanyongo has my heartfelt gratitude for stepping up to the plate to fill the breach in my committee at the last minute. His actions have helped to avert a potential trauma.

I offer sincere thanks to the members of the faculty of the School of Education who helped me on my journey to becoming a trauma counselor supervisor. I began the ExCES program at the same time that I was promoted to supervisor in my job, which made the program an authentic laboratory experience.

To the friends I made in the program: I will never forget you and the support we created for each other as the first all-female cohort. And to Dr. Launcelot Brown,
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I am grateful to my family members who supported me in this undertaking, especially my grandparents, who did not live to see my accomplishment but whose love and support made me capable of attaining it. To my husband, sisters and brother, who put up with my many emotions associated with this project, I am truly grateful. I am especially thankful for my son, Micah, whose presence in my life has made me truly understand the depths of love and compassion as no other relationship could. You are the light of my life.

This list could not be complete without mentioning the friends who listened to the tales of my saga, and who supported me tirelessly. And to my former mother-in-law, Sally, I offer posthumous thanks. You didn’t quite make it to my graduation, but you made a huge difference in my life.
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CHAPTER I: INTRODUCTION

Trauma is ubiquitous in our society, taking a costly toll on the physical and psychological well-being of individuals across all social strata, and creating an ever-increasing need for better understanding of how to help the victim survivors. Levers (2012) states, “Understanding the effects of traumatic events is a complex endeavor. Trauma affects people on multiple levels, including in the most intimately personal as well as in relational, social, and cultural ways.” (p. 3) This current study addresses an aspect of that need for understanding by examining the lived experiences of clinicians who have learned about trauma and who are addressing trauma survivors’ needs by acting as supervisors for other clinicians. While it is clear that trauma affects people on many levels, this study’s scope is limited to examining trauma supervisors’ lived experience through an existential and phenomenological lens.

Psychological trauma is the unique individual experience of an event or enduring conditions in which:

- the individual’s ability to integrate his/her emotional experience is overwhelmed (Giller, 1999) or,
- the individual experiences (subjectively) a threat to life, bodily integrity, or sanity (Pearlman & Saakvitne, 1995, p.60).

The word trauma derives from the Greek word for wound (Figley, 1985), and the wounding effects of trauma can result in a loss of a sense of safety, wellbeing, and meaning in the victim’s life. If the wounding is interpersonal, and occurs within the context of childhood and/or an individual’s support system, e.g. family, church,
school, or social circle, for example, the consequences can be especially far-reaching, impeding normal development, and leaving the trauma survivor searching for support and assistance well into adulthood.

The concept of trauma is often associated with the development of Post Traumatic Stress Disorder (PTSD), which is defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) through the identification of criteria that must be met in order for a person to be diagnosed with PTSD. The diagnosis first entered the DSM (3rd ed.; American Psychiatric Association, 1980) following the Vietnam War by a coalition from the Veteran’s Administration and feminist psychiatrists from the rape crisis and domestic violence movements (Brown, 2008). Its inclusion in the DSM represented the medical field’s recognition of traumatic phenomena that had been identified decades earlier as aftereffects of railroad accidents, war, and interpersonal violence, primarily in the form of single-incident or short-term trauma. The formal identification of PTSD gave legitimacy to the study of trauma and promoted the rapid development of theory and research in the United States.

Trauma researchers have built upon the PTSD concept and expanded it to accommodate growing understanding of the long-term consequences of childhood developmental trauma. These consequences often go unrecognized until the victim’s adulthood when they may be labeled symptoms of mental illness. This expanded concept has been termed Complex Traumatic Stress Disorder (CTSD) (Herman, 1992) to encompass the many possible manifestations of distress in adult individuals who have endured long-term childhood abuse. Complex Traumatic Stress Disorder has not been included in DSM-V (2015) at this time, but a diagnosis
of Developmental Trauma Disorder in children has made it to the publication. Trauma literature pertaining to adult survivors of developmental childhood trauma is reflecting the common acceptance of the CTSD concept and it will be used for the purposes of this paper.

Severe or repetitive childhood trauma is highly likely to create significant long-term distress, such as that represented by CTSD and exemplified by childhood sexual abuse (CSA). In the first national survey of adults concerning a history of childhood sexual abuse (Finkelhor, 1990), victimization was reported by 27% of women and 16% of men. In light of these statistics, and the associated psychological consequences, it follows that many traumatized individuals will consult a counselor at sometime in their lives.

This assumption leads us to consider three interrelated difficulties faced by CTSD survivors in our present culture: 1) lack of public and institutional awareness; 2) gaps in counselor education training programs resulting in graduates who are unprepared to address CTSD; and 3) a question of how trauma-competent supervisors learn to work with counselors and counselors-in-training.

Lack of Public and Institutional Acknowledgement

Several factors contribute to the problem of society’s failure to grasp and acknowledge the prevalence of trauma and its associated social costs. Historically, child abuse has been identified and catalogued by writers for centuries (DeMause, 1999), although public acknowledgement of its occurrence emerges into cultural consciousness only episodically, after which it is again dissociated, repressed, or denied (Brett, 1993).
Other current conditions that hinder widespread understanding of the problem include: a mental health system based upon a medical model that attributes psychological difficulties to biochemical defects best treated by pharmacological methods; a pharmaceutical industry that benefits from and supports the medical model; and a social environment that discourages introspection and reflectivity. The culture dissociates (Bloom & Farragher, 2011) and denies its collective shame around child abuse through distorted media coverage, and through failure to fund organizations associated with identification of the problem and treatment of the survivors. Educational institutions, such as counselor education programs and professional associations, quite naturally reflect these dominant cultural norms in terms of programming priorities, which are based upon their funding streams as well as widespread public resistance to the topic of chronic child abuse.

*Gaps in Counselor Education Programs*

Kitzrow (2002) surveyed 136 graduate counselor education programs accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) to identify what methods the programs were using to train counselors to work with sexually-abused clients, to assess the perceived importance of offering such training, and to examine reasons why such training was not available in some programs. Results of the study, which had a 50% response rate, included findings that the majority of graduate counseling programs responding do not provide training in counseling sexual abuse victims. Although all respondents agreed that such training was important, they cited reasons such as full curriculum
or limited resources in explaining why such training was not offered. Those programs that reported including courses to address sexual abuse stated that the subject was covered in some of the standard classes, or, alternatively, offered an elective specialty course in trauma.

Due to recently legislated changes to the CACREP standards for counselor education, programs accredited by CACREP may be required to add or modify courses to address trauma, but these changes may fall short of what is needed to fully prepare counselors for treating chronically traumatized clients. According to Webber and Mascari (2009), the changes to CACREP standards unveiled in 2009 require counseling student competencies in crisis, disaster, and trauma response (CACREP Standards, 2009). These standards, according to the authors, represent an enhancement to the basic counselor training requirements. While the addition of these standards is a step toward preparing counselors to provide disaster and trauma mental health services, the standards focus primarily on crisis intervention associated with single-incident disaster trauma, and make no mention of the different skills required to address the effects of long-term developmental trauma.

It is useful to note that, while counselor education programs do not require graduates to be trauma-competent, they do require students to be culturally competent. A wealth of articles and books exists describing culturally competent counseling, but trauma-competent counseling implies competence in the art and science of addressing the particularities of trauma that exist across cultures (Brown, 2008). These particularities include symptoms such as dissociation, emotional instability, and co-occurring disorders, such as personality disorders, addictions,
and eating disorders that frequently appear in victims of childhood and long-term trauma.

Brown (2008) maintains that cultural competence and trauma cannot be viewed in isolation from each other. She points out that, “A psychotherapist’s ability to understand how a trauma survivor’s multiple identities and social contexts lend meaning to the experience of a trauma and the process of recovery comprises the central factor of culturally competent trauma practice.” (p. 3) Therefore, it is essential that we not only see our clients as whole human beings in all their cultural and social contexts, but that we address their life difficulties with the same sense of cohesiveness. Cultural competence dictates that counselors work with clients in all their multiple identities, including the contexts in which they may be suffering from the effects of trauma. Both cultural competence and trauma-competence benefit from effective supervision.

It was the focus of this current research to capture the experiences of trauma counselors who are also supervisors, and to shed light on the issues they have encountered in their trauma educations and in the course of their supervisory positions. It is hoped that the results of this research will help to address the current gaps in counselor supervisor education.

**Statement of the Problem: Lack of Education and Training**

Ventura (2010) addressed the lived experiences of counseling students working with trauma clients during their practicum, finding that the students felt unprepared by their training to work with such clients, and unsupported by their supervisors at their practicum sites. From these results, we can assume that
counselors may emerge from training programs without any formal education addressing how to work with victims of abuse, and often without access to a trauma-competent supervisor. It is these same master’s level clinicians who will eventually matriculate into doctoral programs, and/or will become supervisors at some point in their careers, possibly perpetuating an unintended cycle of a failed knowledge-base through their inexperience in treating survivors of trauma (Levers, Ventura, & Bledsoe, 2008). Similarly, participants in research conducted by Sommer and Cox (2005) reported that “…their academic programs did little or nothing to prepare them to counsel sexual violence survivors or to deal with vicarious traumatization.” (p.130). These clear deficiencies in counselor preparation have serious implications for the profession, and it is the intent of this researcher to follow Ventura’s (2010) practicum student results by exploring the lived experience of clinicians who are trauma counselor supervisors. Information pertaining to specific programs and their trauma training requirements is important as a basis for comparison and statistical purposes. However, the value in exploring lived experiences lies in a personal narrative’s ability to inform counselor educators and program directors, on a human level, about the needs of developing supervisors. Such knowledge may then influence the development of curricular remedies for identified deficits.

Borders, Cashwell, and Rotter (1995) propose that a consensus exists among counselor educators concluding that effective supervisors are credentialed, experienced, and have received additional training specific to supervision. They have further noted that some professionals have gone so far as to assert that
untrained supervisors are practicing outside their areas of competence (Cormier & Bernard, 1982; Harrar, VandeCreek, & Knapp, 1990; Upchurch, 1985). These opinions could support the claim that a counselor supervisor who is untrained in the treatment of trauma is also practicing outside the limits of his or her expertise, if that practice includes the supervision of counselors treating traumatized clients.

*The Importance of Supervision in Counselor Development*

Supervision has long been considered an essential part of counselor development (Bledsoe, in Levers (ed.) 2012). Bernard and Goodyear (2004) have included in the definition of supervision such processes as facilitation of growth and development of clinical competence, enhancement of clinical understanding and professional functioning, and the assurance of the quality of services being provided. Bledsoe also notes that, according to Bransford (2009), supervision is identified by many clinicians as critical to their efficacy as counselors, and to their ability to deal with the effects of emotional and employment stress. Supervision, therefore, can provide enhanced therapist functioning and help to prevent burnout.

*The Need for Trauma-based Supervision*

No uniform documented process is commonly utilized for providing supervision to clinicians working with traumatized clients (Bledsoe, in Levers (ed.) 2012), but Levers (2012) has proposed an Integrated Systemic Approach to Trauma (ISAT) as a model for working with traumatized clients. The model represents,...

...an ecological perspective of counseling survivors of trauma...which offers a conceptual framework for aligning multiple levels of trauma response with what appears to be best-practice and best-milieu approaches. (p. 580).
The model, which illustrates a nested approach that includes the clinical relationship, the nexus of personal and treatment issues, and the broader systemic and cultural influences, could be adapted to the training of trauma-competent clinical supervisors in skills that are not routinely part of counselor education.

Sommer (2008) notes that one of the most critical factors is the supervisor’s own knowledge of trauma theory. Lonergan, O’Halloran, and Crane (2004) applied their own findings regarding the development of trauma counselors to Stoltenberg and Delworth’s (1987) Integrated Developmental Model (IDM), which describes stages that all counselors pass through. IDM identifies the three stages of counselor development as: beginning of the journey, trial and tribulation, and challenge and growth. The stages are viewed across three developmental domains as follow: view of therapy, self-care issues, and view of self. Lonergan, et al’s study found that therapists specializing in trauma work had enhanced needs in all three developmental domains, and that supervision was very helpful in navigating these domains. As Lonergan, et al state: “It was clear to participants that therapy and supervision for conducting trauma work does indeed differ from general clinical supervision, in terms of the need for the supervisor both to be familiar with trauma theory and practice and to understand the particular risks involved for the supervisee.” (p. 362). The study indicated that, in addition to training therapists, there was a need to address the training of supervisors, as has been suggested by Figley (1995), and Pearlman and Saakvitne (1998) to provide trauma-specific supervision.
Chu (1988) adds evidence to the need for trauma-competent supervisors by stating that trauma therapists are at risk of falling into relational traps with their clients. These traps include the assumption of the presence of trust, distancing, failure to set boundaries and limits, responsibility, control, denial, projection, idealization, and motivation. The concept of parallel process (Clarkson, 1998) assumes that the same issues could become stumbling blocks in the process between supervisor and supervisee, thus the need for a supervisor who is familiar with traumatic themes is paramount in supervision. Therefore, it is important that the supervisor be trauma competent in order to effectively assist other clinicians working with traumatized clients.

Little information is available about how new supervisors develop a professional identity, or how they think and behave at various stages of development, or what factors encourage their development (Borders, 1993). She states, “In fact, the expert supervisor has yet to be described empirically, particularly in terms of their actual behaviors and conceptual skills.” (p. 2)

Walker (2008) addresses the importance of knowledgeable supervision for therapists working with traumatized clients, emphasizing that, “A key role of supervision is to prevent the isolation of the counselor mirroring the isolation of the client.” (p. 7) A key element in preventing isolation, she notes, is dealing with the counter-transference issues that are inevitable in trauma therapy. Etherington (2000) poignantly described this need while conducting a research study with abused men, feeling like a passive bystander in the face of their stories, “...I needed to talk about my feelings, to understand my counter-transference responses and
receive support.” (p. 380). She continues, describing the sense of alienation, the feeling of ineffectiveness and powerlessness as mirroring the symptoms of PTSD. Etherington (2009) also suggests that trauma supervision might best be focused on the inter-relationship between the trauma itself, the person of the counselor, the helping relationship, and the context in which the work is offered. Addressing these issues places emphasis on the supervisory relationship to provide a safe container for the supervisee to explore his/her feelings.

Various counselor supervision methods have been developed, most of which tend to be task oriented, emphasizing competencies in case conceptualization and the attending skills of the counselor (Cashwell, 1994). However, the specific relational needs of trauma counselors may be more effectively addressed by the use of reflective strategies, such as Interpersonal Process Recall (IPR) developed by Kagan (1980). IPR is designed to increase counselor self-awareness, particularly the counselor’s thoughts and feelings experienced during the therapy session (Borders & Brown, 2005). The use of IPR as a component in the analysis of information gathered in this study will be discussed in greater detail in Chapters II and III.

To summarize, effective supervision is widely held to be one of the primary forces for preventing clinician burnout, vicarious traumatization, and subsequent attrition in the counseling field, especially for those clinicians who are working with large numbers of traumatized clients (Pearlman & Saakvitne, 1995; Trippany, Kress, & Wilcoxon, 2004; and Bober & Regehr, 2006). Little research exists, however, that describes trauma counselor supervisors’ developmental stages and their lived experiences in their supervisory roles. Three areas of focus will be used in...
examining trauma supervisors’ lived experiences: 1) Bronfenbrenner’s (1979) Bioecological Model of Human Development provides a useful framework for understanding the development of supervisors, 2) Van Manen’s theory of Lived Existentials offers a lens through which to view the lived experiences described by trauma counselor supervisors, and 3) identified components of effective trauma-based supervision, such as IPR, provide guidelines for understanding the lived experiences. The use of these models will be described in the following section of the paper.

Purpose of the Study

The purpose of this qualitative, phenomenologically–oriented study was to explore the lived experience of supervising trauma counselors, as described by counselors who are designated supervisors at agencies, universities, and group or individual private practices. This topic is of importance to the counseling field in order that the gaps in trauma training may be addressed to better serve counselors, counselor-supervisors, and traumatized clients. From the experiences examined in this study, themes were identified that can assist counselor educators in developing curricula to ensure that trauma-competent supervisors are available to provide the best supervision possible for the increasing numbers of trauma clients seeking the services of professional counselors.

This study uses current trauma literature from a variety of sources and employs Bronfenbrenner’s Bioecological Model of Human Development, Van Manen’s (1990) theory of four lived-existentials, and identified components of
effective trauma supervision as vehicles for exploring trauma supervisors’ experiences.

In summary, this study looked qualitatively at several aspects of counselor supervisor development as it occurs through lived experience. For example, Ventura (2010) addressed the issue of reflective thinking as an integral part of training counselors to be effective in working with traumatized clients; and several researchers identified self-reflection as an important component of counselor development (Griffith & Frieden, 2000; Hoshmand, 1994; Nelson & Neufeldt, 1998). The active, ongoing ability to self-reflect enables the counselor to synthesize theoretical knowledge with his or her own beliefs and assumptions when conceptualizing client problems and formulating appropriate interventions. Appropriate supervision utilizing Interpersonal Process Recall (IPR), in which audiotapes of counseling sessions are discussed with the supervisor using specific types of non-didactic questions, can help supervisees become more self-reflective. As Griffith and Frieden (2000) have noted, memorization of specific responses to client problems cannot prepare counselors for the variety of situations and problems encountered in therapy, and processes like IPR are needed to help students deal with uncertainty. These observations on reflective thinking are especially applicable to those counselors who go on to become supervisors and encounter traumatized clients of their own as well as those of their supervisees.

The need for self-reflection as a prerequisite for counselors’ development of effective case conceptualization has been addressed by several researchers (Fong, Borders, Ethington, & Pitts, 1997; Griffith & Frieden, 2000; Holloway & Wampold,
1986; Nelson & Neufeldt, 1998), who argue for the development of self-reflective counselors as a major objective of counselor education programs. If we accept this need in counselor education programs, it follows that Counselor Education and Supervision doctoral programs should promote IPR and similar methods in training counselors to become trauma-competent supervisors.

Lonergan, O’Halloran, and Crane (2004) emphasize the differences between general supervision and supervision needed by counselors dealing with traumatized clients.

“It was clear to participants that therapy and supervision for conducting trauma work does indeed differ from general clinical supervision, in terms of the need for the supervisor both to be familiar with trauma theory and practice and to understand the particular risks involved for the supervisee.” (p. 362).

It is hoped that this research will contribute to the incorporation of not only trauma-specific training in counselor supervisor education programs, but also to the development of trauma competent counselor supervisors and educators. As Brown (2008) has established, multicultural competence means understanding individuals within the context of all their identities. This includes traumatic experiences that the individual holds that are a part of his/her identity and that may have occurred as a result of that individual’s identification with certain groups. The research described herein does not imply that counselors and their supervisors will be thoroughly prepared to work with all levels of traumatization, but that there will be a foundation, particularly for the supervisor, so that a therapeutic and supervisory
alliance can be established on the client’s behalf. Efforts in this direction might mean the inclusion of trauma theory in counselor and counselor educator programs, and the utilization of self-reflection as an integral practice in graduate training.

Research Questions

The primary purpose of this research was to examine the lived experience of counselor supervision when the supervision dyad’s process involves discussion of clients who are victims of trauma. This was accomplished by interviewing counselor supervisors (the participants) about their reactions both in-session with their supervisees, and about their own reflections on supervising these cases. In addition, this study inquired about the role of academic and clinical training in preparing counselor supervisors for dealing with these cases.

The following guiding question informed this inquiry:

What are counselor supervisors’ lived experiences when supervising clinicians who are dealing with traumatized clients?

Subsidiary questions that helped in answering the guiding question listed above were as follow:

1. In what ways do the informants understand trauma, as defined in this inquiry?
2. What are the lived experiences reported by the informants in their own sessions with traumatized clients?
3. What are the lived experiences reported by the informants in their supervision sessions with supervisees treating traumatized clients?
4. What information can be learned about the role of the informants’ own supervision and training in preparing them to be trauma competent supervisors?

The subsidiary questions 1 - 3 provide specific areas for focus in constructing the protocol for semi-structured interview and are interpreted through van Manen’s four lived existentials, while question 4 examines the counselor supervisor’s development according to Bronfenbrenner’s bio-ecological model of human development and current knowledge of effective trauma supervision concepts.

**Protocol for Semi-structured Interviews**

Informant interviews were recorded on audiotapes for authenticity and transcribed. Open-ended questions were used to facilitate dialogue between informants and the researcher, with the goal of illuminating the lived experience of being a counselor supervisor working with trauma counselors. The following questions are examples of the probes used in the semi-structured interview.

1. Can you talk about how you became a trauma supervisor?
   a. How do you understand the concept of trauma?

2. Can you describe a memorable supervision session that you feel was successful?
   a. What made it feel like a success?
   b. Can you describe the supervisee’s reactions during the session?

3. Can you describe a supervision session that felt unsuccessful to you?
   a. What made it feel unsuccessful?
   b. What were the supervisee’s reactions during the session?
4. Describe the way you usually structure your supervision sessions.
   a. What are situations in which you might feel the need to change the structure of a session?
   b. Can you describe a session in which you had to abandon your structure altogether?

5. What experiences have prepared you for supervising trauma counselors?
   a. Describe the elements of your experience that have been helpful.
   b. Describe the elements of your experience that have not been helpful.

**Delimitations of the Study**

Homogeneous purposeful sampling was used in this study to recruit 8 informants who have served as clinical supervisors to master’s level clinicians in their careers for at least one year. The informant selection was not be limited to supervisors who graduated from counselor education programs so that the study could be extended to include the experiences of supervisors of varied training backgrounds. The terms “counselor” and “counselor supervisor” are used generically for the purposes of this study and do not refer exclusively to graduates of counseling or counselor educator programs. The professional arenas from which the informants were recruited include community mental health agencies, non-profit counseling agencies, university-based counseling centers, and group and individual private practices. This investigation was limited to informants who have volunteered for this study because they have encountered supervisees working with adult clients who are suffering from developmental trauma, or CTSD associated with
This restriction of the study was necessary for informant homogeneity because the concept of “trauma” is broad and is used to refer to many types of stressful experience.

In order to be eligible for this study, supervisors had to be graduates of a master’s or doctoral level program in counseling, psychology, social work, or other related field that qualifies them to provide clinical supervision to other clinicians. Licensure was not a criterion in this study because some agency supervisors are covered by the licensure of the agency and do not require an individual license to perform their supervisory duties.

**Limitations of the Study**

Due to the nature of this investigation, the study had certain limitations. The investigation was dependent upon the informants’ personal recall of past events and feelings about their experiences. Therefore, the results of the investigation were affected by the accuracy or inaccuracy of the informants’ memories. In addition, the primary researcher in this investigation was acquainted with some informants through the researcher’s previous employment as the Supervisor of Adult Counseling Services at Pittsburgh Action Against Rape from 1998 – 2012. The informants who were known to the researcher were met at professional and peer supervisory meetings and associations, or through the course of collaborative agency work on behalf of shared client interests. Through these interactions, and through familiarity with the research of Ventura (2010) on the need for trauma training for master’s level counselors, the primary ideas for this research were developed.
Theoretical Framework

This qualitative, phenomenologically-oriented study explored the experiences of counselor supervisors who have worked in clinical supervisory positions for at least one year, and who have supervised other therapists working with adult clients with CTSD. This qualitative study was grounded in a theoretical framework that uses Bronfenbrenner’s (1979, 2005) Bioecological Model of Human Development, Van Manen’s (1990) four lived-existentials, and the IPR supervision model to examine the qualitative data obtained in the study.

Bronfenbrenner’s (1979; 2005) model describes complex layers of the environment, each of which has a bearing on an individual’s development. It also suggests that perturbations in any of the layers will necessarily be felt in the other layers, to a greater or lesser degree, thereby affecting the entire system. To study counselor supervisors’ development, it was necessary to explore their lived experiences across their professional lifespan. The environmental layers posited by Bronfenbrenner (1979), and Bronfenbrenner and Morris (2007) are as follow:

- The Microsystem – The setting within which the individual is behaving at a given moment in his or her life.
- The Mesosystem – The set of microsystems constituting the individual’s developmental niche within a given period of development.
- The Exosystem – Composed of contexts that, while not directly involving the developing person, have an influence on the person’s behavior and development.
- The Macrosystem – The superordinate level of the ecology of human development; it is the level involving culture, macroinstitutions, and public policy.

- The Chronosystem – The dimension of time applied to the micro-, meso-, and macro-levels.

Bronfenbrenner’s (1979; 2005) bio-ecological model provides a framework for understanding individual human growth and development within the context of larger systems in the environment. It was, for the purposes of this study, applicable to the understanding of counselor supervisor development within the context of the educational and social systems in which counselors function on their paths to supervisory competence.

Van Manen’s (1990) four lived existentials – lived time, lived space, lived body, and lived human relation – provided a framework for understanding the lived experience of supervising trauma therapists, as described by trauma counselor supervisors as they recalled supervisory sessions with supervisees. The following are samples (from the researcher’s own experience) of how Van Manen’s existentials served as a framework for organizing the respondents’ recollections:

- Lived time: “When the supervisee showed me the client’s note, time seemed to freeze.”

- Lived space: “The lights seemed abnormally bright as the supervisee talked about her client’s trauma.”

- Lived body: “My body felt like it was vibrating as the supervisee described her sense of powerlessness to help her client.”
- Lived human relation: “I could feel my impatience toward the supervisee when she seemed to not understand what her client was feeling.”

IPR (Kagan, 1980) can be used as an effective method for counselor supervision, and the reflective principles were utilized as a method of framing the questions for informants in this study for the purpose of obtaining rich, descriptive data.

**Implications**

Based upon my experience as a supervisor for trauma therapists, and upon the research of Ventura (2010) that explored the difficulties faced by beginning counselors, this aim of this inquiry was to contribute to the trauma and supervision literature by illuminating the need for trauma-competent supervisors. A corollary of this aim was to provide information to assist counselor education and supervision programs in better preparing counselors to become supervisors in ways that help them to serve traumatized clients by helping their therapists.

The goals of this inquiry were to highlight the following:

1. Large numbers of individuals seeking therapy do so as a result of having experienced one or more traumatic incidents in their lives, making trauma as integral to the therapeutic dyad as is multiculturalism.

2. Counselors depend upon supervisors for assistance in dealing with traumatized clients, but may find that the supervisors themselves have little or no trauma training, thus a cycle of incompetence threatens the therapy.
3. Graduate Counselor Education programs have insufficient requirements for ensuring that counselors and their supervisors are prepared to counsel trauma victims. Ventura (2010) advocates for curriculum revision in CACREP programs to include trauma specific training for counselors prior to their practicum and internship experiences. With this current research, I am advocating for similar inclusion of trauma-specific training into counselor education and supervision curricula, thus continuing the learning trajectory for master’s graduates of CACREP programs and providing needed training for those entering CACREP doctoral programs from non-CACREP programs. The desired effect of these revisions is for counselors and their supervisors to enter into their roles with feelings of competence and effectiveness in dealing with traumatized clients.

**Operational Definitions**

The term *trauma-competent* is used throughout this paper to describe counseling supervisors who have developed the skills through education and experience to effectively treat sexually traumatized clients, and to competently supervise other counselors who treat such clients. This term was chosen over *trauma-informed or trauma-specific* because it is the author’s belief that individuals and social programs may have received training in what might be termed *trauma-informed or trauma-specific* treatment protocols, but have in fact had very little experience in actually carrying out such strategies, thus they are *trauma-informed* but not *trauma-competent*. 
The terms counselor, therapist, and clinician are used interchangeably throughout this study and are not intended to refer to graduates of specific educational programs.

**Summary**

The notion that trauma therapy is a specialty practice best learned outside educational institutions needs to be re-examined based upon the numbers of individuals seeking therapy for the consequences of trauma, particularly interpersonal, developmental trauma. The concept of multicultural competence has been endorsed by counseling organizations and, as authors such as Brown (2008) have noted, multicultural competence and trauma competence cannot be viewed separately. To be competent to deal with trauma, therapists must be thoroughly aware of the cultural context in which it occurs. This inquiry was based upon the belief that the reverse is also true: to be culturally competent, therapists must recognize the many ways in which culture contributes to individuals’ vulnerabilities to trauma as well.

The interest in this research was inspired by my years of working as a trauma therapist and a supervisor to other trauma therapists, and by Ventura’s (2010) qualitative study of master’s level practicum students. Ventura’s findings indicate that master’s level students often enter their practicums feeling unprepared for the traumatized clients they encounter, and may have inadequate supervision on site as well. If they are fortunate, the students may encounter trauma competent supervision through their educational institution, but this is not necessarily the case as specific training in trauma is not a routine or required area of study. Students and
beginning counselors are left to the luck of the draw and, as Ventura has pointed out, may unintentionally re-traumatize clients in the course of attempting therapy.

Supervision is cited often as the most important safety net for counseling students and therapists dealing with traumatized individuals, but how does supervision help if the supervisor is not competent in dealing with trauma him or herself? How does the supervisor become competent? Trauma literature stresses the importance of having knowledgeable supervisors but very little has been written about the experience of the supervisors themselves or their journey to becoming competent to deal with trauma with their supervisees. This study sought to address the gaps in the literature by providing insight into the lived experience of supervision of trauma cases. By examining these experiences, the needs of supervisors-in-training, as well as those of counseling students as described by Ventura (2010), might be identified and remedied through changes to training programs. While this study does not propose that master’s level students emerge from training programs as trauma experts, it recommends that master’s and doctoral level graduates have sufficient trauma training to provide adequate assistance to the therapists they will eventually supervise. If students are expected to graduate with a workable understanding of multicultural issues, it is not unreasonable to expect them to have attained a working knowledge of the trauma issues that may accompany them.

Having supervisory trauma competence addresses many of the same issues that plague non-supervisor counselors, such as Vicarious Traumatization, burnout, and feelings of inadequacy. In addition, trauma competent supervisors will attend to
the parallel process involved in supervision, in which the issues experienced in the therapeutic dyad are also relevant to the supervisory dyad. This inquiry has hopefully shed some light on these interactions and how counselors in their roles as supervisors experience them.

**Organization of the Dissertation**

Chapter 1 has provided an overview of this inquiry, including a statement of the problem, the purpose of the study, and the methodology used. Chapter 2 presents and summarizes relevant trauma literature upon which this inquiry into the lived experience of trauma supervision is based. Chapter 3 describes in detail the method used in the study, along with the rationale for its selection. Chapter 4 presents the results of the inquiry, and Chapter 5 provides the analysis, implications of the findings, and suggestions for further research in this area.
CHAPTER II: REVIEW OF THE LITERATURE

The purpose of Chapter 2 was to provide an overview and summary of the trauma and supervision literature relevant to this study, and to illustrate its importance to the field of clinical supervision of trauma counselors. Included in this chapter is a review of the role of trauma as it relates to multicultural competence in therapists and their supervisees. Specifically, this study was an exploration of the experiences of supervising clinicians whose supervisees work with traumatized clients, and sought to illuminate the need for trauma competent supervisor training. The chapter is divided into the following sections: the theoretical framework through which the study was viewed, including Bronfenbrenner’s bio-ecological model for human development; Van Manen’s four lived existentials; an overview of supervision models and use of IPR as a reflecting tool; a description of trauma, its impact on client, counselor, and supervisor development; the rationale for trauma’s relevance to the study; and the implications for the field of counselor education and supervision.

The first section begins with a review of the bio-ecological model of human development (Bronfenbrenner, 1979, 2005) in conjunction with Van manen’s (2014) lived existentials, models of supervision, and IPR as a useful technique in encouraging reflection. The second section presents relevant literature in the fields of trauma, counselor development and supervision, and multicultural competence. The final section of this chapter addresses the need for counselor supervision programs to educate students in the principles of trauma and its effects on clients, counselors, and their supervisors.
The literature reviewed supports the following arguments addressed in this study: (a) Research indicates that interpersonal trauma is generally widespread, and is especially prevalent in social groups not considered part of the “dominant” culture. (b) Trauma and its treatment have been well researched and effective interventions exist. (c) Graduate programs in Counseling and related fields committed to training students to be multiculturally competent are requiring neither course work nor training designed to prepare counselors to address trauma, including that occurring within a multicultural context (Kitzrow, 2002). Brown (2008) describes the disconnection between trauma studies and cultural competence as, “…surprising and ironic.” (p. 8). (d) Research and accrediting organizations (CACREP) have cited supervision as one of the key components in students’ attainment of competence in working effectively with trauma clients; yet no literature exists that addresses how supervisors are trained or become trauma-competent themselves. (e) The effects of a lack of trauma training on master’s students’ practicum experience have been identified by Ventura (2010). Countertransference, risk of re-traumatizing clients, and therapist burnout are a few of the possible consequences of insufficient training and supervision. Ventura writes, “Supervision needs to be intentional to handle these emerging concerns among trauma workers” (p.24). This current research investigated the parallel process experiences as described by trauma therapist supervisors as they sought competence in assisting supervisees.
Theoretical Framework

Bio-Ecological Model of Human Development

The Bio-Ecological Model of Human development (Bronfenbrenner, 1979) was chosen as a framework for this study because it identifies and utilizes a multi-system method for understanding human interactions. This model accommodates the interlocking social structures within which supervisor trainees interact, as well as what Bronfenbrenner calls “bi-directional influences,” an assertion that the supervisory relationship is a two-way street: supervisors are affected and changed by their supervisees in much the same way that the therapeutic relationship changes both parties.

The model consists of the microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Bronfenbrenner, 1979, p.3). The microsystem contains the structures that are closest to the students or supervisor trainees and with whom they have direct contact, in their immediate surroundings. These might include the trainee’s cultural identity and personal experiences with trauma, for example, and the interconnection between the microsystem structures and the other system levels in which the individual resides will be explained in the following paragraphs.

The mesosystem is defined by Bronfenbrenner, (1979), as follows: “A mesosystem comprises the interrelations among two or more settings in which the developing person actively participates...for an adult, among family, work, and social life.” (p.25). Therefore, when a counselor/counselor supervisor trainee becomes engaged in the process of receiving supervision, microsystems (the
counselor education program and work site) are added to the individual’s mesosystem. Microsystem effects that the trainee brings into his/her mesosystem will influence the relationship between systems. As a salient example, we might expect that a trainee’s status as a trauma survivor might affect the individual’s supervisory needs in the context of providing therapy to other survivors of trauma. The potential for similar (and perhaps unanticipated) interaction exists for the next layers of the system.

The exosystem refers to settings in which the developing person is not directly involved, but which may affect the individual in important ways. For example, a trainee would not be expected to have a hand in development of university or program policy, but the actions of those entities will have a significant effect on the trainee. To present an illustration using a previous example, a trauma-survivor trainee may find that the program’s policies do not include trauma-informed training or supervision as an integral part of the educational experience, and that programs assume that only trauma “specialists” will see trauma-survivor clients. The impact of the next system level upon policy processes one might encounter at a university or other organization may not be direct, but Bronfenbrenner’s (1979) description is clarifying.

The macrosystem consists of the value, belief, and cultural norm patterns that are made visible through socioeconomic, philosophical, religious, and political structures and their variations in a particular society, such as the United States, for example. Individuals, organizations, and institutions are influenced by the macrosystem through political and other means of deciding what has value at a
particular time in history. The result is, as most people are aware, that university
programs are influenced by funding, and by external organizations that decide what
topics are to be emphasized in educational settings. To return to our trauma-
survivor trainee example, the trainee's preparation for dealing with traumatized
clients will be affected by the macrosystem through the program's decision whether
or not to provide sufficient training and support for the trainee's preparation to deal
with personal trauma, and that of potential clients. Like all the previously described
systems, the macrosystem must be understood within a chronosystem – a
sociological, historical, and personal context of time.

The chronosystem situates the other systems within a time frame
subjectively experienced by the developing person throughout life, described by Van
Manen as the concept of “lived time.” (1990). The trainee's personal and
professional development occurs through relationship with the systems as
described by Bronfenbrenner (1979, 2005), and subjective experience as delineated
by Van Manen (1990). An overview of Van Manen's Lived Existentials is presented
next as the lens through which this study approaches the developing counselor's
experience of learning to be a trauma-competent supervisor.

Van Manen's Lived Existentials

Van Manen (1990, 2014) identified four aspects of lived human experience,
which he calls “lived existentials,” and labels “lived time,” “lived space,” lived body,’”
and “lived human relation.” This study will employ Van Manen’s four lived
existentials as a framework for a qualitative understanding of counselor
supervisors’ development in learning about trauma counselor supervision.
Lived time is a useful concept for understanding the trauma
counselor/supervisor relationship because distortions of time are often part of
descriptions of traumatic events (van der Kolk, 2015). A qualitative analysis of
written trauma responses, conducted by this writer as part of the requirements of a
master’s program, indicated that a sense of time slowing down during the traumatic
incident was a prevalent theme.

Lived space refers to the felt perceptual sense of surroundings in a listener
who hears traumatic material. For example, the individual may experience a sense
of the light in the room changing as what is being heard is envisioned.

Lived body as a concept acknowledges the fact that we live in the world in
and through our bodies. Van Manen (1990) and other existential philosophers
(Lauer, 1952; Merleau-Ponty, 2003) contend that all experiences are embodied and
cannot be divided into mind or body (Descartes) perceptions. Therefore, the
supervisor hearing traumatic material will have a bodily response, even though that
response may be ignored or dissociated (not consciously acknowledged) at the time.
Awareness of one’s bodily (and other) responses to traumatic material is relevant to
the effectiveness of the supervision relationship because of the parallel process
occurring in the supervisee (Clarkson, 1998), and is a topic of this inquiry.

Lived human relation is the culmination of the previous three existentials in
the space shared between individuals. Whether or not we are physically present and
aware of that presence, as well as that of another, has important implications for the
supervision process and the field of counselor education and supervision in that the
quality of awareness in one individual will affect that of the other.
Supervisor Development

Borders (1994) postulates that, “...potentially good supervisors are born, but all benefit from training experiences in which they focus on supervision knowledge and skills, reflect on their role and responsibilities, and receive input from others about their work as supervisors.” (p. 1) She compares the characteristics of good supervisors to those of good teachers and good counselors. They display the qualities of empathy, genuineness, openness, and flexibility. They are respectful of their supervisees as individuals and developing professionals, and are sensitive to cultural differences.

In terms of their professional roles and skills, good supervisors are knowledgeable and competent counselors and supervisors. Their experiences and training are broad, which gives them perspective on the field, and they are able to effectively employ various supervision strategies with their supervisees based on the individual’s needs and learning styles. (Borders, 1994).

Like good teachers, good supervisors are able to apply learning theory, develop short-term goals, and evaluate interventions and supervisee learning. The supervisory role also includes the ability to act as a consultant by objectively assessing problematic client situations, providing alternative interventions, and brainstorming with the supervisee to find solutions to problems (Borders, 1994).

Smith (2009) notes that clinical supervision for mental health professionals started out somewhat like an “apprentice” model used in other fields. It was believed that if a clinician became a “master” in the profession, he or she would be equally good at supervising others. However, it has been documented (Falender &
Shafranske, 2008) that clinical knowledge and skills are not necessarily transferrable to supervisees through the process of observation and imitation, and that reflection on the counseling work, relationship, and supervision itself fosters counselor development. Clinical supervision is now recognized as a distinct, complex interaction between supervisor and supervisee, and supervisory models and theories have been developed to provide a frame for it. Some of these theories are summarized below.

*Psychotherapy-based supervision models*

Psychotherapy-based supervision models may feel like the natural extension of therapy itself, which provides an uninterrupted flow of terminology, focus, and technique from the counseling session to the supervision session, and back again (Smith, 2009). Examples of psychotherapy-based models (Falender & Shafranske, 2010) include patient-centered, supervisee-centered, and supervisory-matrix-centered.

*Patient-centered* supervision, as the name implies, reflects on the patient’s presentation, placing the supervisor in a didactic role as the expert. The level of unassailable power associated with this role leaves little room for conflict between supervisor and supervisee, which may feel comfortable to both parties, but leaves little room for supervisee development through disagreement (Falender & Shafranske, 2010).

*Supervisee-centered* psychodynamic supervision has been adapted to fit psychodynamic theories such as Ego Psychology, Self Psychology, and Object Relations (Frawley-O'Dea, 2003). In this model, supervisees can grow by reflecting
on themselves and their psychological processes, but it can also make a supervisee highly susceptible to stress under scrutiny (Smith, 2009).

The *Supervisee-matrix-centered* approach adds the element of supervisor/supervisee relationship to the focus of supervision. Supervision within this model is considered relational and allows for reflection on and processing of enactments and relational themes (Smith, 2009).

*Developmental Models of Supervision*

Developmental Models of Supervision in general define progressive stages of supervisee development from novice to expert, with each stage representing a different level of skill. The key to using developmental supervision is supervisor identification and awareness of the supervisee’s developmental stage, while concurrently facilitating the supervisee’s movement to the next stage (Littrell, Lee-Bordon, 1976; Loganbill, Hardy, & Delworth, 1982; Stoltenberg & Delworth, 1987). Through the use of a process labeled “scaffolding” (Zimmerman & Schunk, 2003), the supervisor encourages the supervisee to use prior knowledge to gradually incorporate new information and skills into their professional repertoire. In developmental models, interaction between supervisor and supervisee is considered as important as the new skills and information for the supervisee’s developmental success.

The *Integrated Development Model (IDM)* (Stoltenberg, 1981; Stoltenberg & Delworth, 1987; and Stoltenberg, McNeill, and Delworth, 1998; Falender & Shafranske, 2004; Corey & Haynes, 2010) is one of the most researched developmental models of supervision. It assigns three levels of counselor
development and requires supervisors to utilize skills and approaches commensurate with the supervisee’s appropriate level. A limitation of this model is its lack of application to clinicians past the graduate-school level. Also, it lacks elucidation of specific supervision methods appropriate to each level (Corey & Haynes, 2010).

*Ronnestad and Skovholt’s Model* is based upon a qualitative study conducted by interviewing 100 therapists ranging in experience from graduate students to clinicians with an average of 25 years’ experience (Skovholt & Ronnestad, 1992). Based upon the study, Ronnestad and Skovholt (2003) identified 14 themes of counselor development. These are:

1. Professional development involves an increasingly higher-order integration of the professional self and the personal self.
2. The focus of functioning shifts dramatically over time from internal to external to internal.
3. Continuous reflection is a prerequisite for optimal learning and professional development at all levels of experience.
4. An intense commitment to learn propels the developmental process.
5. The cognitive map changes: beginning practitioners rely on external expertise, seasoned practitioners rely on internal expertise.
6. Professional development is a long, slow, continuous process than can also be erratic.
7. Professional development is a life-long process.
8. Many beginning practitioners experience much anxiety in their professional work. Over time, anxiety is mastered by most.

9. Clients serve as a major source of influence and serve as primary teachers.

10. Personal life influences professional functioning and development throughout the professional life span.

11. Interpersonal sources of influence propel professional development more than ‘impersonal’ sources of influence.

12. New members of the field view professional elders and graduate training with strong affective reactions.

13. Extensive experience with suffering contributes to heightened recognition, acceptance, and appreciation of human variability.

14. For the practitioner, there is a re-alignment from self as hero to client as hero.

In summary, Ronnestad and Skovholt (2003) affirm the complexity of the counselor development process requiring continuous reflection, stating that, “a close and reciprocal relationship (exists) between how counselors/therapists handle challenges and difficulties in the client relationship and experiences of professional growth or stagnation” (p. 40).

*Integrative Models of Supervision*

Integrative Models of Supervision, as the name implies, rely on more than one theory and technique (Haynes, Corey, & Moulton, 2003), reflecting the fact that most counselors practice “integrative” counseling, therefore, necessitating
integrative models of supervision. Haynes, Corey, and Moulton identify two approaches to integration: technical eclecticism focuses on differences, choosing from many techniques and approaches without necessarily subscribing to the theoretical positions in which they originated. Theoretical integration refers to the goal of synthesizing the best of two or more theoretical approaches to create a richer theory. Two examples of Integrative supervision models are explained below.

**Bernard’s Discrimination Model** (1979) is one of the most researched and commonly used of the integrative models of supervision. It is comprised of three focal points for supervision (intervention, conceptualization, and personalization), and three possible supervisor roles (teacher, counselor, and consultant). A supervisor could potentially respond in one of nine different ways (three roles x three focal points), depending upon the needs of the supervisee and the situation.

**Systems Approach** (Holloway, 1995) focuses on the relationship between the supervisor and supervisee with an aim toward establishing a shared power dynamic across six dimensions identified by Holloway:

1. The functions of the supervisor
2. The tasks of supervision
3. The client
4. The trainee
5. The supervisor
6. The institution
Holloway (1995) considers the first two dimensions to be in the foreground of the supervision interaction, while the remaining four are more covert influences in the process.

The supervision models described above are illustrative of the many paradigms used in clinical supervision and this list is not representative of all models, nor is it comprehensive in its description of each model. The intent is to give a broad overview of the goals of various types of supervision, and to emphasize the varied levels of importance given to reflective experiences in the supervisor/supervisee dyad according to differing schools of thought. While the models differ in their reflective emphasis, based upon whether the focus is placed on the client, the supervisee, the supervisory relationship, or an integration of the three, reflection is an integral aspect of all supervisory models.

*Interpersonal Process Recall (IPR) (Kagan, 1980)* is a strategy used in supervision to help counselors to better understand processes and perceptions to which they may not normally attend (Cashwell, 1994). IPR is predicated upon Kagan’s (1980) proposition that people both need each other, and have learned to fear each other. As a result, Kagan believes that, in seeking a safe psychological distance from each other, people learn to behave “diplomatically.” In counselors, behaving diplomatically is expressed in two ways: feigning of clinical naivete, and tuning out client messages. Clinical naivete, Kagan asserts, occurs when counselors act as if they do not understand the meaning behind client statements. This can be an indication that the counselor is unwilling to become involved with the client on a certain level. Tuning out of client messages is more likely to occur when novice
counselors are engrossed in their own thought processes about what to do next. In both cases, the counselor is likely to miss important messages from the client that are then not discussed. IPR is a supervisory strategy designed to help counselors become more attuned to possible unacknowledged dynamics within the counselor/client dyad (Cashwell, 1994).

IPR is typically conducted using video or audiotapes of a client session, during which either supervisor or supervisee may stop the tape, at which time the supervisee is asked to reflect on what his or her thoughts were at the time of the session. The goal for the supervisor is to avoid adopting a teaching style, and to allow the supervisee to explore thoughts and feelings to some resolution (Bernard & Goodyear, 1992). Supervisors using IPR ask open-ended questions (Bernard & Goodyear, 1992; Borders & Leddick, 1987; Kagan, 1980) such as the following examples:

- What do you wish you had said to him/her?
- If you had the chance now, how might you tell him/her what you are thinking and feeling?
- Were those feelings located physically in some part of your body?
- What do you think he/she wanted from you?
- Did he/she remind you of anyone in your life?

In summary, IPR provides a safe space for supervisees to their internal reactions through experiencing the encounter in a process recall supervision session. Clients of counselors receiving IPR supervision were found to attain better results than those of counselors supervised by other methods (Kagan and Krathwohl, 1963;
Kingdon, 1975). Bernard (1989) also demonstrated that IPR is effective for counselor supervision across a range of experience levels. Because of the possibility of magnification of the interpersonal dynamics between supervisor and supervisee, IPR is not recommended as a stand-alone method of supervision, and is best used in conjunction with other approaches (Bernard & Goodyear, 1992).

Supervision exists for the benefit of the client’s safety and integrity in receiving counseling for life stressors. It also exists in order for counselors to be effective and to develop over the course of their careers. This is especially relevant for trauma counselors, who risk higher possibilities of vicarious traumatization, burnout, and attrition from the field due to the nature of trauma work. Therefore, the development of trauma counselor supervisors, as viewed through the lens of Bronfenbrenner’s Bioecological Model of Human Development (1979), offers a critical protective factor in the field of counseling.

Bronfenbrenner (1979) wrote, “No society can long sustain itself unless its members have learned the sensitivities, motivations, and skills involved in assisting and caring for other human beings” (p. 53). He was speaking primarily of the developmental needs of children, but his statement is equally applicable to mental health clinicians, for who assisting and caring for other human beings is a dedicated profession, and who are especially needful of a supervisory level of support.

Bronfenbrenner (1979) emphasized that psychological growth and development is supported by ongoing, “molar” activities engaged in by the growing individual along with interested others. His use of the term “molar” refers to the continuous nature of such an activity (as opposed to “molecular” activities which are
short-lived), and developed “hypotheses” around this central idea. One of these hypotheses echoes many of the supervision models previously mentioned and speaks to the growth-enhancing qualities of a dyad engaged in molar activities:

“The developmental impact of a dyad increases as a direct function of the level of reciprocity, mutuality of positive feeling, and a gradual shift of balance of power in favor of the developing person” (p. 59).

Another of Bronfenbrenner’s (1979) hypotheses addresses the nature and effect of the relationship between individuals engaged in learning activities and supports the need for attending to the supervisory dyad:

“Learning and development are facilitated by the participation of the developing person in progressively more complex patterns of reciprocal activity with someone with whom that person has developed a strong and enduring emotional attachment and when the balance of power gradually shifts in favor of the developing person” (p. 60).

Bronfenbrenner’s (1979) words effectively apply to all developmental dyadic relationships, including that between supervisor and supervisee, and counselor and client. The following section of this paper addresses another relationship: the one that exists between trauma and its effect on individuals who have suffered from it.

**Trauma and its Impact on Clients**

Trauma, particularly that associated with childhood abuse, also known as developmental trauma, is prevalent in our culture. Approximately one in three women and one in six men in North America report a history of sexual abuse occurring in childhood or adolescence (Briere, 1996; Finkelhor, 1990; Polusny &
Follette, 1995). Repetitive trauma that begins in childhood is termed “developmental trauma” because it can alter the natural course of the individual’s emotional, physical, spiritual, and intellectual development (Perlman & Saakvitne, 1995), resulting in long-lasting effects.

The effects of developmental trauma have been associated with cognitive, emotional, interpersonal, and physical difficulties for survivors. These effects can include anger, anxiety, depression, impaired functioning, relationship problems, post-traumatic stress disorder (PTSD), re-victimization, self-injury, and suicidal ideation/attempts as well as behaviors directly connected to chronic physical illness, such as smoking, substance abuse, and eating disorders. (Briere, 1996; Neumann, Houskamp, Pollock, & Briere, 1996; Polusny & Follette, 1995; van der Kolk, Perry, & Herman, 1991; Felitti, et al., 1996). In the words of Vincent Felitti (2010, in Lanius, Vermetten, & Pain), “Time does not heal the wounds that occur in those earliest years; time conceals them. They are not lost; they are embodied.”

The Adverse Childhood Experiences (ACE) study (Felitti, et al, 1996), conducted with patients from Kaiser Permanente Health System, was originally designed as an evaluation of a weight loss program. However, the investigators began to recognize a pattern in which the study’s subjects frequently lost weight, but then quickly regained it, despite encouragement and assistance from the program staff. What the researchers discovered was that the subjects who had the most difficulty also had histories of adverse childhood experiences, such as physical, sexual, and emotional abuse, incarcerated family members, and family members with addictions. Study participants were also found to be highly likely to engage in
risky emotional coping strategies such as smoking, drinking, and other addictions. By developing a scale to quantify the number of adverse childhood experiences a study participant reported, the researchers were able to establish a correlation between a high number of adverse experiences and severity of chronic physical and mental health problems. In this way, the ACE study has helped to bridge the gap between our understanding of trauma’s consequences and our assumptions about the origins of many chronic health conditions.

A survey of 3,132 adults conducted by Stein, Golding, Siegel, Burnham, and Sorenson (1988) revealed that respondents reporting childhood sexual abuse were more than twice as likely to have a current or chronic mental health disorder than individuals who had no childhood history of sexual abuse. The high incidence of mental health problems in individuals with chronic childhood trauma is recognized by trauma experts, who have suggested a new diagnostic category for this phenomenon: Complex PTSD, or CTSD (Herman, 1994; van der Kolk, 1998). CTSD differs from PTSD in that its long-term consequences often require a longer and more involved treatment trajectory by a skilled clinician (Courtois & Ford, 2010). CTSD also takes into consideration the pervasive developmental difficulties that are frequently part of the clinical presentation of adult survivors of childhood abuse.

The information described above indicates that traumatic experiences are far from unusual and are likely to be present in a large segment of the population who seeks counseling services. Yet, trauma is still viewed by many as a specialty practice, best left to those with specific training, implying that such training is obtained “somewhere out there.” As Brown (2008) states, “Working with trauma requires
psychotherapists to get up close and personal with stigma, which can and
sometimes does rub off.” (p.9). Alpert (2006) noted that psychotherapists may have
a bias against doing trauma work because they fear being stigmatized as trauma
survivors themselves, and prefer to not be categorized as a “wounded healer.”

Many therapists who prefer not to work with trauma may feel that they are
not sufficiently trained, or may indeed be averse to working with traumatized
clients because of their own unprocessed traumas. (Lonergan, O'Halloran, & Crane,
2004). Whether discomfort with trauma work is due to stigma, lack of training, or
fears of one’s own history, the reasons are startlingly similar to those that kept
multicultural issues in the background for decades – namely shame, ignorance, and
denial. Those in positions of dominance and privilege (including psychotherapists)
have been reluctant to acknowledge their superior social status (Brown, 2008), and
those who find the idea of victimization (their own or others) repugnant may wish
to maintain a stance of denial. In order to serve traumatized clients more effectively,
it is necessary for the counseling profession to develop increased awareness of the
trauma’s effects on the developing counselor and counselor supervisor.

**Trauma: Its Importance for Counselors and Counselor Supervisors**

In the previous section of this chapter, we listed some of the possible long-
term effects of developmental trauma on individuals who may present for
counseling in adulthood. One of these effects is damage to the client’s system of
meaning making, rendering ineffective an individual’s spiritual or personal beliefs
about him/herself and community. (Brown, 2008). Yalom (1980) described life as a
constant struggle to cope with the existential facts of being human: that we die, that
we are powerless, that we are responsible for our own lives, that life has no inherent meaning, and that we are essentially alone. With this in mind, Brown (2008) states, “Culturally aware and competent trauma therapists thus must be rooted in the recovery of meaning.” (p. 229). To do this effectively, therapists must be aware of the elements of trauma counseling that lead to clients’ feeling heard and understood.

There are many models for working with traumatized clients (Herman, J., 1992; Linehan, M., 1993; Shapiro, F. & Solomon, 1995; Courtois, C., 1999; Gold, S., 2000; Van der Kolk, B., 2015; Chefetz, R., 2015). Some of these models, such as Dialectical Behavioral Therapy (DBT)(Linehan, M., 1993) are designed to help the client develop skills for coping with overwhelming feelings and behaviors prior to working with traumatic memories. Others target the traumatic memories themselves by addressing the derailed developmental processes, which can take months, or even years to complete. Short-term and manualized treatment models, such as Cognitive Behavioral Therapy (CBT)(Meichenbaum, D., 2009), Prolonged Exposure (PE)(Foa, E., Hembree, E., & Rothbaum, B., 2007) and Cognitive Processing Therapy (CPT)(Resick, P., & Schnicke, M., 1992) have been found to be effective with some types of trauma, but are less successful in cases of CTSD because they often do not address the client’s developmental deficits and subsequent deeply-ingrained behaviors and beliefs (Courtois & Ford, 2009; Chefetz, 2015). Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro, 2001) is also a manualized model that is very flexible and can be adapted for use with some traumatized clients with good results (Forgash, 2008).
Therapists working with traumatized clients may be bound by the treatment models and time constraints imposed by the agencies where they work. However, there are core elements of trauma treatment that transcend modality and have been found to be especially important in treatment of CTSD and traumatized members of marginalized groups. (Sue & Zane, 2006; Levant & Silverstein, 2006; Brown, 2003; Olkin & Taliaferro, 2006). These researchers found that the therapeutic qualities that are empirically supported are relational, such as empathy, collaboration, genuinleness, positive regard and respect, and the nature and quality of the therapeutic relationship.

As professional counselors, we are trained and expected to bring authentic relational qualities to our interactions with clients. However, trauma survivors often bring into the therapy beliefs and behaviors that challenge the most competent therapist. This will be especially relevant if the therapist her/himself has a history of trauma.

Brown (2008) states that culturally competent trauma therapy involves, “...knowledge of one's own multiple identities and their meanings. Along with one's sex, gender, and various ethnic, sexual orientation, cultural and social class identities, there is also the question of how trauma is a part of one's identity.” (p. 13). According to research by Pope and Feldman-Summers (1992), approximately 30% of practicing psychologists reported a history of childhood abuse. If we assume that other professionals engaged in the practice of psychotherapy have similar rates of childhood abuse, then our awareness of possible complex countertransference
reactions becomes especially important in addressing the trauma reactions
therapists and their supervisors are likely to encounter.

Ochberg (1978) proposed that victims of deliberate cruelty suffer from the
symptoms in the following list:

1. Shame: embarrassment, humiliation
2. Self-blame: exaggerated feelings of responsibility
3. Subjugation: feeling belittled, dehumanized
4. Morbid hatred: obsessions with vengeance
5. Paradoxical gratitude: positive feelings toward abuser
6. Defilement: feeling dirty, disgusting, or evil
7. Sexual inhibition: reduced capacity for intimacy
8. Resignation: a state of broken will or despair
9. Second wound: re-victimization by legal, medical, or mental health
   systems
10. Socioeconomic status downward drift: reduction of opportunity or
    lifestyle

Trauma counselors and their supervisors are likely to encounter some or all of the
above symptoms in clients with CTSD, making the potential for client (and
found that therapists with trauma histories, those working in a clinic setting, those
with less training, and those dealing with the impact of their work in personal
therapy showed higher levels of disrupted life schemas. Those with more work
experience had lower levels of schema disruption, even if they were themselves
survivors of trauma, indicating that more information is needed about how counselors’ acquired experience serves to mitigate job stress.

Lonergan, O’Halloran, and Crane’s (2004) subjects reported that, “Supervision was very helpful in debriefing, or discussing cases and the emotional toll they took on participants.” (p.362). Furthermore, they stated:

“It was clear to participants that therapy and supervision for conducting trauma work does indeed differ from general clinical supervision, in terms of the need for the supervisor both to be familiar with trauma theory and practice and to understand the particular risks involved for the supervisee.” (p. 362).

Chu (1988) noted that trauma therapists are at risk for falling into traps that are especially likely to be present in survivors of trauma. These 10 traps include the assumption of the presence of trust, distancing, failure to set boundaries, failure to set limits, and issues of responsibility, control, denial, projection idealization, and motivation. Due to the presence in supervision of “parallel process,” (Clarkson, 1998), the supervisory relationship will embody the same challenges relating to trust, boundaries, and power that exist between client and therapist. Therefore, it is critical for supervisors to educate supervisees on the presence of these issues in both domains.

Traditionally, graduate programs have not had a specific focus on trauma work nor have they addressed the effects of therapy on the therapists. (Alpert & Paulson, 1990; Mahoney, 1998; Pope & Feldman-Summers, 1992). Lonergan, O’Halloran, and Crane’s (2004) study indicated that there was a need for training
supervisors to provide trauma-specific supervision, which confirmed the recommendations of Figley (1995), and Pearlman and Saakvitne (1998).

**Counselor Development and Supervision**

Ventura (2010) discusses the implications for counseling students entering the practicum phase of their training and noted that, outside the work done by Black (2008) on objectives for trauma training, and Figley (1995), Pearlman and Saakvitne (1995) on *compassion fatigue* and *vicarious traumatization*, respectively, no literature exists on trauma training for master’s level counseling students. She states, “Reliance on supervision in trauma work, while essential, is not common.” (p.35). Further, Ventura cites statistics from a study by Pearlman and Maclan (1995) which showed that only 64% of trauma therapists reported receiving any supervision, although 82% found it helpful.

Ventura’s (2010) research into post-practicum counseling students’ experiences with traumatized clients identified several themes relative to supervision:

- Site supervision was sometimes non-existent, or not helpful in dealing with traumatized clients because the site supervisors themselves were not trained in the treatment of trauma.
- University supervisors were sometimes more knowledgeable, but usually supervision came after client contact and students felt it was “too little, too late.”
- Students sometimes felt site supervisors assigned them clients who the site staff felt were too damaged, and therefore were “safe” for students because of the belief that no further damage could be done.

- Students relied mainly on instinct rather than counseling theory in their work with trauma survivors, and believed that site supervisors were relying on this same means in their supervision and counseling activities, thus setting up a dysfunctional parallel process in which client safety was at risk.

Ventura (2010) points out the damage potential for clients working with students and supervisors who lack an understanding of trauma theory. She says, “Supervisors are the gatekeepers of the field, as they are charged with training, evaluating, and guiding developing counselors.” (p.180). This is in concordance with the American Counseling Association’s Code of Ethics (2014) which states, “Prior to offering supervision services, counselors are trained in supervision methods and techniques.” (Section F.2.a.). Ventura also notes that agencies often lack the resources to hire credentialed supervisors and find it expedient to promote tenured counselors to supervisory positions, a practice that can cause anxiety for both the inexperienced supervisor and the supervisee.

It can be argued that counselors should not see traumatized clients until they are sufficiently trained to be effective in this area. The ACA Code of Ethics (2014) makes this point by stating, “Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience” (italics mine),
state and national professional credentials, and appropriate professional experience. (C.2.a.). Such expectations make theoretical sense, but fail to take into account the fact that trauma is most often embedded in other presenting problems (such as depression, self-injury, eating disorders, or personality disorders) and are not always identified by the client or the therapist as the consequences of traumatic experience, although statistics supporting the trauma/symptom connection are readily available. Some of these include:

- The majority of adults diagnosed with Borderline Personality Disorder (81%) were sexually and/or physically abused as children. (Herman, et al, 1989; Ross, et al, 1990).
- 90% of alcoholic women experienced childhood sexual abuse or parental violence. (Miller & Downs, 1993).
- Violence is a significant causal factor in 10-25% of all developmental disabilities. (Sobsey, 1994; Valenti-Hein & Schwartz, 1993)
- 70% of women living on the streets or in shelters report abuse in childhood. (Chesney-Lind 2001).

This statistical sampling indicates that traumatized clients are likely to appear on the caseloads of trainee and novice counselors because it is unrealistic to assume that agencies responding to the populations listed are staffed only by seasoned, trauma-competent clinicians and supervisors. Trippany, Kress, and Wilcoxon (2004) state unambiguously, “Counselors in all settings work with clients who are survivors
of trauma.” (p.31). Therefore, the question remains: how do therapists and supervisors become seasoned and trauma-competent?

Competence in any subject can best be conceptualized as a *developmental* process, implying that it is ongoing and recursive. Ivey and Ivey (1998) conceptualize counselor development within the context of human development and the client’s life situation, with a model called Developmental Counseling and Therapy (DCT). DCT seeks to transcend pathology as it is described in the Diagnostic and Statistical Manual (DSM), in which the concept of *naming* is used as a system for behavioral or attitudinal classification. Levers and Maki (1994) suggest an alternative concept in which *naming* is used for the assignment of meaning, which elevates the naming process to an active beginning for therapy rather than an endpoint. DCT is especially applicable to working with traumatized clients because it shift’s the counselor’s focus from an individual view of psychopathology to a context of the client’s cultural and developmental history in which many of the client’s difficulties are seen as adaptive responses to abnormal situations. Such a viewpoint is essential for a counselor and supervisor to be both trauma-competent, and multi-culturally competent.

Using Bernard’s Discrimination Model of Supervision, the following are possible examples of trauma-competent supervision:

Criterion (a) of the process element of supervision (helping the counselor open a client interview) is often a critical moment in establishing rapport with a traumatized client. The trauma-competent supervisor will understand and be able to convey to the supervisee the need for caution and for avoiding assumptions about
the client based upon his or her presentation (e.g., a rape survivor may deliver a
detailed description of the assault while exhibiting no visible affect).

Criterion (c) of the conceptualization element (skill to recognize appropriate
or inappropriate goals for a client) would present an opportunity for the supervisor
to help the counselor realize that urging the rape survivor to have more congruent
affect in the first few sessions is not an appropriate goal for the client in this
situation, and the supervisor’s role in the personalization element could be to help
the counselor understand his or her own feelings about the client’s disclosure.

provided by a more senior member of the profession to a more junior member,” (p. 8) in which the focus is on, “the supervisee’s clinical interventions that directly
affect the client, as well as, those behaviors related to the supervisee’s personal and
professional functioning (Bradley & Kottler, 2001, p. 5). If we accept the above
definition, and acknowledge that supervision is an integral (and parallel) part of
what helps counselors develop competence, then training supervisors to be trauma-
competent as well as multi-culturally competent is a crucial element that is missing
or insufficient in our current counselor education programs.

Implications for Counselor Education and Supervision Programs

Ventura (2010) has added to the professional counselor education literature
by illuminating counseling students’ struggles in dealing with traumatized clients,
many of which relate to insufficient or absent supervision. She has also identified
needs for change to counselor education programs, such as emphasis on teaching
counselors to be self-reflective. Peterson (1995) stated that educating reflective
practitioners is the single most important factor in preparing future counselors, which speaks to the importance of clinical supervision. If counselor supervisors are to adhere to the requirements of the ACA Code of Ethics (2014), which states that, “A primary obligation of counseling supervisors is to monitor the services provided by supervisees,” and “…to review the supervisees’ work and help them become prepared to serve a range of diverse clients,” (F.1.a.), then supervisors themselves will need to be competent in the areas in which counselors work. Helping counselors be self-reflective is an integral part of teaching them to be both trauma-competent and multi-culturally informed.

Pearlman and Saakvitne (1995) identify four components of trauma therapy supervision:

1. A solid theoretical grounding, including a theoretical understanding of psychotherapy in general and trauma therapy in particular, a theory of the psychological responses to interpersonal violence, and an understanding of normal child development
2. A relational focus that attends to both conscious and unconscious aspects of the therapeutic relationship and the treatment process
3. A respectful interpersonal climate that allows attention to countertransference and parallel process
4. Education about and attunement to the therapist’s vicarious traumatization.
Each of these components requires self-reflection on the part of both therapist and supervisor – a parallel process that constantly mirrors the therapist/client relationship and provides critical awareness and oversight to the therapeutic dyad. Yet state laws, professional ethics, and training programs often tacitly encourage therapists to presume their own mental health, knowledge, expertise, and authority by making ongoing supervision voluntary after a period of post-graduate requirements. As Pearlman and Saakvitne (1995) state, “The implicit expectation is that the therapist should be unfailingly confident (the ‘if you don’t know, fake it’ mentality)” (p.378). Such a mentality is exactly what Ventura’s (2010) research revealed in students and some of their supervisors, which resulted in their self-reported reliance on “instinct” rather than sound theoretical knowledge and interpersonal skills.

In conclusion, Ventura’s (2010) research into the need for a pedagogy that includes enhanced supervision, understanding of trauma, and self-reflective learning for master’s level counseling students supports Brown’s (2008) observation about trauma-competent multicultural counseling:

“...just as cultural competence is of importance in working with clients so that psychotherapists can hear and know the multiple meanings of their trauma experiences in light of their various identities, so such competence is a necessary component of responding to vicarious traumatization in themselves.” (p. 253.)
Brown’s statement reminds us that effective psychotherapy is performed by therapists who are both self and other-aware. Such awareness, as we have noted earlier in this chapter, requires equally well-prepared supervisors.

**Summary**

Chapter 2 has surveyed the literature currently available on the state of counselor preparedness and the need for counselors to have basic competence in working with traumatized clients. Ventura’s (2010) research identified serious deficiencies in preparation that some master’s level students experienced during their practicum placements. These deficiencies included little or no knowledge of trauma or how it is treated, as well as lack of trauma-competent supervision at the site. Training program-based supervision was often too little, too late, and students felt they had to fall back on “instinct” to deal with clients’ trauma presentations, thereby exposing clients to the risk of further traumatization.

In this chapter, literature relevant to supervisor development, issues inherent in trauma work, and recommendations for competence from authorities in the field of trauma therapy has been reviewed, revealing an educational gap between what is needed and how counselors are prepared. While optional courses on trauma are offered through some counselor training programs and through professional groups such as the International Society for the Study of Trauma and Dissociation (ISSTD), they remain just that – optional. The choice of whether or not to become knowledgeable in an area that affects many of the individuals who present at counseling offices for help remains with the individual therapist.
The ACA Code of Ethics (2014) clearly states that a primary obligation of counseling supervisors is to monitor the services provided by supervisees, for the precise purpose of ensuring client welfare (F.1.a.). The code further states that supervisors are to be trained in supervision methods and techniques before offering supervision services (F.2.a.). However, as the literature shows, most supervisors do not obtain an advanced degree in counselor education and supervision, and most tend to be promoted from the ranks of staff counselors with no further training in supervision practices.

Another factor examined in this chapter is the connection between the requirement for multicultural competence in counseling and supervision, and the need for trauma competence. The ACA Code of Ethics (2014) requires that counselors and supervisors do not practice outside their areas of professional competence, yet very few counselors or their supervisors receive formal training in working with trauma. Given the prevalence of trauma and the likelihood that traumatized clients will appear in most therapists’ practice at some point, the question of how these therapists learn about trauma remains unanswered. Perhaps some learn from their supervisors or colleagues, but the question only continues to expand: how did the supervisors or colleagues learn? What was their experience in working with traumatized clients?

This current research examined the lived experience of trauma counselor supervisors through the dual lenses of Bronfenbrenner’s (1979) bio-ecological model, Van Manen’s Lived Existentials, and utilized the principles of IPR in
designing the interview structure. The use of these models will be examined in the following chapter on research methods.
CHAPTER III: RESEARCH METHODS

This chapter presents the methods used in the current study as well as the rationale for use of those methods. The chapter also includes sections on the use of Bronfenbrenner’s Bioecological Model of Human Development, and Van Manen’s Lived Existentials as lenses for viewing the research data. Design of the study questions and approach to informants was guided by the principles of IPR.

The Philosophy Guiding this Research

The philosopher, Dilthey (1976) said, “We explain nature, but human life, we must understand” (in Van Manen, 1990, p. 4). Dilthey’s statement refers to natural science’s tendency to taxonomize natural phenomena (such as biology) and to explain the behavior of things, while a human science attempts to achieve an understanding of the lived structures of meaning through qualitative phenomenological study of lived human experience (Van Manen, 1990).

It would have been possible to quantitatively identify and collate the facts associated with becoming a trauma-competent supervisor: questions of schooling, work experience, and training would have been easily answered through distribution of questionnaires to the identified population of research interest. In this manner, we would have been able to identify some similarities in the target areas that might allow us to make some assumptions about what elements of professional history were similar in the evolution of a trauma counselor supervisor. What would remain unknown through such an inquiry, however, is the actual lived experience of supervising trauma counselors. Knowing the educational background of a supervisor does little to illuminate the developmental process through which a
counselor passes on a journey from trauma-competence as a therapist to becoming a supervisor.

If counselor educators and supervisors are to adhere to ACA’s ethical code (2014) and protect client welfare through effective training of counselors and supervisors, it is necessary to have an understanding of the developmental process on a lived experience level. Deep knowledge of the process obtained by a qualitative phenomenological inquiry can provide opportunities for educational enhancements at various levels of supervisors’ development based upon actual descriptions of those who have been through the process of becoming trauma counselor supervisors. A brief description of qualitative inquiry and phenomenological inquiry in particular appear in the following sections.

Qualitative Inquiry

Denzin and Lincoln (2000) define qualitative research as, “...a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. (pp. 3-4)

Denzin and Lincoln (1998) also described qualitative research as an interactive process shaped by the researcher’s “personal history, biography, gender, social class, race and ethnicity, and those of the people in the settings.” (p.4) This description supports the literature cited in the previous chapter of this study, in which themes of multicultural competence, trauma competence, and parallel process have been identified as salient to client/therapist and supervisee/supervisor roles.
The researcher's role in qualitative analysis is that of human instrument of data collection. Quantitative research depends on the accuracy of its instruments for its credibility, but in qualitative research, “the researcher is the instrument” (Patton, 2002, p. 14). This is not to deny that validity and reliability are important in qualitative research, however, Healy and Perry (2000) assert that the quality of a study should be judged in terms of its own paradigm.

A qualitative phenomenological approach was chosen for this study for several reasons: First, van Manen (1990) speaks of using personal experience as a starting point in a research investigation, and the idea for this study had its roots in my personal lived experience of being a trauma counselor and supervisor for over 20 years. My effectiveness as both a counselor and a supervisor depends upon my ability to enter into the lived experiences of my clients as well as my supervisees. It was this lived experience of other trauma counselor supervisors that I wanted to explore, rather than any numbers associated with quantifying such experiences. Second, van Manen also refers to “searching idiomatic phrases,” (p.60) as a way of gaining insight into lived experiences. My years as a trauma counselor supervisor have taught me that van Manen is correct in that clients and supervisees speak in idiomatic phrases that express their lived experience, and that to note them and discuss them is to gain understanding of that experience. Finally, gathering information by means of an interview serves very specific purposes, according to van Manen:
1. It may be used as a means for exploring and gathering experiential narrative material that may serve as a resource for developing a richer and deeper understanding of a human phenomenon.

2. The interview may be used as a vehicle to develop a conversational relation with a partner (interviewee) about the meaning of an experience.

(p. 66)

Both of these purposes were relevant in this study. The information gathered from my participants served as a resource for developing my understanding of the process of the trauma counseling and supervising phenomena, and helped me to make connections between lived experience and implications for counselor pedagogy, which is explained further in Chapter V. The use of the interview as a vehicle to development of relation with the participants was enhanced by our shared collegial experiences as trauma counselor supervisors, underscoring van Manen’s (1990) caution to researchers to not lose sight of the question in attention to method. The interviews for this study arguably contained more information than was necessary to address the research questions because of the similarities in professional experience between researcher and participants. Van Manen’s descriptive, “chaotic quest for meaning,” (p.67) was avoided by judicious use of editing skills and reference to other qualitative research sources for direction.

According to Patton (1995), qualitative research strategies cannot be finalized before data collection begins. Qualitative research, as opposed to quantitative research, has an emergent process that allows the researcher to focus on the observation and interpretation of meaning in the context in which it is
occurring. An emergent process was notable in this study in that what had begun as a study of the lived experience of trauma counselor supervisors, took on the added qualities of description of the process of becoming a trauma counselor supervisor. The natural flow of interview conversation included the experiences of being and becoming, which I then had to incorporate into my analysis and interpretation in light of my original research questions. The research questions and probes on the lived experience of being a trauma counselor supervisor led naturally to explanations of the process of becoming competent in trauma as well as supervision. This analytic process was made easier for me by utilization of tools and methods available to qualitative researchers, which included keeping a self-reflective journal, speaking with my dissertation chair, and continuously re-reading and re-evaluating the transcripts of the interviews. My self-reflective journal included notes I made during and after the interviews, and reflected my feelings and biases about the answers I received as well as about the participants themselves. Overall judgment of the credibility and usefulness of the findings and interpretations of qualitative data are the responsibility of the researcher, and I strove to maintain balance between my own presuppositions and biases and those of the clinicians I interviewed.

To summarize, as Guba and Lincoln (1998) have stated, the knower and the known are inextricably intertwined, implying that the value of qualitative research lies in its acknowledgement of human interaction as essentially dialogical, despite differences in role, as in client/therapist, supervisor/supervisee, student/educator, or researcher/respondent. The dialogical human interaction can be illuminated
through the application of phenomenological research, which was the chosen method for this study.

**Phenomenology**

Phenomenology has its roots in the philosophy of Edmund Husserl in the 19th century. As a method of scientific inquiry, its purpose, as described by McLeod (2001), is “to produce an exhaustive description of the phenomena of everyday experience, thus arriving at an understanding of the essential structures of the ‘thing itself’, the phenomenon.” (p. 38). To study something phenomenologically is to study the thing in the lived world. The research questions for such a study are, according to Creswell (cited in Heppner, Wampold, & Kivlighan, 2008), “…developed in order to understand the everyday lived experiences of individuals and to explore what those experiences mean to them.” The informants chosen for the study (by meeting certain criteria established by the researcher as relevant to the subject) were influenced as little as possible by the researcher, being asked only to communicate their lived experience in response to basic questions decided upon by the researcher. It then became my responsibility as researcher to interpret these findings through lenses chosen for the inquiry. This study examined the research questions through the lens of Van Manen’s Four Lived Existentials.

**Van Manen’s Four Lived Existentials as a Theoretical Lens**

Van Manen’s (1990) four lived existentials are: lived space; lived body; lived time, and lived human relation. He considered his four lived existentials to be helpful guides for reflection in the research process because they pervade the lifeworlds of all human beings, regardless of their social, cultural, or historical
situations. The following are brief definitions and examples of the four existentials as they were applied to this study.

**Lived Space**

Lived space is *felt* space. (Van Manen, 1990) It is connected to, but not limited by the physical dimensions of a room, or the confines of a building. It is the feeling one has while inhabiting a certain room, building, city, or country. For instance, a supervisor who travels from one office to another (as is common in the current mental health system) to see supervisees may notice distinct personal feelings associated with each office space – the lighting, noise level, and configuration of a particular space may evoke feelings of melancholy, irritation, or calmness, that is in turn affected by the other three existentials.

**Lived Body**

We are always bodily in the world (Van Manen, 1990). It is through our bodies that we experience the world, and others in it. Through our bodies, we take in the experience of meeting someone else – through our bodies we speak and are spoken to, with or without words. Our traveling supervisor from the previous example may notice tension in the neck or shoulders in a particular space during supervision, leading to excessive clock-watching in anticipation of the session’s end, which leads us to our next existential, lived time.

**Lived Time**

Lived time is subjective time rather than objective, or clock time (Van Manen, 1990). Our sense of lived time is altered by our experience of what is happening in the moment. Time seems to slow down when we are anxious or uncomfortable, and
it seems to pass quickly when we are interested, having fun, or relaxing. If our traveling supervisor is suffering from bodily discomfort that is at least partially evoked by unpleasant office space as previously described, the supervisor is likely to feel that time spent in the office is passing slowly, leading to the frequent glances at the clock. The supervisor’s reaction, however, will most likely affect, or be affected by the last existential, lived human relation.

*Lived Human Relation*

Lived relation is the way we experience others in the interpersonal space that we share with them (Van Manen, 1990). To return to our supervisor one last time, it is possible that his or her lived space, body, and time can be altered by the lived human relation experience he or she has with a particular supervisee in that office space. For instance, if the supervisor experiences the supervisee as engaging, self-reflective, and personable, the negative aspects of the surroundings – space, body, and time – may be less pronounced. On the other hand, the supervisor’s discomfort may affect the supervisee, making him or her less engaging and thereby adding to the overall theme of negative experience.

Van Manen’s four existentials can be differentiated to some extent, but they cannot be separated because they co-exist and interact to form the “lifeworld.” They provided an appropriate lens through which to view our study, and they were utilized in conjunction with current information from trauma literature.

Bronfenbrenner’s (1979, 2005) theory of ecological development served as a template for understanding respondents’ descriptions of their own development as trauma counselor supervisors. Through examination of the various social systems in
which a trauma counselor developed into a supervisor of other clinicians, a more comprehensive understanding of this transition process was possible.

Self-reflective questions similar to those used in Interpersonal Process Recall (Kagan, 1980) were utilized in interviews with participants in this study. By serving as an inquirer, I invited study participants to recall their thoughts and feelings in their reflections as trauma counselor supervisors.

**The Current Study**

This study was based on the philosophy that informed Ventura’s (2010) research on beginning counselors’ lived experience in dealing with traumatized clients. The results of her study indicated the need for beginning counseling students to be trauma-informed before their practicum experience, and for students to have effective supervision. Effective supervision implies that supervisors need to be trained in supervision techniques and that they need to have sufficient understanding of trauma treatment to be able to assist trainees.

*The Purpose and Design of the Study*

Based upon Ventura’s (2010) findings and my own experience as a trauma counselor supervisor, this current study inquired into the lived experience of trauma counselor supervisors for the purpose of improving the field of Counselor Education in its efforts to train effective supervisors. Through the use of semi-structured interview questions, 8 counselors who have provided supervision to clinicians who have treated traumatized clients were identified, interviewed, and recorded by the researcher. The descriptive data obtained in the interviews was interpreted by the researcher through the lens of Van Manen’s lived existentials,
Bronfenbrenner’s bioecological model, and Interpersonal Process Recall as a phenomenological inquiry. My years of experience as a trauma counselor supervisor and consultant guided the interviews and subsequent interpretation as well.

Research Design

Sample

The sample group in this study used 8 clinicians (counselors, social workers, LMFTs, psychologists, or their international equivalents) who currently, or in the past, have supervised other clinicians who acknowledge that they have worked with traumatized clients. The methods of identifying the informants in the sample group were through a professional list serve and word of mouth. As a therapist in the trauma field for 20 years, I had contact and connection with likely candidates in several arenas. No one with whom I had a current supervisory connection was included in the study.

Methods and Procedures

Semi-structured interviews of 30 – 60 minutes were conducted in person, or via Skype. These interviews were arranged by posting my request for participants on a professional trauma therapist list-serve to which I belong. I sent a copy of my approved IRB proposal to the moderator of the list serve for his approval, and after receiving it, I was able to post the request to the rest of the group. Within a matter of days, I received five offers to participate from the list serve members. Arrangements to do the interviews via Skype were made because all of the volunteers were in other parts of the United States or from Canada or Australia. The appropriate forms for signature and basic personal information were faxed to their private offices or
sent by email, and were returned in this manner. A copy of the semi-structured interview questions was sent also so that the participants could do some basic preparation for the interviews. Arrangements for conducting the interviews were challenging for the participants from Canada and Australia due to the time differences, but this was accomplished by our mutual willingness to get up very early in the morning or to stay up late at night. The three participants from Pittsburgh were therapists known to me from places of previous employment or from conferences. They were conducted in my professional office in Pittsburgh and relevant paperwork was filled out in person. Prior to beginning the interviews, I reviewed the paperwork and consent forms with the participants, asking them if they had any questions about the procedure. The interviews were recorded in an audio format only, with the informants remaining anonymous for the purpose of the study. The transcriptions were performed by a nationally known transcription service, and printed out on my home printer after they were downloaded to my private account. As the researcher, I was the only person with information regarding the informants' identity. To ensure trustworthiness of the information, transcripts were provided to the participants to review before the information was analyzed. I kept a reflective journal of my personal experiences of the interview process as well as my observations of the participants.

The questions for each interview included the following:

6. What has your experience been like in treating victims of trauma?
   
   b. How do you understand the concept of trauma?
c. How does the concept of trauma fit into your experience of being a counselor?

7. Do you find working with traumatized clients more difficult than working with non-traumatized clients?
   a. If you find it more difficult, what kinds of feelings do you experience in working with trauma cases?
   b. What personal and professional resources do you use in working with traumatized clients?
   c. What role has culture played in your trauma work?

8. What has your experience been like supervising counselors who deal with traumatized clients?
   a. What differences do you notice in counselors’ needs for supervision with traumatized versus non-traumatized clients?
   b. What personal and professional resources do you use in supervision to assist supervisees?
   c. What role has culture played in your work as a supervisor?

9. How do you organize your supervision experience when supervisees present traumatized versus non-trauma clients?
   a. What do you notice about transference and countertransference when supervisees present trauma clients?
   b. What do you notice about parallel process between the supervisee/client and supervisor/supervisee?

10. What experiences have prepared you for supervising counselors
who work with traumatized clients?

a. How did your clinical education prepare you for supervising trauma cases?

b. What personal and/or professional experiences have helped you become an effective trauma counselor supervisor?

c. What support or educational experience do you wish you had had to prepare you for becoming a trauma counselor supervisor?

*Explication of Methods*

The use of a semi-structured interview method was based upon the flexibility it affords when utilizing a single-session interview. It provides a basic structure to the interview while still allowing for discussion and expansion of topics without losing the thread of the research question (Cohen & Crabtree, 2006). While utilizing the semi-structured interview approach, I relied upon my skills as a counselor to develop rapport and to encourage the participants’ natural inclination to describe their lived experiences as trauma counselor supervisors. As described previously in this chapter, the participants, who are also therapists, seemed to veer off-topic at times. However, in the analysis phase, I found that much of what had seemed off-topic had relevance to the participants’ lived experience. For example, one of the participants made a seemingly off-hand remark about “not telling anyone” about her work, that later became clearly relevant as a lived experience condition of her workplace environment.

In order to remain self-reflective throughout the research process, I kept a journal of my thoughts and feelings about the interviews, participants, and the
information I was obtaining and analyzing. The journal kept me aware of ways in which my own biases and presuppositions might influence both the interviews and research process. I asked myself the following questions: Am I leading the interviewee with questions or probes? How do I feel about this process/person? Am I conscious of wanting to be liked or approved of by the interviewee? What is the participant’s body language telling me? Have I asked the appropriate probes as follow up questions?

As the instrument in this qualitative research study, I was aware that my twenty years of experience as a trauma therapist and supervisor allowed me to evaluate and understand the questions asked of participants, and the responses received in a thorough way. In my job as a clinical supervisor for a rape crisis center, I was working with clients and with supervisees who were dealing with trauma. In my doctoral program, my work in supervision of master’s level students furthered my knowledge and understanding of supervisory processes on a lived-experience level. Having had these experiences eventually led to my choice of topic for this dissertation, with fervent hopes that my research would be of use in changing the pedagogical experience for counselor education students to make them more prepared for their inevitable contact with traumatized clients and supervisees.

*Data Collection*

Digital audio recordings were the main vehicle for collecting information for this study. For purposes of credibility in qualitative design, Patton (2002) lists triangulation of data sources as a methodology. Triangulation of sources refers to measurement of the consistency of data through more than one source. In this
study, I utilized my notes taken during the interviews, the audio recordings, and the subsequent transcriptions of those recordings.

Data Analysis

Berg (2009) describes analysis of qualitative data as an ongoing and recursive process. After each interview for data collection, I reviewed my findings and my questioning process so that I would be better prepared for the next interview. This process was repeated as I conducted my analysis of each interview, going back over the transcripts and notes. Within the course of several interviews, I began to notice patterns and noted them on the transcripts and on individual index cards. Certain “phrases of significance” appeared during my analysis and these formed the basis of the themes identified in Chapters 4 and 5. Phrases of significance that did not fit into identified categories were considered “units of meaning” as described by Giorgi (1985). Through this recursive process, I was able to identify phrases that illustrated van Manen’s lived existentials and to formulate the five themes that best represented the data.

As I identified the themes in the data, I continuously referred to the trauma and supervision literature as well as the theoretical and philosophical bases of van Manen, Bronfenbrenner, and phenomenology. These sources provided solid sources of reference and grounding as I analyzed the large volume of data inherent in this qualitative study.

After the seventh interview, I noticed that data was becoming saturated and that no new data points were being revealed. However, I conducted the eighth interview to confirm the process since it had already been scheduled.
Limitations of this Study

As in many qualitative research designs, the small sample size makes generalization of the results of this study to a larger population difficult. My personal biases and presuppositions cannot be ruled out as potential factors limiting this study, despite methods undertaken to improve credibility. Also a significant limitation is the homogeneity of the sample, which is discussed in greater detail in Chapter five.

Summary

This study was a phenomenological inquiry into the lived experience of what it means to be a trauma counselor supervisor. Information was collected from informants who have had the experience of supervising therapists who acknowledge working with traumatized clients. The information was collected via a semi-structured 30-60 minute interview and audio recorded from in-person or Skype interviews consisting of a series of open-ended questions. Informants were given the opportunity to review transcripts of their recorded comments to assure accuracy. The information was then analyzed through the lens of Van Manen’s Four Lived Existentials, and through the researcher’s lived experience as a trauma counselor supervisor.

Chapter 4 describes the findings in detail and includes a content analysis of the data obtained through the interview process. Chapter 5 outlines the findings and implications for this research in the field of counselor education and discusses the need for further research into pedagogical changes needed to prepare counselors to be competent therapists and supervisors.
CHAPTER IV: RESEARCH FINDINGS

Van Manen (1990) states, “The purpose of phenomenological reflection is to try to grasp the essential meaning of something.” (p. 77). The present study is an attempt to grasp the essential meaning of what it is like to learn about trauma, to learn about supervision, and to become a trauma counselor supervisor.

This chapter provides a case-by-case narrative of semi-structured interviews conducted with the eight informants who participated in the study. Participant demographic information is delineated in Table 1. This chapter also includes eight charts illustrating phrases of significance related to supervision that were noted during the interviews. Phrases of significance refers to analytical categories that stood out to me, and that form the basis of themes identified and discussed in Chapter 5. A description of my own experience while collecting the interview information is included in this chapter and leads to a cross-case analysis of the information from the eight participants. This information is explored in this chapter and further elucidated in Chapter 5.

The participants in this study were eight clinicians from the United States, Canada, and Australia, all of whom had at least a master’s level education, had counseled adult survivors of childhood sexual abuse, and had gone on to become supervisors of other clinicians seeing trauma clients. Three of the participants were located in Pittsburgh, two of whom participated in face-to-face interviews, while the others were conducted via Skype. All participants were advised of the potential confidentiality risks associated with electronic media technology.
Six females and two males participated in this study. Some of the participants were known from the therapeutic community in the Pittsburgh area, while others were known by name as members of a professional therapist organization. None of the participants were currently involved in a supervisory relationship with the researcher. All of the participants were presently, or had been, professors at universities in addition to being clinical supervisors and consultants in agencies or private practice. Supervision challenges described by the participants took place in their university offices, their agency offices, and their private practices.

Table 1.

Informant Demographic Information

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Race</th>
<th>Yrs. as Tx.</th>
<th>Yrs. as Supv.</th>
<th>Supv. Tng. Pre/in-svc</th>
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<td>7</td>
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</tr>
</tbody>
</table>

pre-svc

in-svc
Individual Informant Interviews

This section addresses issues related to the individual participant interviews, as those issues relate to the process of coding and analyzing the data obtained. My own biases and presuppositions are identified in the interest of addressing researcher bias.

All of the interviews were digitally recorded, whether in-person, or via Skype. In addition, I kept a reflective journal that included notes from the interview and my own feelings and opinions that emerged throughout the process. A semi-structured interview protocol was used to give the material basic structure, but all of the interviews were primarily conducted in a conversational and collegial manner. Much of the rich and complex material came up in the less-structured and convivial conversational parts of the interviews. As a therapist with 20+ years experience working with traumatized clients, and 9+ years experience as a trauma counselor supervisor, I felt my rapport with the participants flowed naturally from our shared experience.

Presuppositions and Biases

The first presupposition was that trauma is present in large numbers of human beings who seek treatment for issues of emotional distress, especially those who have received diagnoses such as personality disorders, anxiety disorders, depression, phobias, and eating disorders (Jennings, 2001). Currently, the DSM-5 (APA, 2016) lists these diagnoses and hundreds of others as discrete, sometimes co-occurring disorders but most practitioners do not connect these disorders to developmental trauma, such as childhood sexual abuse. They lack awareness of the
professional literature which identifies that approximately one third of women and one sixth of men in North America report a history of sexual abuse that occurred in childhood or adolescence (Briere, 1996; Finkelhor, 1990; Polusny & Follette, 1995, in Kitzrow, 2002). While not all victims of abuse seek treatment, it follows that large numbers of people who do seek treatment for what is labeled “mental illness” will also have a sexual abuse history. These data indicate that trauma is a ubiquitous human experience and that speaking of trauma therapy as a “specialty practice” is misguided. Experience from my own practice over the past 20+ years has shown that most adult survivors of childhood sexual abuse (CSA) have been to numerous therapists over the years in search of one who “gets it” with regard to the often-complex emotional issues associated with CSA. Unprepared counselors are themselves vulnerable to feeling de-skilled and to suffering from vicarious trauma, burnout, and dysfunctional countertransference reactions (Trippany, Kress, & Wilcoxon, 2004).

The second presupposition was that therapists at all levels of education lack basic information in how to deal with traumatized clients when they emerge into the field. To date, therapist educational programs have not provided students with the skills needed to address even the basic needs of trauma survivors. Ventura (2010) observes that teaching students to be self-reflective is a starting point for helping to prepare them for dealing with traumatized clients in their practicum experience. It is my own personal bias that students would also benefit immeasurably by having a basic introduction-to-trauma course that is required, rather than optional, prior to being sent to practicum and internship. A study by
Follette, Polusny, and Milbeck (1994) reported that 96% of mental health professionals reported that they felt the need for education to effectively cope with difficult trauma cases. Among those who have studied the effects of working with trauma clients on counselors (Cerney, 1995; Chrestman, 1994; Dutton & Rubenstein, 1995; Pearlman, 1999; Rosenbloom; Stamm, 1999; Schauben & Frazier, 1995), all recommend trauma-related supervision as a variable in mitigating vicarious trauma and burnout.

The third and final presupposition is that, despite the literature noted above, effective trauma-related supervision is hard to find. The majority of supervisors in the counseling professions are master’s level practitioners who have been promoted to supervisory positions without benefit of supervisory training (Borders, Cashwell, & Rotter, 1999). When coupled with information described in the previous paragraphs on the ubiquity of trauma and the lack of trauma education provided to master’s-level counselors, the third presupposition indicates that counselors are becoming trauma counselor supervisors with training in neither trauma nor supervision. As Etherington (2009) reminds us, “As well as having a solid grounding in the various functions of supervision, supervisors supporting people who work with traumatic abuse also need to have a good grasp of trauma theories, which are constantly being updated.” (p. 180).

My own experience in learning about trauma at my first counseling job by “total immersion” and a crash-course of reading the available trauma literature is not unusual, as evidenced by the peers with whom I have spoken. I was also lucky enough to have begun my career at a rape crisis agency, where supervision was
trauma-informed and where I had peers who understood what I was seeing in my clients. Clinicians who start out at other types of agencies, such as drug and alcohol, or eating disorder clinics have described their introduction to the presence of trauma in their clients’ lives as occurring in a more circumspect manner – with supervisors less likely to be trauma informed.

*Participant Interview Analysis*

Based upon the assumptions and biases described above, I utilized my self-reflective journal and conversations with my dissertation chair to discuss my feelings and reactions to the interview information. During the interviews, I found that many of my presuppositions were confirmed, as was what I’d found in reading the trauma literature discussed in Chapter 2. I have been acutely aware of my own biases as a long-time trauma counselor supervisor in doing the interviews, however, the age and experience of the study participants made them less vulnerable to unintended influence on my part. Pietkiewicz & Smith (2012) suggest the following steps in performing qualitative analysis:

1. Multiple reading or listening and making notes on the participant’s description and the researcher’s reactions, highlighting distinctive phrases and emotional responses.

2. Transforming notes into emergent themes: the researcher tries to formulate a concise phrase at a higher level of abstraction while still grounding it in the participant’s account, These may be thought of as “units of meaning” (Giorgi, 1985).
3. Seeking relationships and clustering themes: grouping the units of meaning together according to conceptual similarity and providing each cluster with a descriptive label.

4. Synthesis and written analysis exemplified by abstracts from the interviews.

Following the interview process, I listened to the recordings and read the transcripts several times, making notes in the margins of the transcripts. After reading the transcripts several times, I re-read my notes on the transcripts, looking for significant phrases and patterns in the participant narratives. I reviewed my reflexive journal, noting my feelings and reactions to each participant at the time of the interview. During my reading of the transcripts, I was conscious of trying to understand them through the lenses of my research questions and my presuppositions and biases. It was obvious by the seventh interview that no new themes were emerging and the data had reached saturation; however I did an eighth interview for the purpose of confirming my previous findings, thereby increasing the trustworthiness of the pattern identified. I then began placing the phrases of significance into charts and analytical categories where I could identify patterns, which could then be linked to the literature discussed in Chapter 2. The themes and categories were viewed through the lens of trauma theory, supervision theory, and van Manen's (1990) four lived existentials. This information was placed into charts to illustrate the phrases of significance in their original depth and content as narrated by the participants. The domains outlined in the charts were as follow:

1. Van manen's Four Lived Existentials
2. Learning about trauma
   a. Explores how participants learned about trauma counseling
   b. Examines the dilemmas that counselors faced in the process
   c. Asks what helped in the process of learning and what was needed

3. Learning about supervision
   a. The presence or absence of supervision training or education
   b. Explores the challenges faced by supervisors of trauma counselors
   c. Examines the cultural challenges in supervision
   d. Looks at what helped and what was needed in the process

4. Units of meaning
   a. Phrases of significance that do not fit into other categories but were important to include.

The purpose of the charts is to give readers an opportunity to recognize the depth of the participant’s experience. By compiling these charts and reviewing the analytical categories, I was able to identify major themes that emerged in this study. These themes will be discussed in Chapter 5.

**Findings: Case-by-Case Analysis**

Six of the interviews for this study were conducted from my home via Skype. Participants who participated via Skype had signed their consent forms and demographics and returned them through email or by fax prior to the interview call. Participants had received a copy of the interview questions ahead of time to review. Calls lasted anywhere from 25 minutes to 75 minutes, with the average being around 45 minutes. The two in-person interviews were conducted in my office in
the Point Breeze section of Pittsburgh, and paperwork was signed at the time of the interview. All interviews were conducted in private and were recorded on my cellphone and/or computer to be transcribed later.

**Participant One**

Participant one is a 68-year-old Caucasian female U.S. resident with a degree as an Advanced Registered Nurse Practitioner (APRN), which enables her to have a specialty in psychiatric nursing. After reviewing our paperwork and the purpose of the study, we began our interview in a conversational way. Semi-structured interview questions were inserted into the conversation as guides to keep us on the topics being studied, but they felt very natural in the flow of the conversation. The interview ended after approximately 34 minutes when all of the questions had been answered and the discussion had come to a natural conclusion.

Participant #1 reported that she has been in the mental health professions for 30+ years and is aware that she has worked with adult survivors of childhood sexual abuse for all of those years, though she didn’t recognize trauma before she became trained in Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro, 1989). She stated:

I think before I learned EMDR, I believed that everything that we experienced as difficulty in our life came from relationships, whether it be relationships with others and then eventually relationships...within ourselves, and so my focus of work was on relationships. It’s not that I didn’t deal with people who had trauma, but I didn’t think of the word trauma during that time.
EMDR, with its specific emphasis on trauma in war veterans at the time in the 1980s introduced Participant #1 to the concepts of trauma within relationships, which she described as, “…a reframing and maybe a different paradigm, or…it just compliments my work.”

Participant reported that she had received no education or training in trauma in her graduate program. After finishing graduate school, she took a job in a clinic where she was assigned all the eating disorder clients because, as she remembers, “I was the new kid on the block when I transferred to this one unit, they gave me the eating disorder clients because they were difficult and I was the newbie.” While working in this clinic, the informant began to realize that a lot of her clients were also victims of sexual and other types of abuse. She struggled to understand the connection between trauma and eating disorders, so she began reading books by Christine Courtois and Judith Herman. She also sought private consultation at that point to assist her in her trauma work.

When asked about challenges she faced in working with traumatized clients, Participant #1 talked about her work in a child behavior unit where the connection between some children’s trauma and disordered eating were clear, saying,

So there was like a child with a dissociative disorder, probably the first child I ever saw. She witnessed her brother being killed by her grandmother. I mean, there were awful experiences that made it understandable, okay, why this would happen.

Other cases she saw, such as an anorexic girl who took 45 minutes to eat an apple, were less understandable, she said:
Her parents would come to see her, and they were affluent, they looked like they were together, so I couldn’t understand it. Like, “Where does this come from?”

At this point in the interview, we proceeded to questions about how Participant #1 transitioned from clinician to supervising clinician. She mentioned that she had done some supervision in her early years in the eating disorder clinic, and afterwards described, “After I left I was hired on to be an associate professor to train residents, which was really very interesting because psychiatrists having a nurse as a supervisor really challenges...”. However, she believes her real leap into consultation/supervision emerged after she was trained in EMDR work and became certified as an EMDR consultant, which is the basis of most of her supervision work now. Prior to EMDR training, Participant #1 had not had any formal training in supervision. She described her learning about being a supervisor as follows:

But I think the actual experience of being in your office and learning about it and then having something come up that you don't know what the hell this is and how do you deal with it and getting some consultation or taking a course or reading a book, or now, webinars, conferences. I just think it's life-long learning, that you just have to keep expanding who you are as a clinician.

When asked to describe supervision challenges she encountered with trauma counselor supervisees, Participant #1 stated:

I’m always including the importance of learning about ego-state work, and about transference and countertransference, particularly the kinds of issues that can come up with clients who are sexually abused. I mean, I think that
there’s issues that can come up in terms of rescuing, that can come up with a lot of different clients, but the vicarious traumatization – victim, abuser, all of those aspects – I think are important to address...

She talked of one particular supervisee, an Orthodox Jew whose clients are also Orthodox Jews, and the in-depth understanding she’s (Participant #1) had to acquire through being self-reflexive and willing to learn to be a culturally competent supervisor. As she puts it, “Because rather than being seen as the other, period, I’m the other who wants to know, who wants to understand.”

Another supervision challenge Participant #1 identified was that some student supervisees were adamant that they would not be working with trauma because they were choosing specific specialty practices. She recalled, “And so just even getting them to think about trauma..., of course – just the idea of traumatization, that they can frame it in a very different way than I understood it.”

She noted that members of the nursing profession often do not easily accept suggestions about self-reflection and emotions. In her words:

Well, oftentimes nurses are tough. They’re so guarded and protected that getting to emotions, they’re like these stoic individuals. So sometimes it’s like a wall to get through. ...I think it may depend on the nurses who choose to go into work in psychiatric units...they may be willing to be a little bit more introspective...

My final question to Participant #1 was an invitation to talk about what supervision of trauma therapists has meant to her, and what ideas or concepts have helped her along the way. Her initial response was as follows:
I love what I do. It’s an honor to be part of somebody’s journey...sometimes it’s tough work but it’s very rewarding, and I think what helps me get through the tough times is knowing I’ve been down that road before and it’s going to move to a different place.

Participant #1 is also the co-founder of an advanced EMDR peer group that has been meeting once a month to discuss cases for over 20 years. They have also hired consultants via Skype to talk with them about particular issues. She notes that the physical and relational configurations of her offices over the years have been important in affecting her stress level. Recalling the differences between offices she said, “...I’ve had so many years of being in private practice in an office that I know the difference when I was not connected and when I was connected, just where the set-up of the office wasn’t conducive to connecting with the people I liked.” For Participant #1, participating in professional groups, online listserv groups, and talking with colleagues are paramount in helping her to feel less isolated in the work of trauma therapy and supervision.

Table 2 lists the numerous phrases of significance discussed in this interview along with their correlation to analytical categories mentioned earlier in this chapter. Each participant in the study will have a corresponding table to augment the text within this chapter, and the information therein will be combined to identify themes that have emerged from this data, to be discussed in Chapter 5.
### Analytical Categories

<table>
<thead>
<tr>
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<th>Quotations of Significance</th>
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<tr>
<td><strong>1. FOUR LIVED EXISTENTIALS</strong></td>
<td></td>
</tr>
<tr>
<td>- Lived Body</td>
<td><em>I see trauma as...like our immune system has the ability to fight off bacteria and viruses but then sometimes things happen that overwhelms our system and we need some help.</em></td>
</tr>
<tr>
<td>- Lived Space</td>
<td>N/A</td>
</tr>
<tr>
<td>- Lived Human Relation</td>
<td><em>So the individuals with the eating disorders...they were oftentimes very oppositional and angry about everything that you did. So they were not pleasant to work with.</em></td>
</tr>
<tr>
<td>- Lived Time</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>2. LEARNING ABOUT TRAUMA</strong></td>
<td></td>
</tr>
<tr>
<td>- Specific populations/methods</td>
<td><em>They gave me the eating disorder clients because they were difficult and I was the newbie. But, in the course of that work, there were a lot of people who were victims of sexual abuse, and so that really was my start. So I think even though EMDR and Francine Shapiro may have started with like Iraqi war veterans, I look at trauma more developmentally.</em></td>
</tr>
<tr>
<td>- Challenges in Trauma Counseling</td>
<td><em>I think I was more on my own trying to figure out how to work with this particular population and recognizing how the (eating disorders and sexual abuse) were correlated.</em></td>
</tr>
</tbody>
</table>
- What helped/what was needed  
  Being aware of self care and trying to keep things really balanced...the connection with people locally and abroad. I think the most important is not to isolate with this work.

3. LEARNING ABOUT SUPERVISION

- Methods of learning  
  Because I did some supervision for eating disorders when I was younger...After I left I was hired on to be an associate professor to train residents. But I would say my consultation came after I was trained in EMDR work, I then became certified, and then I became an EMDR consultant and facilitator.

- Challenges in supervision  
  I mean, I think that there’s issues that can come up with clients who are sexually abused...the vicarious traumatization, victim/abuser, all of those aspects...I think are important to address with supervisees.

  Sometimes the therapy doesn’t work out if there’s not some attempt at understanding and recognizing that there are (cultural) differences...

- What helped/what was needed  
  I love what I do...sometimes it’s tough work but it’s very rewarding. And also reading and going to conferences...the dissociative listserve and the EMDR listserve.

Participant Two

Participant #2 is a 62-year-old Caucasian female master’s level clinician who has worked for over 25 years in mental health and non-profit victim service
agencies. She notes that all of her current work is informed by the concept of trauma. She now has a private practice and runs a consulting business for county agencies that contract for staff training in providing trauma-informed services. She is also employed as a professor at a local university to provide courses in trauma to master’s-level counseling students. Her trauma track courses are optional at this time and not required for graduation.

Participant #2 learned about trauma counseling through her work in female offenders programs and rape crisis centers. At the time, she said:

I didn’t have a language for them…and it was through those women that I first had people talking to me about adult and childhood sexual abuse experiences…Basically, it was all self-identified traumatic histories…and we jumped in and there wasn’t a lot of written material…

When asked about how she moved into being a trauma counselor supervisor, Participant #2 described her first job as a supervisor at a residential program, where she was hired into the position. She then went on to work at a rape crisis center and later promoted to the position of supervisor. She described this transition as follows:

The way I got there was torturous and traumatic, and it was very odd to go from a peer to supervision of my peers. So that first six months was delicate in how we all made that transition, but we all made it together. I didn’t make it by myself.

There was no specific training for this supervisory job and her promotion, she says, was based upon the fact that she’d been a supervisor for over seven years at another
agency. The promotion was traumatic in that it occurred in the wake of the previous supervisor’s pressured departure from the agency.

Participant #2 noticed that the biggest supervision issues she encountered at the rape crisis agency were related to supervisees’ secondary traumatic issues due to holding large amounts of traumatic information. She speculated that this was because the clients at the agency were being seen for extended periods of time, as compared to time-limited therapy. That extended period of time allowed the work to become more complicated for the client and therapist in their relationship. She described the challenges in the following way:

Probably my experience with trauma work is it may take longer for (trust and safety) to be expressed, particularly transference. However, once it is, sometimes can be very intense because we’re dealing with people that are in isolation, true isolation of engaging with others, and also disconnected from their own selves. So often times that transference is extreme...So the countertransference for people that need to be needed (supervisees) is of course significantly higher.

Issues of cultural difference between supervisees and their clients, along with the parallel processes between therapist and supervisor, were mentioned as of particular importance to Participant #2, as evidenced by the following statement:

Well, I guess, first, I need to say that I think any cultural difference that the therapist is not versed in needs to be explored. And it’s really the therapist’s responsibility to get that information in dialogue with her client, but also academically, she needs to pursue a better understanding of whatever
diversity she’s working with. As a supervisor, I think it was always important
to recognize the staff’s own lived experiences. And then in turn, as a
supervisor, my primary interest was my therapists and how safe were they,
how clear were their own interpretations.

Participant #2 believed that the experiences that prepared her for being a
supervisor were having had three knowledgeable supervisors as well as what she
describes below:

   Probably my own work...with traumatized clients. And...an absolute belief in
team approach, particularly the trauma work. That it takes a village to help a
person, and that we have to collaboratively work together. So supervision for
me was just another aspect of working together in the best interest of their
client..

She suspects that her experience of having had good supervision might be unique in
many ways, compared to what she’s heard from other therapists. These supervisors
trusted her knowledge base and experience, and encouraged her to try new things,
such as starting a group for adult trauma survivors, that no other agencies were
doing at the time. Of the therapist who was hired by Participant #2 to provide
outside supervision, she said the following:

   I wish I would have had the luxury of working with (name deleted), and not
just supervised by her. I think as a therapist...I would have had a greater
opportunity to learn in that collaborative relationship.

As far as what Participant #2 needed and wished she had had early in her work with
trauma and supervision, she mused:
I wish I would have had more resources available to me and those resources didn’t exist. I wish my graduate program had taught trauma. I had to look to individuals...locally, developing a friendship and a professional relationship that got me more information...and then finding an international study group. It was those folks that kept shaping the work...

What supports Participant #2 in her work is, “That I believe 100% in honesty, authenticity, and unconditional love (for clients). And I also think that’s what supports my work with other professionals, is that I don’t sugarcoat anything...I don’t keep secrets.”

Table 3

*Topic: The Process of Becoming a Trauma Counselor Supervisor*

<table>
<thead>
<tr>
<th>Analytical Categories</th>
<th>Quotations of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. FOUR LIVED EXISTENTIALS</strong></td>
<td></td>
</tr>
<tr>
<td>- Lived body</td>
<td>N/A</td>
</tr>
<tr>
<td>- Lived space</td>
<td>So it was really like everything in the text book about how one might cope with trauma was in the office.</td>
</tr>
<tr>
<td>- Lived Human Relation</td>
<td>It was like, I saw two rape clients and the next thing you know, “(Participant #2) will see them.” So I had all these crazy outrageous cases and a waiting list for openings.</td>
</tr>
<tr>
<td>- Lived Time</td>
<td>And I was like, “You’re giving me the craziest, most difficult clients. When do you think I’m going to have openings?”</td>
</tr>
<tr>
<td><strong>2. LEARNING ABOUT TRAUMA</strong></td>
<td></td>
</tr>
<tr>
<td>- Specific populations/Methods</td>
<td>The first work I did with known trauma survivors was in the program for female offenders...and it was through those women that I first had people talking to me about adult and childhood sexual abuse experiences.</td>
</tr>
</tbody>
</table>
- Challenges in Trauma Counseling  So that was the first time that people were
telling me, “this happened. And then as an
adult, this happened,” and they were both
v violent sexual experiences.” So it was at
that point that I started to seek more
information, and it was really limited...

- What helped/what was needed  I’ve researched this on my own. I had
access to the fact that they existed,
because I was a Women’s Studies major. So
I already had a sense of academic works
by women, and so then I was able to find
things like Carol Gilligan, who presented
a different way of looking at the human
condition.

3. LEARNING ABOUT SUPERVISION

- Methods of learning  In the residential program, I started as the
supervisor. And then at the rape crisis
center, I was promoted to that position.
There was no more specific training than
the fact that they know I’d been a
supervisor for over seven years at another
site.That was the only training I had.

- Challenges in Supervision  The way that I got (to be a supervisor) was
torturous and traumatic, and it was very
odd to go from a peer to supervision of my
peers. So that first six months was
delicate in how we all made that
transition...

- The Role of Culture  So there’s all these layers of the
diversity issues from age to race to
religious beliefs for both parties, and
then how are they respected primarily
for the client? And then in turn, as a
supervisor, my primary interest was
my therapists and how safe were they,
how clear were their own
interpretations?

- What helped/what was needed  Probably my own work with traumatized
clients. And a sense of...an absolute belief
in team approach...it takes a village to help
Participant #3

Participant #3 is a 68-year-old Caucasian woman who is a psychologist in Canada. She has been seeing traumatized clients for more than 30 years, and has been supervising others for more than 20 of those years. She is in private practice currently, but began her career working in rape crisis agencies and observed the following:

Well, I think I got into trauma work like many of us did, through the back door of working with women who’ve been sexually abused...and it wasn’t called trauma then...I was asked to do some group work with some women who had been sexually abused and I guess that’s really where I started to learn – from women in the groups.

Participant #3 currently does a lot of work with traumatized military veterans, some of who also suffered childhood sexual abuse. She believes a lot of trauma is not seen or acknowledged by the public and by therapists. She says, “So, for me, one of the things I’m always looking for is signs of trauma so that I can rule it out rather than waiting to try to rule it in.”

One of Participant #3’s early experiences with a traumatized client was what she calls her, “introduction into DID (dissociative identity disorder),” which she describes in this way:
My client – I looked away and I looked back and he was curled up on the floor and was sucking his thumb. Fortunately, he stayed in that state for a while, which gave me a chance to sort of stop and think, “What in God’s name am I going to do now?”

Participant #3 realized that she was seeing behaviors in her clients that didn’t make sense, so she started reading more about trauma and dissociation, and it started to make a difference in her awareness of the connection between trauma and dissociation.

She did not have any supervisors who were trauma-informed or helpful at the time. She had a placement at a psychiatric hospital with a supervisor who was somewhat helpful, but the patients were labeled psychotic and the only treatment for their distress was medication and institutionalization. She remembers one client in particular:

And one of the things I remember from that was a young woman who had a horrendous history of sexual assault. She was 19 or 20, and she was saying that her medications were making her sicker and she wanted them changed, and her psychiatrist had said, “she’s just resistant to treatment and we’re not changing it.” I’m like, “Oh boy.”

Participant #3 took advantage of an online supervision course that was offered a few years ago by a university in Calgary. She cannot remember much of it but, when it comes to being qualified as a supervisor, she says, “But I did that and so now when push comes to shove I can call up my little piece of paper.”
Through her work in supervising students at a university and as a consultant in private practice, Participant #3 has had several supervisory dilemmas. She sometimes has to consider whom she will take on as a supervisee. She had reservations about one woman in particular:

I turned down one woman a couple of years ago because her whole world view is that everything everybody does is bullying. And I thought, “It doesn’t matter what I do. I’m going to end up as a bully.”

Another supervisee became involved in a romantic relationship with the psychiatrist in charge of the practice where the supervisee worked. Participant #3’s challenge as a supervisor in this situation focused on the exploitation of the supervisee by the psychiatrist.

One thing Participant #3 likes about supervision is that the students ask her questions that make her think. She says this is good for her head and keeps her learning. In her words:

...Sometimes they’ll ask some questions that make me really think, “Oh they might really truly be the right thing. Just because I’m the experienced trauma therapist, what’s another way to do this? Or is there another way to do this?

Something that Participant #3 tries to convey to her supervisees is that they will have to face the fact that some clients don’t ever change, or that they change very slowly. She recognizes that some of her supervisees come to the field with hopes of changing the world. As she states, “There’s classic things that we all end up doing. Trying to rescue them (clients) and adopt them and save them.
Participant #3 has had some rich and challenging experiences with supervisees of other cultures, one of who was a woman from China who perceived any direct questions as rude and invasive. Upon deeper questioning, the supervisee was found to have her own trauma history, which complicated supervision.

Another difficult supervision experience was illuminated by Participant #3 in the following descriptive passage:

And I had an East Indian guy, who was a Muslim, who gave sexism a good name. Ugh, it was awful...and I was so glad when he said he was going to move to Toronto. I said, “Good. Go.” He was the kind of person who would come and stand six inches in front of you. I’m 5’2,” he was six foot something...he was trying to intimidate me. He’d say to me, “Well, why don’t you look at me?” I said, “Because you’re standing too close and I can’t get my head up there.” And he was very sexually inappropriate with many of his female clients, and I would hear about it and I’d hear how he talked about them. He was just creepy.

A final cultural supervision challenge encountered by Participant #3 relates to the difficulties in keeping good boundaries in the small town where she practices. The LGBTQ community in the area is limited and closely-knit, and Participant #3, on more than one occasion, has found herself supervising friends of clients, or even friends of friends unknowingly.

When I asked Participant #3 what has helped her in her trauma-counseling work, she listed EMDR as a practice. She was skeptical of it at first because she is
wary of manualized methods, but she’s found it flexible and adaptable. She described her approach to supervision in similar terms:

Yeah, it’s whatever is going to work for the (client), and I think that’s how I approach the supervision. Some supervisors I think are more structured than I, but I’ve never been able to be very rigid – I’m just not good at it. It’s just not me. We just go with whatever’s going on, and sometimes it’s me who goes back to what we talked about two weeks ago and wants to follow up on it…I’ve gotten the ability to be able to pick up the threads of things and pull them together. Some of them (supervisees) have said to me, “I think you’re mean. Just when I think I’ve got you conned, or distracted, you go back to and you just come up with a sentence or a short question…and I have to talk about it.”

Participant #3 states that she would have benefitted from having a mentor, somebody who wasn’t necessarily a supervisor but who would help her figure out some of her trauma and supervisory challenges. She would also have liked more peer support – something in short supply in the military approach to trauma. She observed:

At least in the Army world where I work, they’re so conditioned that it’s all supposed to be evidenced based. It is almost a bad word when you say something that’s not (part of an evidenced based practice). So it’s not really open to anything else. I’ve been there for a long time and I’ve gotten them to leave me alone.
She’s had to work silently, and in secret with veterans, especially when using Reiki and other non-exposure methods of counseling. She recalled one experience in the following words:

I had one guy, who was an Afghanistan vet, and he would get so split and so dissociated that one half of him would be brushing sand off his body, and the other part would be looking around my office. (Colleagues in the office) said, “That’s not possible.” And I did some body work and Reiki, and he settled right down. And it worked, but I didn’t write that down. I didn’t tell anyone.

Table 4

**Topic: The Process of Becoming a Trauma Counselor Supervisor**

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<th>Quotations of Significance</th>
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<tbody>
<tr>
<td><strong>1. FOUR LIVED EXISTENTIALS</strong></td>
<td></td>
</tr>
<tr>
<td>- Lived Body</td>
<td>Yeah, like, “You’re not allowed to hit me.”</td>
</tr>
<tr>
<td>- Lived Space</td>
<td>And I said, “And I know you can get out of this room six different ways I wouldn’t even think about…and if you don’t like what’s going on in here, just walk out the door. Slam it if you want.”</td>
</tr>
<tr>
<td>- Lived Human Relation</td>
<td>They’re all trained to kill me before I even notice.”</td>
</tr>
<tr>
<td></td>
<td>So I find that the more human I’m able to be, the less upset I get. And when I’m able to say to myself, “Now, wait a minute, we’ll find something.”</td>
</tr>
<tr>
<td></td>
<td>It doesn’t matter what I do. I’m going to end up as a bully.</td>
</tr>
<tr>
<td>- Lived Time</td>
<td>I looked away, and I looked back and he was curled up on the floor and was sucking his thumb. …Fortunately he stayed that</td>
</tr>
</tbody>
</table>
way for awhile, which gave me a chance to sort of think, “What in God’s name am I going to do now?”

2. LEARNING ABOUT TRAUMA
   - Specific populations/Methods
     Well, I think I got into trauma work like many of us did, through the back door of working with women who’ve been sexually abused...
     And I thought, “There’s something very odd here,” and that’s when I start to pay attention to them dissociating or having a flashback, and fairly quickly working with soldiers who’ve been traumatized. I had to get pretty good at picking it up because they sure weren’t going to tell me about it.
     And one guy, he decided that the EMDR worked really well for him. He decided it was voodoo...
   - Challenges in Trauma Couns.
     And whether it’s one big T trauma or or it’s a whole bunch of little ones, I’m often amazed at the number of times when people just don’t see it, or want to see it.
   - What helped/was needed
     But I kept seeing things that just didn’t make a whole lot of sense, and so I started doing more reading around DID and around trauma, mostly in the sexual abuse area, all of a sudden (it) started to make a difference.

3. LEARNING ABOUT SUPERVISION
   - Methods of Learning
     I’ve been doing some (supervision training) informally, and then many years ago University of Calgary offered an online course to be an approved supervisor. So I did that and I don’t really remember much of it. But I
did that and so now when push comes to shove I can call up my little piece of paper.

- **Challenges in Supervision**

I've got one right now that’s a bit of a problem...he’s a young man who got involved in a...romantic relationship with his psychiatrist. He started working with the psychiatrist at his practice...and then living together.

I'd rather put my energy into supervising trauma because I think that so much of it gets missed; it doesn’t get well attended to.

I had one guy who was fairly wedded to: “So we should focus on short term stuff.” Then I ran into him somewhere...and he said, “I have been seeing the same client for a year and a half. He got to me.” And he said, “He’s getting better.” And I said, Well, isn’t that what I told you?”

- **Cultural Supervision Issues**

I had a Chinese woman that I was supervising...and for her to be direct...she thought she was being rude. And then when I dug around a little bit, I discovered that she had her own history of trauma.

And I had an East Indian guy, who was a Muslim, who gave sexism a good name. Ugh, it was awful...and I was so glad when he said he was going to move to Toronto. I said, “Good. Go.” He was the kind of person who would come and stand six inches in front of you. I'm 5'2” he was six foot something...he was just trying to intimidate me. He’d say to me, ”Well, why won’t you look at me?” I said, “Because you’re standing too close and I can’t get my head up there.” He was very sexually inappropriate with many of his female clients, and I would
hear about it and I’d hear how he talked about them. He was just creepy.

- What helped/what was needed

I think it would have been good to have a mentor, somebody who wouldn’t necessarily be a supervisor but just helpful and try to sort out some of what’s going on.

I think just having maybe some more collegial opportunities to have some discussions about some of the issues that other people have done that have worked.

And so just when I think I’ve totally lost my mind about something, I can go on (the listserve).

4. UNITS OF MEANING

I didn’t tell anyone.

Participant #4

Participant #4 is a 64-year-old Caucasian male psychologist who lives and practices in the United States. He is currently in private practice and is employed part-time by a correctional facility where he provides therapy services to incarcerated men. He also maintains a part-time faculty position with a university.

He has worked with adult survivors of childhood sexual abuse for over 30 years, and has served in a supervisory capacity for 20 of those years. His graduate program did not offer any training in trauma or supervision.

Participant #4 describes himself as developmental in theory, therefore, he believes he naturally sees trauma through the lens of developmental experiences in people’s lives. A school friend who was managing an inpatient adolescent family therapy program then invited Participant #4 to join him at the program, where they
soon discovered that many of the mothers of the residents had been through developmental trauma.

We discovered that a lot of the...mothers that we saw in family therapy were traumatized people that had been through developmental trauma. And at that time, it was just starting to sort of get on people's radar. So we developed an inpatient program for female survivors of developmental traumas. So that’s how we got started. And we didn’t really know what we were getting into.

When I asked Participant #4 about his early experiences with traumatized clients, he noted that one of his first cases involved a woman who had sustained abuse in a cult. He felt at a loss as to how to help her, saying, “And I was just trying to figure out how to do the DID work, let alone (cult abuse), so. And there was no help from anybody that I knew back when I started.” He further states:

I remember...several of them that were very, very severe even relative to my experience now, that I would feel afraid and not know why...just knowing there were people like that out there, putting that into your consciousness is very disturbing because you start to realize, “Hey, there are a lot of people like this walking around.” And so it made me look at everybody differently. And so one of the things I noticed...was that I had to learn how to do it. So I wasn’t terribly engaged with these folks. I just kind of accepted what they told me and listened really well and noticed that people got at least marginally better. They calmed down a bit with me. But the consequence of taking that passive role was that I absorbed too much without processing it.
Participant #4 had no formal supervisory training and described his early supervisory work as being that of a “de facto teacher or mentor.” He teaches his supervisees to learn how to engage with traumatized clients so that they do not absorb large amounts of unprocessed material. He himself had no knowledgeable supervisor and believes he learned about trauma by, “sit(ting) in front of 8 to 10 DID patients every single day for years.”

Of the startup program they were running, Participant #4 said, “So there were a group of us that were running these damn programs. We didn’t have any peers. We hired our own psychiatrists. There was nobody.”

In answer to my questions about his supervisory experiences, Participant #4 noted:

So I have quite a few therapists that I’ve supervised over the years. Most of them, young therapists, don’t recognize (trauma). They don’t always recognize it unless it just hits them in the face too hard, but if you’re not really looking for it, you don’t see it very easily. Now sometimes I would see it for them and maybe suggest that they look at their patients a bit differently. But that was an acquired skill, on my part as a supervisor, how to teach people to look differently. So that took some time for me to learn how to do.

Participant #4 has noticed that transference and counter-transference issues are more problematic for supervisees in their work with traumatized clients, and with clients with personality disorders also, because he believes those disorders to be trauma-based. He elaborated:
But certainly, once the trauma is recognized, it takes it up to another level for people in terms of overwhelm. The heuristic of that I think, is that it gives them the opportunity to learn about what it is that’s overwhelming them so they can begin to process it not only with their patient but in their own head. Good supervision with this has to do with understanding what trauma is, how it’s affecting your client, and learning how to engage it enough that you don’t get vicariously traumatized as well.

Another struggle for supervisees that Participant #4 watches for is that they tend to get stuck in a particular silo of thought. He believes that working with trauma, and dissociation in particular, does not benefit from any one paradigm. As he puts it, “Dissociation is more like a street fight than it is any kind of theoretical paradigm, right? It’s just a God damn street fight.”

The role of cultural differences in supervision is most pronounced, according to Participant #4, in the prison setting where he works part time. Most of the prison population is African-American, and supervising African-American therapists there has had its challenges. He describes a dilemma he often faces:

There’s a kind of an intolerance...at least I’ve seen this...there’s a certain intolerance of African-American people who are not part of that poverty culture that they get a bit intolerant of the reactivity of other African-Americans who are in that. So sometimes I have to watch that carefully. Other times, they do identify, but sometimes they’re on the other end and they just want to rescue them. But they do seem to have a different response.
My question about what was helpful and what was needed to prepare him for being a trauma counselor supervisor elicited the following responses from Participant #4:

So being supervised very early on, sometimes I think that this would’ve constrained me more than helped me. And I have consultees now who are in that boat. They were studying under very accomplished...published authors in self-psychology, which I don’t have any trouble with, but if you are being supervised by somebody like that, no matter how good they are, if they don’t know about dissociation...theoretical models really handcuff us in this work.

...Trauma becomes a heuristic for understanding so many other things. When I teach it, I don’t just teach trauma. I teach attachment...and I also tease apart the DSM because my big point is that trauma is not just diagnostic in terms of PTSD and dissociative disorders. It’s across the board...any particular diagnostic presentation can have a trauma origin to it.

Table 5

**Topic: The Process of Becoming a Trauma Counselor Supervisor**

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<tr>
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<td>I would feel afraid and not know why.</td>
</tr>
<tr>
<td>- Lived Body</td>
<td>It’s highly segregated, very violent, and it’s almost like there’s barbed wire around a certain portion of the city. And so the bulk of my patients come from there. It’s a very particular dynamic that is different from the people that I see in my office.</td>
</tr>
<tr>
<td>- Lived Space</td>
<td>That became the crucible for my clinical life.</td>
</tr>
<tr>
<td>- Lived Human Relation</td>
<td>(Supervision) really has become kind of a forte for me, and I seem to have a knack for kind of seeing things that other people</td>
</tr>
</tbody>
</table>

107
It's just a God damn street fight!

- **Lived Time**

I would sit in front of 8 to 10 DID patients every single day for years.

2. **LEARNING ABOUT TRAUMA**

- **Specific populations/methods**

  We discovered that a lot of the...mothers (of adolescents in inpatient) that we saw in family therapy were traumatized people that had been through developmental trauma.

  So we developed an inpatient program for female survivors of developmental trauma. We didn’t really know what we were getting into.

- **Challenges in Trauma Couns.**

  ...Nobody teaches people how to be a therapist.

  I would feel afraid and not know why.

  There was no help from anybody that I knew back then.

- **What helped/What was needed**

  So being supervised very early on, sometimes I think that this would’ve constrained me more than helped me.

  Theoretical models really handcuff us in this work.

3. **Learning about Supervision**

- **Methods of Learning**

  (Becoming a supervisor) happened rather quickly, and probably prematurely. Just because doing that kind of work, no one knew how to do it. I became a de facto teacher or mentor. What I found about being a supervisor...when you study what you do meticulously...is that I would sit in front of 8 to 10 DID patients every single day for years.
That was an acquired skill, on my part as a supervisor, how to teach people to look differently. So that took some time for me to learn how to do (Supervision) has become kind of a forte for me, and I seem to have a knack for kind of seeing things that other people don’t.

- Challenges in Supervision

This is what I teach to my supervisees. You have to learn how to engage with these people. If you don’t, you are absorbing so much unprocessed content that it’s going to mess you up.

Most of them, young therapists, don’t recognize (trauma). They don’t always recognize it unless it just hits them in the face too hard, but if you’re not really looking for it, you don’t see it very easily.

Good supervision...has to do with understanding what trauma is, how it’s affecting your client, and learning how to engage it enough that you don’t get vicariously traumatized as well.

...My supervisees...get stuck in a particular silo of thought.

- Cultural Challenges

...There’s a certain intolerance of African-American people who are not part of that poverty culture that they get a bit intolerant of the reactivity of other African-Americans who are in that. So I have to watch that carefully. Other times they do identify, but sometimes they’re on the other end and they just want to rescue them.

- What Helped/What was needed

So I’ve been studying wine for 40 years. Almost like I study psychology.
Participant #5

Participant #5 is a 61-year-old Caucasian female from Canada who is self-employed as a psychologist and also teaches at a university. She has been working with traumatized clients for 35 years, and has supervised other trauma therapists for the past 24 years. She had no trauma or supervisory training in her graduate education.

She dates her work with sexually abused clients back to her first job in a rape crisis center, where the concepts of trauma and empowerment of women were being talked about openly. She gives an example of how the knowledge acquired there affected the rest of her education:

...I was introducing to my classmates information about trauma and sexual abuse, and sitting in a practicum where peers would be talking about their client who seemed to be spacing out and maybe they had schizophrenia, and I was saying, “Maybe they've been abused.”

Participant #5 believes that therapists don’t have to get too far below the surface of most disorders to find a traumatic background. She’s been advocating at universities with which she’s affiliated for a trauma course as a routine part of the graduate degree. Not necessarily a specialization, but she believes that everybody should be taught about trauma.
One of her earliest experiences with a severely traumatized client occurred early in her career. She describes her reaction:

...I had a couple of people within my first few years of work who presented with DID. So not just ego states, but coming in and one of them told me that she was DID and knew her different personalities. One of them was an animal, and I was just like, "Whoa!" I will say that neither of them stayed in therapy with me for more than a few sessions. I think I wasn’t giving them the response that they wanted, so we didn’t get very far into sorting it out.

Participant #5 is aware that she herself dissociates due to her own history. This, she says, affected her the most when she worked at a women’s prison with inmates who were serving time for murder.

So that was also a very complex population, and I think it was probably the woman who told me that her father was abusing her up until the age of 28. I think at that point, I think that was kind of beyond comprehension...I think that did it for me. It’s the same as when they are children. It’s like, “if I do this, will you love me now?”

In answer to my question about how she evolved from trauma clinician into a trauma counselor supervisor, Participant #5 explained that, in Canada, a distinction is made between being a “supervisor” and being a “consultant.” The term “supervisor” is used only if one is supervising a student because that supervisor is responsible for the other person’s work. Supervising a peer is referred to as “consultation,” although the terms are commonly used interchangeably despite the
legal differences. She herself has benefitted from supervision and has tried to pass on what she learned:

So I've had lots of experience with being supervised, and I think coming from a psychodynamic training background, that at least what I could offer to many other therapists is that notion of paying attention to your own transference reactions, your counter-transference, what attachment stuff that the client is putting on you, as well as just helping them understand trauma...and shame and dissociation. And of course, many students at an MA level, as well as PhD are not getting any of that information. So at least I could talk about those kinds of things including parallel process...

Participant #5 credits her EMDR training and consultation with teaching her about the concept of collaborative practice, which she then utilizes in her supervision work. She illustrates this in the following anecdote:

And so when I’m talking with supervisees, ...for example I’ve heard people say, “Yippee! I can't wait to start doing EMDR on my clients.” That just makes me crazy. You’re going to be experimenting on them.

Participant #5 also sees challenges in supervision with the concept of boundaries. She notes:

I would say when you’re working with traumatized clients that you do need to pay attention more to self-care, and of course, to boundaries. You have to be much more aware of that. And also, things like pushing away. So when a client is telling you something about their abuse, and you don’t respond, and you let it slide, that’s shaming for the client. And they are also sort of testing
the waters. ...And you have to be aware of dissociation. Most counselors don’t know anything about it.

My next question to Participant #5 was to ask about the role culture has played in her supervision challenges, and her answer was as follows:

I just last week saw one of my consultees who is from Romania originally, and she said, “You know, I have such a hard time listening to stories of abuse. I freeze. I don’t know what to say because in my country it doesn’t happen very often, and so we don’t have much experience with it.” We’re in 2017 and I think I didn’t give a very good response. So I said, “Here are some books for you to read, because it’s not good to freeze when your clients are talking about that.”

My final question to Participant #5 concerned things that have helped her in learning to be a trauma counselor supervisor. She credits the fact that she was a mature student with helping her to focus on learning about trauma, and also with becoming a supervisor. Her region of Canada has high populations of Asian and Indigenous peoples, which has made her more aware of how she supervises, although she has mostly Caucasian supervisees.

Participant #5 depends upon her own supervision for support, and reads voraciously about trauma. She’s also active on several professional listserves and attends a lot of workshops. She says she would have appreciated a course in supervision like the one a Canadian university is now offering. Instead, she read books about doing supervision.
Having colleagues with whom she could discuss things would have helped Participant #5 in working at the women's prison, and as a supervisor she feels that it is exhausting to hear supervisee's stories. She has, at times, asked peers and supervisees to restrict the level of detail they share. It is important to her to have a way to be present with clients and supervisees, while keeping the trauma somewhat at bay:

We used to have this expression, called “catch and release,” or, “Surrender and Catch,”...where you surrender your boundaries to get a sense of what the experience is for the other person, and then you release it back to them. You don’t hold onto it. Or, I’ve been sitting there thinking, “Not my stuff, not my stuff, not my stuff.” Just as a way of not having it get to you.

Finally, Participant #5 asserts that self-care is of paramount importance in her being able to do the work she does without becoming saturated:

I just feel like I have to be so well. Like I can’t be hungry, I can’t be tired, I can't be dehydrated. I take really good care of my body, and I work out at the gym three days a week. I'm a long-distance trail runner, just for release.

Table 6

Topic: The Process of Becoming a Trauma Counselor Supervisor

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<thead>
<tr>
<th>Analytical Categories</th>
<th>Quotations of Significance</th>
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<tbody>
<tr>
<td>1. FOUR LIVED EXISTENTIALS</td>
<td>I’m aware that I dissociate myself, that I have my own history, that blah, blah, blah.</td>
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<tr>
<td></td>
<td>Or I’ve been sitting here thinking, “Not my stuff, not my stuff, not my stuff.”</td>
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<tr>
<td></td>
<td>Like I can’t be hungry, I can’t be tired, I can’t be dehydrated.</td>
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</table>
- **Lived Space**  
So I certainly know what a rich psychotherapy environment is back east. It's very different than here on the west coast.

- **Lived Human Relation**  
And so when I’m talking with supervisees, I've heard people say, “Yippee! I can't wait to start doing EMDR on my clients. That just makes me crazy.

- **Lived Time**  
We’re in 2017, and I think I didn’t give a very good response. You see I've been working at this for 30 years, and I’m so cynical. I don’t believe that (sexual abuse) doesn’t happen.

So witnessing some of those things, I certainly carried some images and memories with me that were quite upsetting.

## 1. LEARNING ABOUT TRAUMA

- **Specific populations/methods**  
I started doing my work in a rape crisis center in 1982. We were talking about trauma and the empowerment of women and power dynamics and all that sort of thing.

And right after I graduated...I went to work in a women’s prison where we had women who were on remand all the way through to women who were serving sentences for murder.

- **Challenges in Trauma Couns.**  
...Very early in my professional career...I had a couple of people...who presented with DID...coming in and one of them told me that she was DID and knew her different personalities. One of them was an animal, and I was just like, “Whoa.”

People come to see me for low self-esteem and depression, anxiety, sexual issues, relationship issues.

...You don’t have to scratch far below the
surface before you find that there’s a traumatic background there.

- What Helped/Was Needed
  When I worked at the women’s prison, there were several of us working there, so we could debrief with one another, and we just learned the value of that.

2. Learning About Supervision

- Methods of Learning
  I’ve had lots of experience with being supervised, and I think coming from a psychodynamic training background, that at least what I could offer to many other therapists is that notion of paying attention to your own transference reactions, your counter-transference, what attachment stuff that the client is putting on you, as well as just helping them understand trauma.

  I think I got more from my EMDR consultation...about collaborative practice.

- Challenges in Supervision
  Shame and dissociation. That’s a lot of what we talk about. And of course, many students...are not getting any of that (trauma) information.

- Cultural Challenges in Supv.
  ...I saw one of my consultees who is from Romania...and she said, “You know I have such a hard time listening to stories of abuse. I freeze. I don’t know what to say because in my country it doesn’t happen very often, and so we don’t have much experience with it.”

  ...I think I didn’t give a very good response. You see I’ve been working at this for 30 years, and I’m so cynical. I don’t believe that (sexual abuse) doesn’t happen.
...We didn’t talk about culture when I was being trained...but we have a very high Asian population here...and First Nations, where talking about themselves is not considered appropriate.

**What Helped/Was Needed**

I went back to grad school as a mature student.

Information...which I think I got more from my EMDR consultation was (about) collaborative practice. Just being really, really clear and transparent.

And as I say, my own supervision, that’s been so helpful. I think the other thing is I read a lot. And Ofir Zur...does online training for ethics...but he also puts out little newsletters about ethical dilemmas and boundaries and issues in supervision...

I certainly would have appreciated the course (in trauma) like they have at this other university, and to be supervised for doing supervision there. Instead I read books about doing supervision.

And I think the other thing that would have helped was more information...about vicarious trauma.

---

**Participant #6**

Participant #6 is a 38-year-old Caucasian man who currently works as the Director of Clinical Services at a rape crisis agency in the United States. He has been working in the mental health field for 11 years, with adult survivors of childhood sexual abuse for 6 years, and has been a supervisor of other trauma clinicians for the last 3+ years. He is also currently in a doctoral program specific to counselor
education and supervision that he hopes to finish this year. His master’s education offered a course in crisis intervention that he did not take. Prior to beginning his trauma-focused work, Participant #6 worked with clients diagnosed as seriously mentally ill, and although there were traumas identified with this population, he did not see the same level of difficulty as he does in the trauma population he sees now:

So there is definitely a difference with regard to trust. I can definitely see that survivors that I work with, they really have issues with lack of trust, a lot of guilt. So I think it is more difficult to build rapport with a trauma survivor, due to their traumatic events. And it’s actually because I’m a male, that is a layer too.

Participant #6 became interested in working with trauma because of an undergraduate class he took on human sexuality, in which there was a section on rape and survivors of sexual assault. He remembers the professor’s passion on the subject and started thinking about working with this population. He describes his next steps:

So I had the opportunity to do my practicum and my internship at a rape crisis center. And then I had the experience working with survivors of sexual violence, which I still do. So that shows that I really enjoy it.

He learned some things about trauma from some of his graduate program peers who were working at various agencies, and they would often stay after class to discuss trauma cases in an informal group supervision format. Nevertheless, the stress of working with trauma survivors was encountered by Participant #6 early in his practicum, he recalls:
...But I remember the first week that I was working at a rape crisis center, and I was there to see my first client. And when I got inside of the elevator, there was this family. The mother, there was probably a sister, and this little boy who was probably five or six. And obviously, they were there to be seen by one of the therapists. And I remember that when I was walking to my car, I started crying thinking about...it really hit me, “Oh my God, this really happened. It’s out of a textbook. It’s reality.” And I remember it to this day, that really affected me seeing that boy there and knowing that he was there because he was sexually abused. What was the question again?

When I asked Participant #6 about his experiences with supervision at his practicum and internship placement, he stated that the agency was very conscientious of his being new. They were used to working with sexual abuse survivors there and could support him without judgment. He knows this could have been different because non-profit agencies often have waiting lists, which can propel the staff to assign even difficult cases to any therapist who has schedule space, even if the therapist is an intern.

Cultural issues that Participant #6 has encountered in his trauma work take several forms, including being a white male whose caseload is comprised mainly of females. They often suspect that he cannot identify with their fears:

I have found that sometimes they look at me, and...they say, “Okay, I’m more vulnerable to being sexually abused.” They are like, “You don’t have to worry about it. If you want to leave here at 8 pm and go and walk on the streets
when it’s dark, or do whatever, you can. You are not going to have that in your mind, but we do.”

The next question I asked Participant #6 was about his transition from clinician to supervisor of other trauma therapists. He summarized it as follows:

Yeah, it’s a lot different, because I think there’s much more responsibility. And I think especially in the beginning when I was supervising, I was not sure if I had the experience to be doing that. To be a supervisor. Because I remember when I started supervision, I had what? Five years of experience? Myself as a clinician. So sometimes I had to supervise clinicians and...not that we have answers for everything. But I felt as lost as a clinician, if you will. I was like, “Okay, what’s happening here?” So I didn’t feel prepared.

Participant #6 said that he’d been a supervisor in his previous job, but that the experience was very different at the rape crisis center:

As when I was supervising clinicians that they didn’t do this type of therapy, there wasn’t as much. So I can see that treating survivors of sexual violence definitely takes a toll on the amount of training for therapists to work with trauma of any nature...And that’s why a lot of clinicians, they end up in the field of sexual violence, just because, “Oh my God, that’s wonderful that I’m going to be helping survivors of sexual violence,” but they don’t know what that entails. It’s like my example of my first week of practicum. That had a huge effect on me. So a lot of clinicians, they don’t know that you need to be well trained. You have to have skills.
One of the particular issues Participant #6 has encountered in his supervision work is with the parallel processes of transference and counter-transference between the therapist/client, and the therapist/supervisor dyads. He describes an example:

One of my supervisees...is bilingual...and sees a lot of non-English-speaking clients. And I wasn’t born here, so I had a lot of struggles in my past when it comes to being an immigrant. So because she is working a lot with this population, and it’s affecting her because of her struggles too, because she is not American. She comes and she talks with me about her clients, and then I start to think about my own issues that I had. And when I see I’m kind of lost and then I’m talking about myself, and then I have to kind of come back and say, “Hey, this is not about you.” I start to have my trauma memories...

An experience that Participant #6 had at his last job helped to prepare him for being a supervisor:

When I was at my last job, we had interns from (university). So because all the clinicians there were super busy and they were seeing a lot of clients, they had so many things to do. They would say, “Hey, do you want to take one of the interns?” So I would have an intern...and so that’s how I started supervising these students. So that helped me develop my supervising skills.

Participant #6 feels supported in his role as a trauma counselor and supervisor by his own bi-weekly supervision as well as the collegial nature of working at an agency with like-minded co-workers. He also knows that he needs time between sessions to help him collect himself, and often uses that time to do something to relieve himself of the energy of the session. Cleaning his office is an activity that he
finds soothing, and he illustrated this with an example of cleaning as a parallel process with his client:

I had this client who I really like her in a sense that she was so consistent with coming to therapy. She was a very disciplined client, with regard to her healing and effort she was putting into treatment. She called one day and she said, "My brother died. And I won't be able...to go to session, but I will be there next week." So she came to therapy and...she was sad and she was struggling with her brother’s death. And she started to describe to me how her brother died, because she was next to him. And she was describing it so vividly, that I started to think about my own struggles. But I was having a really, really hard time, I was having an anxiety episode. Because in my mind, I was going to that place where, “Oh my God, that could be my brother.” So far away from him. That day, (the client) left...and then I started cleaning. Really doing something to kind of renew that energy, everything was so heavy. So next week when she came back, she was carrying all these bags. And I was like, “Whoa, you have a lot of bags there.” And she was like, “Oh, yes. Because when I left here last week, I felt so heavy that I got home and I had to clean my whole basement and my house. So these bags that I have...I’m taking to Goodwill.” It was interesting, because we had kind of the same process.

Experiences that Participant #6 wishes he would have had include more introduction to supervision in his master’s degree program. He remembers being supervised, but he doesn’t remember being prepared to become a supervisor, and was thrust into a supervisory position at work while he was in his master’s
program. He also would have benefitted, he says, from having had a mentor to help him explore what he wanted to do in his career.

Table 7

*Topic: The Process of Becoming a Trauma Counselor Supervisor*

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<td><strong>1. THE FOUR LIVED EXISTENTIALS</strong></td>
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<tr>
<td>- Lived Body</td>
<td>So if I’m feeling more stressed and my energy level is too low, I can definitely feel that I’m not that present with my client in that moment...</td>
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<td></td>
<td>I started cleaning...Really doing something to kind of renew that energy, everything was so heavy.</td>
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<tr>
<td>- Lived Space</td>
<td>So I feel like I’m zoning out. I feel like I am not there. I’m in my head somewhere else.</td>
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<td>And when I see I’m kind of lost and then I’m talking about myself...</td>
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<td></td>
<td>I was going to that place where, “Oh my God, that could be my brother. So far away from him.</td>
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<tr>
<td>- Lived Human Relation</td>
<td>And I remember it to this day, that really affected me seeing that boy there and knowing that he was there because he was sexually abused.</td>
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<td>Because I remember when I started supervising, I had what? Five years of experience? Myself as a clinician. But I felt as lost as a clinician, if you will.</td>
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<td></td>
<td>I was like, “Okay, what’s happening here?” So I didn’t feel prepared.</td>
</tr>
<tr>
<td>- Lived Time</td>
<td>I definitely need some time between sessions. That helps me a lot to collect myself.</td>
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</table>
2. LEARNING ABOUT TRAUMA
   - Specific Populations/Methods
     Is got interested in working with trauma survivors because of an undergrad class that I took. I remember my professor talking about (rape and survivors) it and she was so passionate.
     So I had the opportunity to do my practicum and my internship at a rape crisis center.
   - Challenges in Trauma Couns.
     I’m thinking about the fact that I’m a male, and I’m a trauma focused therapist. And 80-90 percent of my clients are female. So I can’t relate to them as a male.
     …When it comes to people of color, there is a difference in the sense that there are so many struggles that they have because of their culture. There is intergenerational trauma. We’re talking about other things that will play on where they are.
   - What Helped/Was Needed
     (In a student group) we talked a little about trauma there and even about ourselves and how that was affecting us. We would linger after the group was over.

3. LEARNING ABOUT SUPERVISION
   - Methods of Learning
     My PhD program is focused on education and supervision. So there is a lot of focus on supervision.
     I supervised in my last job too…we had interns from (university). So because all the clinicians there were super busy…they would say, “Hey, do you want to take one of the interns?” So that’s how I started supervising these students. That helped me develop my supervising skills.
   - Challenges in Supervision
     And I think especially in the beginning
when I was supervising, I was not sure if I had the experience to be doing that. Because I remember when I started supervising, I had what? Five years of experience myself as a clinician. So sometimes I had to supervise clinicians... but I felt as lost as a clinician, if you will. I was like, “Okay, what’s happening here?” So I didn’t feel prepared.

- Cultural Challenges

One of my supervisees...is bilingual, and she sees a lot of non-English-speaking clients. And I wasn’t born here...so I had a lot of struggles in my past when it comes to being an immigrant. So because she is working a lot with this population, and it’s affecting her because of her struggles too, because she is not American. She comes and talks with me about her clients, and then I start to think about my own issues that I had. And when I see I’m kind of lost and then I’m talking about myself, and then I have to kind of come back and say, “Hey, this is not about you.” I start to have my trauma memories.

What Helped/Was Needed

I have supervision every other week. I think what is so helpful is knowing that you have someone...that if there is anything that happens, you can go and say, “Do you have a minute? Can we talk? I just had a really hard session.

I wish they were more focused in my master’s degree on supervising. I actually don’t remember having anything related to supervision. I remember being supervised...but I don’t remember being prepared to become a supervisor. And ...I became a supervisor while I was going to school.

Having a mentor would have helped... (someone) that would help me explore what I wanted to do. I didn’t have any one to talk to.
Participant #7

Participant #7 is a 64-year-old Caucasian female living and practicing as a clinical psychologist and neuropsychologist in Australia. She has worked with adult survivors of childhood sexual abuse for more than 30 years. She has functioned as a supervisor of other trauma therapists for the past 10 years. In the past 20 years, she has specialized in trauma in her practice:

But the last 20 years trauma has become the centerpiece of my work and my understanding of what walks in my door. I wasn’t really trained in trauma. I had to train myself in trauma. And so I think it’s taken me half of my career to really get there and to really grasp just how central trauma is to just about everybody I work with. So...I sometimes wonder how I ever worked before. She’d always been interested in trauma but feels that in the last 20 years she’s learned about trauma and dissociation in much greater depth.

As the field has grown and deepened, I have grown and deepened in what I understand about it. I’ve worked with veterans for a very long time. But dissociation is much newer to me. And just can’t get enough about knowing it. Because once you see it, you can’t stop thinking about it.

Participant #7 feels like she’s always been given the hardest cases, perhaps because she’s a neuropsychologist. Working to build relationship with the hardest cases, she says, comes to her naturally as a result of her experiences growing up:

I actually think it’s no coincidence that my father was a war veteran, and so I, without realizing it, until I looked back in retrospect, ...I was the person in our family that could relate to my father. And so I think I learned more at my
father’s knee about how to build a relationship with someone with untreated, undiagnosed PTSD. And so I was able, I think, not so much from my training, that came later, but my capacity to form a connection with a traumatized person...came from my family. And so I think, because of that, people would send those people to me, because they would come and they would stay...They would feel like I could see them and that I could connect with them. And so after that, we’d sort of work out what we were going to do from the seat of our pants.

At the beginning of her career, Participant #7 did not know the right questions to ask about trauma. She also was not aware of experiencing counter-transference with her clients as much as she does now.

I think I notice it more now because I’m just more alert to everything now...For instance, the amnesias I get often. The patient will say they were amnesic for the last session, I’ll think, “Goddamn, so am I! And I haven’t taken enough notice of it, so let’s see if we can pull it back.”

When I asked Participant #7 about how she became a supervisor, she gave the following reply:

It almost happens because you’re getting old I think! I’ve got a reputation for being interested in dissociation, and so those that are interested in dissociation know that there are never enough supervisors who know about dissociation...you could count on one hand...I actually feel an obligation as a clinician that we’ve...got to pass on what we’ve learned to the next generation. I was doing a lot of educational workshops around Australia and
so I got known as someone who has an interest...and experience in that area, and then after my workshop, they contact me and ask if I can be a supervisor. In Participant #7’s opinion, transference and counter-transference are much more complex for therapists working with traumatized clients. She sees it as her responsibility to get supervisees to self-reflect on their own feelings so that they can maintain boundaries and remain grounded.

The newer therapists start to understand the complexities of what they’re dealing with, and so sometimes they then feel quite anxious and worried about the fact that they’re wanting a manual or they want something that’s going to give them some structure about how-to. So I think a lot of it is supporting people to be able to create a therapy that’s going to match the client, an individualized therapy that’s going to help...and to be able to follow with the client and stay grounded in themselves. And so I think a lot of it is really about getting them to recognize their own transferences, counter-transferences, their own capacity to maintain boundaries, their own capacity to remain grounded, and lots of work on being able to do deep empathy without overidentification.

Participant #7 notices a parallel process that occurs between herself and her supervisees at times. This often manifests itself through attachment history:

Certainly what does come up is the client’s own attachment history starts to become more evident and then we have their client’s attachment history, my supervisee’s attachment history, my attachment history. And we’ve got all
this attachment stuck in the room. And I think I have to watch out not being
to maternalistic. I want to mother them.

In answer to my question about cultural issues that arise in the course of
supervision, Participant #7 noted that her area of Australia is fairly homogeneous,
unlike other parts of the country where there are large populations of indigenous
peoples. She describes her work with the military population as a subculture that
needs to be understood when doing trauma and supervision work.

Participant #7 didn't get any formal training in trauma or supervision that
she considers useful. She states that she is of the generation that didn't get trained
to be supervisors, however Australia has now mandated that therapists do training
for supervision if they want to become registered supervisors. She, herself, did not
have any supervisors that she thinks of as role models, though she did have some
influential professors who were not clinical

What supports Participant #7 primarily is a peer supervision group that
started out as an EMDR group, and that has been meeting for 21 years. She
describes them as follows:

There’s the core group of five of us, I think two psychiatrists and three
psychologists. We were looking for other people who were doing EMDR,
which meant they were looking at trauma. We’ve been meeting together
every five or six weeks in a really good restaurant with really good food and
really good wine for 21 years in a private room where we can talk about
cases. And that has been fantastic for me. That’s really been like my own
supervision, that’s been peer supervision. And I think those meetings
prepared me for then helping other people. Because it’s what really has helped me there I take away as this is what is useful in supervision. This sort of interaction is what I have found most useful clinically.

Other things that Participant #7 find useful in supporting her work include going to as many trainings as she can, teaching her own workshops, and continuing to learn as much as she can. She says, “I’m just constantly learning and encouraging my supervisees to do the same thing, just like take everything you can and integrate it. So I don’t think I’m possibly a supervisor if I didn’t do that.”

Participant #7 would have liked some basic training in trauma and dissociation, but realizes that the mental health community in Australia is still very split in its conceptualization of what types of trauma are targeted for research and what is considered effective trauma treatment. For example, the Royal Commission of Australia has been very proactive in investigating cases of organized abuse within institutions such as the Catholic Church, but authorities still balk at looking into the much more common issue of familial abuse. As a result, Participant #7 often feels isolated and marginalized in her work.

Table 8

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Certainly what does come up is the client’s own attachment history starts to become more evident and then we have the client’s attachment history, my supervisee’s attachment history, my attachment history. And we’ve got all this attachment stuck in the room.

- **Lived Human Relation**

  ...I was the person in our family that could relate to my father. And so I think I learned more at my father's knee, about how to build a relationship with someone with untreated, undiagnosed PTSD...My capacity to form a connection with a traumatized person came from my family.

  I think I have to watch out not being too maternalistic. I want to mother them.

- **Lived Time**

  My peer support group has been crucial. The fact that we've all been doing it for 21 years, same group every month or so. We can’t get past six weeks before we start to feel deprived.

2. **LEARNING ABOUT TRAUMA**

   - **Specific population/methods**

     I had to train myself in trauma. As the field has grown and deepened, I have grown and deepened in what I understand about it. I’ve worked with veterans for a very long time. But dissociation is much newer to me.

     We were looking for other people who were doing EMDR, which meant they were looking at trauma.

   - **Challenges in Trauma Couns.**

     I think I’ve always been given the hardest cases.

   - **What Helped/Was Needed**

     I think my family background prepared me for being able to build a relationship with a traumatized person.

     I think I do education, then I try it,
then I keep what I think works, then I teach it.

It would have been nice to have had trauma training when I was doing clinical psychology training. I don’t think university courses have caught up...here you’re not getting any really good training in how to work with trauma.

3. LEARNING ABOUT SUPERVISION
   - Methods of Learning

   It almost happens because you’re getting old, I think.

   I’ve had to train myself. And I was of the generation where we didn’t get trained to be supervisors. I’ve been a member of a peer support, or a peer supervision if you like, group for...nearly 21 years. And I think those meetings prepared me for then helping other people. This sort of interaction is what I have found most useful clinically...is other clinicians.

   - Challenges in Supervision

   Transference is a much bigger issue for sure...and the newer therapists start to understand the complexities of what they’re dealing with, and so sometimes they then feel quite anxious and worried about the fact that they’re wanting a manual or they want something that’s going to give them some structure...

   - Cultural Challenges

   I work a lot with the military, so there’s a whole military subculture that you have to really have your head around if you’re going to be able to do the work.

   - What Helped/Was Needed

   I’m just a complete workshop junkie.

   I’ve been a member of a peer support...group for nearly 21 years...That’s really been more like my own supervision that’s been peer supervision
Participant #8

Participant #8 is a 47-year-old Caucasian woman who has been a social worker for 13 years in the United States. She is currently in private practice and also teaches master’s counseling students at a university. She has been working with adult survivors of childhood sexual abuse for 12 years, and has been supervising other trauma counselors for the past 7 years. She had an elective course in supervision through her graduate program university that she says has helped her in her work as a supervisor.

My first question to Participant #8 was about the role of trauma in her practice today. She explained as follows:

I would say that being a therapist always includes trauma. That unless you’re working in a specific field where discussing trauma is not either required or permitted. I always assume that any time the client walks through my door, in that session, I could be engaging with someone who’s been traumatized, either since the last time I saw them or possibly that day will be the day they choose to tell me about a trauma. Certainly, if I have a new client coming in, I’m always aware that this client might have some trauma, extensive trauma, and I’m always aware of the possibility.
Participant #8’s career started at a community mental health agency where she was given a caseload of 30 to 40 clients, some of whom were identified as trauma survivors. At that point, she had no formal training in how to work with trauma clients:

I learned to treat trauma survivors, I would say, trial by fire, that I knew the basics of counseling. I knew how to listen. I knew how to empathize. I knew how to investigate. I wouldn’t say I really understood at all what trauma looked like or how to treat it until I had one particular extremely traumatized client, and it was really learning on the job...I think there was always the fear of retraumatization, of handling something poorly, of hurting a client because I wasn’t sure. I don’t think I was ever really clear on exactly what to do.

From the beginning of her career at the mental health agency, Participant #8 believes that she was given some of the most difficult cases, including some clients who had been at the agency for 10 or 15 years. She stated:

The agency was about 20 years old when I joined it...and I had some of the most difficult cases. I sometimes had clinicians giving me difficult cases. I think there maybe was this sense that, “Here’s somebody new and fresh that might have more information because everybody else is really stuck.” And some of the difficult cases I’m grateful for because they taught me how to be a better clinician, but they’re very scary and very intense and they never shied away from giving hard cases to new people.
She had one knowledgeable supervisor for a period of time, when EMDR was beginning to be more of an accepted treatment for trauma. Other supervisors over the years she described as, “…worse and better.”

Participant #8 described her work with one particular long-term client as a difficult trauma learning experience. This client’s story was one that pulled Participant #8 in and, in many ways, invaded her life. She described it as follows:

I think I must have been so in tune with her at times when she was mostly talking about recent traumatization that I was suffering secondary PTSD…I was having flashbacks of things that didn’t happen to me. I was having nightmares...And it was really her experiences that I had kind of taken in without realizing.

She credits a supervisor with helping her to reframe this case and decide on a course of action. She recalled:

...I was telling him how difficult it was and I was really struggling, and I don’t know what to do, and this client was suicidal all the time. And she would call me from another (place) and say, “I don’t know how I got here.” and I was just overwhelmed and he said, “So, maybe it’s time to transfer the case.” And I was like, “Oh.” And man, I don’t know but I pulled myself together. I was just like, “Okay. If I’m going to keep this case, I have to keep myself together.” And that was actually, probably, the most helpful thing he did. He gave me an out that I didn’t want…and so I said…I have to figure out how to do this...

After working at the agency for two or three years, Participant #8 took a semester-long course in clinical supervision that was offered by a local university. She worked
as a field supervisor with graduate students as part of the process to obtain a certification certificate in clinical supervision. She states, “So I’m very grateful that I have that because many supervisors have no training. They just sort of get pushed into it.”

Part of the supervisory training, according to Participant #8, was the requirement for submitting process recordings of her supervisory sessions. After completion of the program, she was assigned clinicians to supervise for the next few years.

Participant #8 responded to my question about supervisory challenges in the following passage:

Clinicians working with traumatized clients require much greater focus on processing their own emotional content. I noticed that they’re experiencing more stress on the job. They’re concerned about how to process what they’re learning and experiencing in the sessions...I had a clinician who was working in a school in (place). And every week, there would be a student getting shot. Students being killed, brothers and sisters of students being killed. And she said, “I can’t do it every night. I’m coming home. I’m having nightmares. I can’t sleep. I don’t know what to do.” And so I was mostly helping her cope and keeping her focused on the work she needed to do. And lots of self-care work for those clinicians...to support them through the incredibly painful process of hearing someone’s trauma requires a different kind of supervision.
In her current work with supervisees who see trauma cases, Participant #8 understands that much of the supervision centers on the supervisee’s need for self-care. She notes:

I’m able to be distant and empathic and encouraging them to be empathic but also, too, always mention self-care. It’s like a reflex now that if someone’s dealing with trauma to say, “What are you doing for yourself? What are you experiencing? How are you caring for yourself? Have you noticed anything like nightmares?” Or any of the symptoms that I’d expect for secondary traumatic stress.

Participant #8 sees many clients who identify as transgender, and therefore she is aware of the need to modify her use of language at times. She is particularly conscious of the importance of culture in her supervision work as well, describing it as, “And so gender as culture is very challenging, both as a clinician and as a supervisor, I think.”

When I asked Participant #8 what experiences in her life have helped to prepare her for becoming a trauma counselor supervisor, she replied:

My own terrible experiences in working with traumatized clients. I would say that…what mistakes not to make, how to be better trauma informed, to actually say to (supervisees), “Do you need to go to a trauma training?”…I had my psychodynamic approach, but that doesn’t teach skills so much. It’s more orientation, so I was a little in the dark. And I learned, but I do worry, of course…did I make (client) worse? Because I was uncovering trauma for my client and it was severe and long term and she got worse.
Currently, Participant #8 finds talking informally with colleagues about cases to be a support in her work. “Just talking to other clinicians who are also engaging with trauma can be helpful, but I think a mentor could’ve been useful,” she said, “but I’ve always just had supervisors and colleagues.” Participant #8 answered my question about what would have helped to better prepare her for becoming a trauma counselor supervisor by presenting the following concerns:

I didn’t know. I know about general therapy, but...when you’re dealing with someone who’s been traumatized and it gets worse, it doesn’t get a little worse; it gets a lot worse. And everything is full-blown, and they’re reliving. And I’m thinking, “Oh, my goodness. Is this full-blown PTSD now?”...I wish there had been a specific unit in my training course that spoke about supervising clinicians working with trauma...Expert supervision in trauma I feel makes all the difference. Regular supervision that also covers trauma is not as effective just because I don’t know that the supervisor is asking the right questions, is looking for the right things.

Table 9

<table>
<thead>
<tr>
<th>Topic: Learning About Becoming a Trauma Counselor Supervisor</th>
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<tr>
<td><strong>Analytical Categories</strong></td>
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<td><strong>Quotations of Significance</strong></td>
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<tr>
<td><strong>1. LIVED EXISTENTIALS</strong></td>
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<td>- Lived Body</td>
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<tr>
<td>I would become more and more detached and my empathy would decrease, and I would start to become a spectator and less of a joiner, if I sense that I was getting too overwhelmed.</td>
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<tr>
<td>I was having flashbacks of things that didn’t happen to me.</td>
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<tr>
<td>I know what burnout feel like...I recognize that sort of deadness and</td>
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numbness that can come...

- Lived Space
  I’m a bit of a loner, clinically...
  I guard my sleep like crazy!

- Lived Human Relation
  And it was actually a supervisor who helped me in the funniest way...and he said, “So maybe it’s time to transfer the case.”
  ...He gave me an out that I didn’t want.

- Lived Time
  And I don’t remember any of the moments that happened, but it was just so horrifying to know what she was actively experiencing.

2. LEARNING ABOUT TRAUMA
   - Specific populations/methods
     I learned to treat trauma survivors, I would say, trial by fire...
     I wouldn’t say I really understood at all what trauma looked like or how to treat it until I had one particular extremely traumatized client, and it was really learning on the job.

   - Challenges in Trauma Couns.
     I think there was always the fear of retraumatization of handling something poorly, of hurting a client because I wasn’t sure. I don’t think I was ever really clear on exactly what to do.

   - What helped/Was needed
     I did have a knowledgeable supervisor for awhile. There was this new thing, EMDR.
     And it was actually a supervisor who helped me in the funniest way...

3. LEARNING ABOUT SUPERVISION
   - Methods of Learning
     I took a course at (university) to train me how to be a supervisor. It was a formal semester-long training program to teach people how to be clinical supervisors.

   - Challenges in Supervision
     Clinicians working with traumatized
clients require much greater focus on processing their own emotional content.

- Cultural Challenges
  
  I also work with transgender people...
  My use of language is careful and different...And so gender as culture is very challenging, both as a clinician and as a supervisor, I think.

- What Helped/Was Needed
  
  Well I wish there had been a specific unit in my training course that spoke about supervising clinicians working with Trauma...if not formal but at least informal opportunities to talk to clinicians who had been working with trauma for a long time...

  I sleep well. I guard my sleep like crazy.
  I make sure I’ve eaten well for my sessions.
  It’s really trial and error over the years.

Final Thoughts

After all interviews had been concluded and transcribed, I reviewed the recordings, the transcriptions, my reflexive journal, and my notes that I had kept during the process. The data had reached a saturation point by the time interview #7 had been concluded, but I proceeded with #8 for confirmation that no new data points were emerging. I was able to recognize clear patterns across all of the interviews and these have been illustrated in the charts for all eight participants. The themes that emerged in my analysis of the data charts are discussed in detail in Chapter 5, but the summary of data collected in Chapter 4 resulted in 5 identifiable themes that appear to be central to understanding the lived experiences of trauma counselor supervisors. The central themes are as follow:
1. **“Trauma is ubiquitous.”** This theme refers to the fact that all the participants were exposed to traumatized clients early in their careers, even if it was through populations not necessarily identified as trauma survivors initially. The participants then found themselves faced with challenges in how to help their clients.

2. **“Trauma counseling is Trial by Fire.”** This theme refers to the concept that all the participants at all levels of education entered the field with no formal education or training in how to assess or treat trauma, which resulted in their experiencing fear and uncertainty while they searched for information. Some participants felt they were purposefully given very difficult clients early in their careers, which added to the sense of “trial by fire.”

3. **“Supervisors by default or convenience.”** This theme refers to the fact that the participants were promoted to their positions for reasons that include age, length of service, and clinical experience rather than whether or not they had formal training in supervision. The two participants who had supervision courses felt they were helpful.

4. **“What was needed.”** This theme refers to the education and training in trauma and supervision which most of the participants wished they had had. Given the prevalence of trauma in the culture and the amount of research information available, participants believe that having this information early in their careers would have helped them immensely.

5. **“It takes a village.”** This theme refers to the need expressed by all of the participants for supervision, particularly ongoing peer supervision. All of the participants highly valued collegial support as a way to deal with the stressors
associated with being trauma counselor supervisors. Some participants reported feeling isolated in their work as trauma counselor supervisors, for reasons such as philosophical differences, geographical location, or a lack of like-minded colleagues. The increasing popularity of professional listserves and method-specific (e.g. EMDR) groups has helped decrease the sense of isolation for participants and they now function as sources of clinical information.

*Similarities*

The similarities in experience between the participants in this study were notable, and the overall sentiment was one of having to teach oneself how to address trauma as a clinician, and as a supervisor. Parallel process as it occurs between client and therapist, and therapist and supervisor is of major importance among the rich findings in this study. All the participants were aware of how trauma has affected them as clinicians, and how their own experiences have informed their work as supervisors, especially within the realms of transference and counter-transference. Many eloquently expressed their feelings in terms of the lived experiences of body, time, space, and human relation when recalling their work, and most identified similar processes in their supervisees. All participants were profoundly affected by their shared need for support through supervision, especially ongoing peer supervision. While some reported having had effective supervision themselves over the years, most did not and were conscious of their own efforts to provide their own supervisees with useful assistance. Training in EMDR was a theme shared by many of the participants, as was participation in professional groups and listserves.
Differences

A notable difference was that the participants who had begun their careers at rape crisis agencies seemed to have an advantage in earlier exposure to the concepts of trauma and its recognition as a women’s issue, while others entered the trauma field by more indirect means. Another difference was that two of the participants had received some supervisory training. One participant had voluntarily taken an online course, and the other had participated in a semester-long supervisory course that included instruction in self-reflexive learning. The participant who had attended the semester-long course found it to be very helpful in her work as a trauma counselor supervisor, while the participant who had taken the online course did not remember anything about it but felt that the certificate was valuable to her.

Summary

The interviews described in this study were conducted with the intent to capture some of what it is like to become a trauma counselor supervisor. I conducted eight individual interviews with clinicians who have worked with traumatized clients and who have also been trauma counselor supervisors for at least one year. The audio-recorded interviews were conducted in person or by Skype and lasted for approximately 30 to 65 minutes. I kept a reflective journal of my feelings and impressions about each interview, along with notes written on the transcriptions as I reviewed them. I read and re-read the transcripts many times, while always keeping my own biases in mind. The themes I identified emerged from the groundwork laid in Chapter 2, including current trauma theory, the ecological
development model, supervision theory, and human development factors. The data had reached the saturation point after the 7th interview, meaning that no new data points were emerging that had not already been discovered in the previous interviews. I completed the 8th interview, finding that the information was similar to that obtained in the previous seven interviews and that further data collection would not shed new light upon the topic of this study.

Chapter 5 contains the full exploration of the results and implications of these findings; however, I have summarized the findings and themes that emerged over the course of this study and briefly describe them here at the conclusion of this chapter. One of the most consistent themes existing across all of the interviews was the complexity of the journey participants had to navigate in becoming trauma counselor supervisors. Not only was there no training around the high incidence of trauma in the population seeking therapy, there was, overall, little training in how to be an effective supervisor. Only one of the supervisors interviewed had had a semester-long training course, which she believes has been very helpful to her in her transition to being a trauma counselor supervisor, particularly because the course included the self-reflexive activity of recording her supervisory sessions for later review. Therefore, most interviewees encountered a double struggle in their careers: to learn to be competent trauma counselors, and then to educate themselves in becoming competent supervisors for other trauma counselors.

Another prominent theme that emerged in the interviews is the feeling expressed by the participants that they, for the most part, did not have effective supervision themselves early in their careers. All of them expressed their appreciation for the
peer supervision they had along the way, and that many of them have now that supports them in their work. Two interesting subthemes emerged in the course of this study, one of which was that participants who had worked at rape crisis agencies got earlier exposure to the acknowledgement of trauma and the language for discussing it. The other was that several participants reported that they were given “the most difficult” cases early in their training, which confirms a finding by Ventura (2010) indicating that complex cases are sometimes “dumped” on students and early career clinicians because of other clinician’s frustration with those cases.

These themes and their implications are discussed in greater detail in Chapter 5, and will address the gap between what is known about the prevalence of sexual trauma in the general population and what preparation counselors and their supervisors receive to address these issues.
CHAPTER V – DISCUSSION

The purpose of the current study was to explore the lived experience of how trauma-competent counselors become competent supervisors. The questions asked in the course of the research described in Chapter 4 were developed around the presuppositions that, though trauma is ubiquitous in our society, student and early-career counselors are sent into the field with little or no training in how to deal with traumatized clients. In her study of master’s level practicum students, Ventura (2010) discussed the implications of students being sent into a practicum site with no education in understanding trauma, and then encountering site supervisors who share a similar lack of understanding. One of the results she found was a recurrent theme of traumatization for the therapist and possible re-traumatization for the clients. This theme was echoed in the results of this current study, which calls into question whether or not portions of the ACA Code of Ethics (2014) are being honored. The Code states that, “Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience (italics mine), state and national professional credentials, and appropriate professional experience (C.2.a). Although this study’s participants came from a variety of clinical backgrounds, one has to assume that all therapy professional groups aspire to send their graduates into their careers with at least minimal exposure to the kinds of human distress they might expect them to encounter. Studies of counselor education training programs into the needs of students (Bledsoe, in Levers (ed.) 2012) include supervision as a crucial part of the educational process. However, at the time that this current study was begun, little research existed on whether
supervisors were trauma-competent, or indeed how they had ascended to their supervisory positions.

The findings of this current study are congruent with the presuppositions presented in Chapter 1, showing the need for basic trauma training for counseling professionals, and the literature review outlined in Chapter 2, illustrating the fact that gaps exist in trauma education for both counselors and supervisors.

Eight informants participated in this qualitative inquiry in which they provided information that facilitates our understanding of the lived experience of becoming a trauma counselor supervisor. Consistent themes began to emerge across participants’ experience by interview #5 and were confirmed by the following three interviews. At that point, no new themes were identified and data could be consolidated into the six identified themes. This chapter includes a summary of the findings and implications of the information for the field of Counselor Education, a Summary of the themes identified, along with suggested implementation of the findings, questions and hypotheses generated by the study, the limitations of this study, and a discussion of possibilities for future research.

**Summary of Findings and Implications**

This study was viewed through the lenses of Bronfenbrenner’s bio-ecological model for human development, van Manen’s four lived existentials, and literature related to trauma, supervision, and counselor development. Bronfenbrenner (1979) identifies and utilizes a multi-system method for understanding human interactions, which accommodates the interlocking social structures within supervisors and supervisees interact, as well as what he calls, “bi-directional influences.” This is an
assertion that the supervisory relationship is a two-way street: supervisors are affected and changed by their supervisees in much the same way that the therapeutic relationship changes both parties. By looking at some of the participants' responses, we can recognize bi-directional influences in action. For example, Participant #1 said about her role as a consultant/supervisor:

...One of the reasons I really like being a consultant (is) because it motivates me. I think it motivates me more to want to learn and be informed, because I'm responsible for someone else's practice as well...I can always get better, and the better I get, the more I'm able to help another consultee, so I never get bored.

This example illustrates the bi-directional interaction that occurs within what Bronfenbrenner (1979) calls the mesosystem, which is comprised of interrelations between two or more settings in which a developing person actively participates. In this case, the supervisor's interactions with supervisees has a direct influence on the supervisor's work as a therapist, and this, in turn, makes her a better supervisor in a recursive, continuous dialogue between two systems.

By utilizing the previously mentioned lenses, and as exemplified by the quote from Participant #1, the six themes that emerged in the course of this study will be examined individually. Following discussion of each theme, implications for the counseling field will be discussed.

**Theme 1: Trauma is Ubiquitous**

Participants confirmed that, no matter where they began their counseling practices, they encountered adult survivors of childhood sexual abuse. For those
who started out at rape crisis or victim service agencies, the recognition of trauma and the use of trauma-specific language were encountered quickly. Participant comments related to this theme are as follow:

My focus was on eating disorders...but in the course of that work, there were a lot of people who were victims of sexual abuse (Participant #1). ...The mothers we saw in family therapy were traumatized people that had been through developmental trauma (Participant #4). I started doing my work in a rape crisis center. So we were talking about trauma and empowerment of women and power dynamics and all that sort of thing (Participant #5).

Implications for the field

Childhood sexual abuse is developmental trauma and affects approximately 1 in 3 women and one in six men in North America (Briere, 1996; Finkelhor, 1990; Polusny & Follette, 1995). Therefore, it is highly likely that all clinicians will encounter traumatized clients sometime in their career. According to Ventura (2010) and this current study, such encounters are likely to occur early and frequently. The effects of developmental trauma in adult survivors are often not clearly identified as such, and may be obscured by a multitude of diagnoses and chronic life problems. In the words of Vincent Felitti (2010, in Lanius, Vermetten, & Pain), “Time does not heal the wounds that occur in those earliest years; time conceals them. They are not lost; they are embodied.”

The research cited above indicates that traumatic experiences are far from unusual, yet trauma is still viewed by many as a specialty practice, best left to those with specific training. Whether trauma continues to be viewed as a specialty
practice because of societal denial, personal repugnance, stigma, fears of one’s own trauma history, or lack of time and space in educational curricula, it is critical that the counselor education field be aware of what the effects of not preparing counselors might be. As Pearlman and Saakvitne (1995) state:

...working as a trauma therapist is subversive work; we name and address society’s shame. There are and will continue to be forces within society that work to silence this work and the clients. When we do not recognize the social and political context for our work, we unwittingly participate in this return to silence, denial, and neglect. (p. 2)

**Theme 2: Trauma Counseling is Trial by Fire**

Findings from several participants in this study confirmed what Ventura’s (2010) students encountered during their practicums when they were assigned some of the most difficult clients. Some quotes from the current study follow:

And because I was the new kid on the block...they gave me the eating disorder clients because they were difficult (Participant #1). I think they gave me a lot of cases for clients who had been at the agency for more than 10 or 15 years. I think there maybe was this sense that, “Here’s somebody new and fresh that might have more information because everybody else is really stuck.” (Participant #8)

In her 2010 study, Ventura wondered whether such practices are the result of hazing, supervisor apathy, or simply failing to conceptualize the impact of trauma on either the client or the student. In the current study, the reasons are not clear, but the implications are frightening for both counselor and client. The participants in
the current study had a variety of reactions to being immersed in deep clinical water without appropriate support:

I kept seeing things that just didn’t make a whole lot of sense, and so I started doing more reading around DID and around trauma, mostly in the sexual abuse area, all of a sudden it started to make a difference (Participant #3). I would feel afraid and not know why. (Participant #4) I’m aware that I dissociate myself, that I have my own history. (Participant #5).

Some participants found assistance in learning about trauma therapy through particular therapeutic models. Some of these models, such as Dialectical Behavioral Therapy (DBT) (Linehan, M., 1993) are designed to help the client develop skills for coping with overwhelming feelings and behaviors prior to addressing traumatic memories. Others target the traumatic memories themselves by addressing the derailed developmental process. The therapeutic model mentioned most frequently by study participants was Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro, 1987), which is a manualized model that is very flexible and can be adapted for use with developmental trauma with good results (Forgash, C., 2008).

*Implications for the Field*

Therapists working with traumatized clients may be bound by the treatment models and time constraints imposed by agencies where they work. However, there are core elements of trauma treatment that transcend modality and have been found to be especially important in treatment of CTSD and traumatized members of marginalized groups (Sue & Zane, 2006; Levant & Silverstein, 2006; Brown, 2003; Olkin & Taliaferro, 2006). These researchers found that the therapeutic qualities
that are empirically supported are relational, such as empathy, collaboration, genuineness, positive regard and respect, and the nature and quality of the therapeutic relationship.

As professional counselors, we are trained and expected to bring authentic relational qualities to our interactions with clients. However, trauma survivors often bring into the therapy beliefs and behaviors that challenge the most competent therapist. This will be especially relevant if the therapist her/himself has a history of trauma.

Brown (2008) states that culturally competent trauma therapy involves, “...knowledge of one’s own multiple identities and their meanings. Along with one’s sex, gender, and various ethnic, sexual orientation, cultural and social class identities, there is also the question of how trauma is a part of one’s identity.” (p. 13). According to research by Pope and Feldman-Summers (1992), approximately 30% of practicing psychologists reported a history of childhood abuse. If we assume that other professionals engaged in the practice of psychotherapy have similar rates of childhood abuse, then our awareness of possible complex countertransference reactions becomes especially important in addressing the trauma reactions therapists and their supervisors are likely to encounter.

**Theme 3: Supervisors by Default or Convenience**

Seven out of eight of the participants in this study attained supervisory status by default due to age, clinical experience, or necessity as determined by their employer. Only Participant #8 proceeded to supervisory work after having taken a semester-long supervisory course. The following are some of their experiences:
At the rape crisis center, I was promoted to that (supervisory) position. The way that I got there was torturous and traumatic, and it was very odd to go from a peer to supervision of my peers (Participant #2). That happened rather quickly, and probably prematurely. Just because of doing that kind of work, no one knew how to do it. So I mean, I became a de facto teacher or mentor (Participant #4).

Participant #8 described her transition to supervisor after attending a formal supervision course at a local university: “I was working with...graduate students and supervising them in their clinical learning. I was their field supervisor.”

**Implications for the Field**

Supervision has long been deemed a critical factor in assuring counselor effectiveness and stability. It is especially important for trauma therapists, and its necessity has implications for the training of trauma competent supervisors. Lonergan, O’Halloran, and Crane’s (2004) subjects reported that, “Supervision was very helpful in debriefing, or discussing cases and the emotional toll they took on participants.” (p.362). Furthermore, they stated:

“It was clear to participants that therapy and supervision for conducting trauma work does indeed differ from general clinical supervision, in terms of the need for the supervisor both to be familiar with trauma theory and practice and to understand the particular risks involved for the supervisee.” (p. 362).

Chu (1988) noted that trauma therapists are at risk for falling into traps that are especially likely to be present in survivors of trauma. These 10 traps include the
assumption of the presence of trust, distancing, failure to set boundaries, failure to set limits, and issues of responsibility, control, denial, projection idealization, and motivation. Due to the presence in supervision of parallel process, (Clarkson, 1998), the supervisory relationship will embody the same challenges relating to trust, boundaries, and power that exist between client and therapist. Therefore, it is critical for supervisors to educate supervisees on the presence of these issues in both domains. The participants in this study noted examples of these supervisory issues:

I’ve got one (supervisee) now that’s a bit of a problem…he’s a young man who got involved…in a romantic relationship with his psychiatrist. He started working with the psychiatrist at his practice. (Participant #3)…Good supervision with (trauma) has to do with understanding what trauma is, how it’s affecting your client, and learning how to engage it enough that you don’t get vicariously traumatized. (Participant #4) And at one point, she was living in the basement suite of her therapist’s home. (Participant #5)

Theme 4: What was Needed

Seven of the eight participants in this current study described their professional journeys to becoming trauma-competent in terms of a struggle to learn not only about trauma, but also about how to be supervisors. Some of their comments about learning about trauma are as follow:

I wish I would have had more resources available to me, and those resources didn’t exist. We were all working on such a little availability of any literature that was directly trauma-focused. (Participant #2) I think it would have been
good to be able to have a mentor. (Participant #3) I wasn’t really trained in trauma. I had to train myself in trauma, and so I think it’s taken me half of my career to really get there and to really grasp just how central trauma is to just about everybody I work with. (Participant #7)

Participants had suggestions for what was needed and what would have helped them in their journeys to becoming trauma counselor supervisors:

And then at the rape crisis center, I was promoted to that position. The way that I got there was torturous and traumatic, and it was very odd to go from a peer to supervision of my peers. (Participant #2) Just because doing that kind of work, no one knew how to do it. So, I mean, I became a de facto teacher or mentor. (Participant #4) I certainly would have appreciated the course like they have at this other university ... to be supervised for doing supervision. (Participant #5) And I think especially in the beginning when I was supervising, I was not sure if I had the experience to be doing that... because I remember when I started supervising, I had what? Five years of experience? Myself as a clinician. (Participant #6)

Implications for the Field

The ACA (2014) Code of Ethics states that, “Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience.” (C.2.a.) Section F contains the directive that, “Prior to offering supervision services, counselors are trained in supervision methods and techniques.” (F.2.a.) The complex learning curve required to become trauma
counselor supervisors, as described by the participants in this study, evokes many questions about how counselors can be trained in accordance with the standards set forth in the Code of Ethics as described above. Pearlman and Saakvitne (1995) identified four components of trauma therapy supervision that address both of these standards:

1. A solid theoretical grounding, including a theoretical understanding of psychotherapy in general and trauma therapy in particular, a theory of the psychological responses to interpersonal violence, and an understanding of normal child development.

2. A relational focus that attends to both conscious and unconscious aspects of the therapeutic relationship and the treatment process

3. A respectful interpersonal climate that allows attention to countertransference and parallel process

4. Education about and attunement to the therapist’s vicarious traumatization

Additionally, section C.2.a of the (2014) ACA Code of Ethics states the following: “Whereas multicultural counseling competency is required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population.” The experiences reported by the participants in this study embody the complexity of knowledge required to become a trauma counselor supervisor that involves the integration of trauma, supervision,
and cultural competence. As Lonergan, O’Halloran, and Crane’s (2004) study confirmed:

“It was clear to participants that therapy and supervision for conducting trauma work does indeed differ from general clinical supervision, in terms of the need for the supervisor both to be familiar with trauma theory and practice and to understand the particular risks involved for the supervisee.” (p. 362)

Brown (2008) adds that culturally competent trauma therapy involves,

“...knowledge of one’s own multiple identities and their meanings. Along with one’s sex, gender, and various ethnic, sexual orientation, cultural and social class identities, there is also the question of how trauma is a part of one’s identity.” (p. 13)

From the interviews with the eight participants in this study, we may speculate that their struggles to integrate the principles of trauma, supervision, and culture, might have been eased by the inclusion of basic trauma and supervisory courses during training.

**Theme 5: It Takes a Village**

This theme refers to the reports from all of the study participants that various types of support from supervisors and colleagues are necessary to being a healthy and effective trauma counselor supervisor. The types of support varied, with peer supervision groups being the most frequently utilized, followed by individual supervision or consultation and professional listserves, which are usually based upon membership in a particular professional organization, such as the ISSTD
or EMDR groups. Some of the participants’ comments on this theme are listed below:

...I know the difference when I was not connected and when I was connected. The connection with people locally and abroad. I think the most important thing is not to isolate with this work. (Participant #1) It’s an absolute belief in team approach, particularly the trauma work. That it takes a village to help a person, and that we have to collaboratively work together. (Participant #2) We could debrief with one another, and we just learned the value of that (Participant #5) I think talking about cases with colleagues informally is actually incredibly helpful...(Participant #8)

Implications for the Field

Theme #5, as well as its four antecedent themes, exemplifies Bronfenbrenner’s (1979) Bio-ecological Model of Human Development. The microsystem for each participant, e.g. personal history, identity, and immediate surroundings, influenced how the individual began his or her professional journey. As Participant #7 stated, for example: “I think it’s no coincidence that my father was a war veteran...I was the person in our family that could relate to my father...my capacity to form a connection with a traumatized person, I think, came from my family.”

Participants’ mesosystems (the settings in which they lived, studied, and worked, for example) profoundly influenced their professional trajectories in becoming trauma counselor supervisors. Bronfenbrenner (1979) defined the mesosystem as that which, “...comprises the interrelations among two or more
settings in which the developing person actively participates…” (p.25) Interactions between the participants’ educational, social, and work systems are illustrated by the following quotes:

...So I think I was more on my own trying to figure out how to work with this particular population. And so I just did a lot of reading to try to understand what was happening in the experience of those individuals, and then sought some private consultation. (Participant #1) And I was a Women’s Studies major, as well as a Psychology major. And it was through that class that I got interested in women in prisons and detention centers. (Participant #2)

I think I got into trauma work like many of us did, through the back door of working with women who’ve been sexually abused...(Participant #3)...When I first got my degree and got licensed, I had a good friend up here...who was managing an inpatient adolescent program...and he invited me up because he needed help with it. (Participant #4)

The participants’ interactions with the exosystem in which they existed, e.g. their educational institution or workplace’s policies, impacted their professional trajectories in various ways:

But at least in the army world where I work, they're so conditioned that it’s all supposed to be evidence-based. It is almost a bad word when you say something is not. So it’s not really open to anything else...and so I didn’t tell them that I knew Reiki...and it worked, but I didn’t write that down. I didn’t tell anyone. (Participant #3) And let me just add to the education piece that trauma becomes a heuristic for understanding so many other things. When I
teach it, I don’t just teach trauma. I teach attachment. (Participant #4) I started doing my work in a rape crisis center. I was introducing my classmates to information about trauma and sexual abuse…(Participant #5) Bronfenbrenner (1979) defines the macrosystem as consisting of the value, belief, and cultural norm patterns that are made visible through socioeconomic, philosophical, religious, and political structures and their variations in a particular society. In this study, the participants were Caucasian women and men working in the United States, Canada, and Australia and could be broadly identified as belonging to western society. All of the participants indicated that they were aware of a level societal denial of childhood sexual abuse that influences not only political agendas, but also affects therapeutic, research, and educational understanding. Some of the relevant participant quotes are listed below:

Well, I find it interesting because I think that there’s a lot more people who have a lot more trauma out there than they realize, and often people just think, Oh well, that was just normal. (Participant #3) ...I was introducing to my classmates information about trauma and sexual abuse, and sitting in a practicum where peers would be talking about their client who seems to be spacing out and maybe they had schizophrenia, and I was saying, “Maybe they’ve been abused.” (Participant #5) It’s still so hard to believe we still have this thing where half of our profession – let alone mainstream society – doesn’t believe. I don’t see how you get to not believe in something that’s scientifically evident...that’s organizational abuse which...our society’s been shocked at. Everything’s come out about churches, and orphanages,
and...scouting...and then I try to say to someone, the most frequent abuse is happening, not in organizations but in families. They don’t want to hear it.

(Participant #7)

Finally, all of the systems described above are situated within what Bronfenbrenner (2005) describes as the chronosystem: the time frame subjectively experienced by the developing person throughout life. The professional development of the study participants over time and through life transitions was evident across the interviews. Some references follow:

It’s not that I didn't deal with people who had trauma, but I didn't think of the word trauma during that time. (Participant #1) It’s interesting because when you look back at the literature, they’re describing what we now call PTSD, but they sure didn’t call it that then. (Participant #3) And at that time, it was just starting to sort of get on people’s radar. (Participant #4) And I was advocating even five years ago that either there should be a course in trauma just as part of the graduate degree. (Participant #5) Because I remember when I started supervising, I had what? Five years of experience?

(Participant #6) But in the last 20 years trauma has become the centerpiece of my work and understanding of what walks in my door. Before that...I wasn’t really trained in trauma. And so I think it’s taken me half of my career to really get there and to really grasp just how central trauma is to just about everybody I work with (Participant #7) They get worse before they get better. But as a young clinician, I think maybe when it was at its worst, I was in about my fourth year. Even processing...in my own supervision, years
later, still asking the question, “Did I make it worse? Did I make a mistake?”
and I’ll probably have that forever, but I’m at peace with it now. (Participant #8)

**Summary of Themes**

The purpose of this study was to explore the lived experiences of clinicians who became trauma competent supervisors. Through the process of semi-structured interviews with eight participants, rich, detailed information about their process was discovered and analyzed. The resultant five themes represent the outcome of that process and provide suggestions for possible pedagogical changes in counselor education and supervision.

The themes identified in this study confirmed that trauma is ubiquitous and that participants were exposed to traumatized clients from the very beginning of their careers, despite the fact that they had had little or no specific training in how to deal with those clients. The notion that learning about trauma was “trial by fire” was expressed in various ways by all the participants, regardless of agency or specialty in which their careers began. Many of the participants began their careers decades ago, yet, according to Bledsoe (2012), pre-service and in-service curricula still contain significant gaps in training regarding trauma and adequate supervision for counselors working with traumatized clients.

The data derived from the eight participants in this study also indicate that the role of supervisor is often conferred upon counselors based upon agency need, convenience, age and experience of the counselor, or other factors not related to the suitability or training of the counselor. The learning curve in the process of
becoming competent supervisors was steep as described by the study participants. Their personal and professional struggles to shift effectively from trauma counselor to trauma counselor supervisor are poignantly described in their transcripts and statements of significance.

In their own words, participants variously described what they needed and wished they’d had, but did not get. Those things included pre-service information and basic training about the prevalence of trauma and the particular needs of traumatized clients, along with competent supervision. Most participants stated that their supervision was not helpful, or non-existent, leaving them with insufficient role models for their own elevation to supervisor status.

A final, overarching theme expressed by all the participants was the sense that “it takes a village” to deal with trauma. The participants’ trajectories through learning about trauma and learning about supervision highlighted their need for the support of supervisors and colleagues throughout the professional years. This finding confirms Levers’ (2012) assertion:

Even highly experienced trauma counselors find clinical supervision helpful, and for more seasoned therapists this can be conducted as peer supervision or even trauma-informed learning groups that are developed by clinicians to support one another in this intense line of work. (p. 16).

In summary, the findings in this inquiry support the need for changes to the current counselor education and supervision pedagogy to address the gaps in preparation of students for dealing with trauma and its effects. Suggestions for curriculum enhancement are addressed in the following section.
Suggestions for Pedagogical Implementation of the Research Findings

The data from this research inquiry indicate that changes to counselor education programs are needed to prepare students for working with trauma as counselors and as supervisors. Specifically, those changes would need to include the following: 1) graduate program awareness and acceptance of the prevalence of trauma as a universal phenomenon that their students will encounter; 2) student self-awareness and reflectivity; 3) trauma-competent supervision and peer support for students and clinicians.

1) Graduate program awareness and acceptance of trauma as a universal issue. As Bledsoe (2012) noted, gaps exist between what is known about trauma and what is addressed in counselor education programs to prepare practitioners pre-service. Currently, some counselor education programs are offering trauma courses on an elective basis, but enrollment for these courses is limited by space, time, and a lack of professionals willing and able to teach these courses. Accrediting organizations such as CACREP set the requirements for course work to be covered in counselor education programs, and have recently added requirements for crisis and disaster competence, but have not addressed developmental trauma issues which will be the primary presenting issue of the majority of trauma clients.

The American Counseling Association and CACREP have long recognized the need for counselors to be culturally sensitive in order to effectively assist their clients and therefore cultural competence is a curriculum requirement. What is missing is the recognition that cultural
competence and trauma competence are not separate, nor are they “specialty” practices. No one would presume that cultural awareness is a practice applicable to only “some” clients and practitioners, nor would they expect it to be learned “on the job.” Section A.2.c. of the American Counseling Association Code of Ethics Preamble (2014) lists as one of its professional values, “2. honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts.” (p.3). The failure to consider the occurrence of trauma a part of an individual’s unique social and cultural context is disconcerting.

Browne (2008) wonders at the disconnection between the fields of trauma studies and cultural competence. She notes that trauma studies arose out of the social justice movements of the 1970s, namely feminism and the anti-Vietnam war. Yet somehow, cultural diversity as addressed in the mental health system has long been limited to the concepts of race and culture, despite attempts by feminist psychotherapists to bring to the foreground sexuality, rape, and identity issues. Brown states,

Disability, immigration status, experiences of colonization, and other social locations have informed people’s experiences of identity, and thus of trauma, (emphasis mine) and they have also largely gone unaddressed within the mental health discourse.” (p. 10)

Courses teaching the connection between trauma and culture need to be mandatory at both the master’s and doctoral level in counselor education
programs. One way to facilitate the connection between trauma competence and cultural competence is for counselors, supervisors, counseling students, and the agencies who benefit from the presence of student interns to advocate for themselves and their clients by sharing their experiences and educational needs with those educational programs tasked with providing for those needs. At present, counselor education programs and their graduates exist on the precipice of an ethical dilemma in their failure to provide training in a condition experienced by so many individuals who seek professional help.

2) **Student self-awareness and reflectivity.** Ventura (2010) suggested the following methods for helping master’s level counseling students to be self-reflective: Interpersonal Process Recall (IPR) (Kagan, 1990), reflective team supervision (Andersen, 1991), and journal writing. These methods, described briefly below, are also applicable to training supervisors as well and could be enhanced with trauma-specific topics.

*Interpersonal Process Recall.* Integrating IPR (Kagan, 1990) into counselor education programs serves to aid students in becoming self-reflective, particularly with reference to their in-session thoughts and feelings around client issues. Because traumatized clients tend to bring specific issues (such as distrust, for example) into the counseling session, counselor self-awareness is of paramount importance to avoid countertransference breakdowns early in the therapeutic dyad. The counselor/supervisor dyad
can act as a parallel process and safe space for using IPR in addressing client issues specific to trauma as well.

*Reflecting Teams.* (Andersen, 1991) In the use of reflecting teams, trainees can role-play specific trauma case issues while other students listen and observe the process. At the conclusion of the role-play, the observing members of the team discuss their observations of the case in a tentative, nondirective manner while the role-play members listen. This method, like IPR, can be used just as effectively with supervisor trainees.

*Journaling.* The act of writing down one’s feelings has been used for centuries as a means of self-expression and a safe outlet for feelings deemed too personal to be spoken aloud. My work with trauma survivors often includes the recommendation for journaling to address hidden feelings and disowned aspects of the self. The contents of the journal can be shared with the therapist or support group, or may remain a private source of self-awareness for the client. With the benefits of parallel process in mind, journaling serves a similar purpose for counseling and supervisory students by providing an outlet for reflections on trauma topics or clinical cases.

3) **Trauma Competent Supervision and Peer Support**

Levers (2012) observed that single-theory clinical responses to clients’ trauma-related issues have proved to be inadequate. Current trauma literature has deepened our understanding of the multi-faceted effects of trauma, which in turn translate into the need for multimodal systemic and integrative approaches to helping traumatized clients. She has also stated
that the concept of therapeutic alliance is not limited to the client/therapist
dyad, but extends to the counselor's colleagues and the service delivery
system. The dyad, as observed by Levers, is nested within the larger social
units or systems in a parallel to Bronfenbrenner's bioecological framework
upon which she has based a comprehensive approach to trauma work
entitled the Integrative Systemic Approach to Trauma (ISAT). This three-
level conceptual framework aligns multiple levels of trauma response in an
ecological perspective for counseling trauma survivors. The three nested
levels are as follow:

1. The Clinical Relationship – includes client/clinician dyad and other
   healing modalities, such as group therapy, 12-step programs, etc.

2. The Nexus of Personal and Treatment Issues – includes all actors
   involved in trauma treatment and significant persons in client’s
   life who may affect treatment outcome, e.g. clinical supervisor,
   agency administrator, as well as personal and professional
   characteristics of the counselor, treatment milieu, clinical
   supervision, and other clinician support mechanisms.

3. The Broader Systemic and Cultural Influences – include the overall
   treatment system, funding mechanisms, and the mental health and
   other regulatory policies that exist at all levels and that may have
   an ultimate effect on treatment outcome.

The ISAT model illuminates the current realities of trauma treatment
systems and offers a template for enhancing trauma treatment
conceptualization for use in counselor education programs. Much of the literature relevant to counselor education addresses Level 1 (Clinical Relationship) issues in master’s level programs, doctoral level courses focus on some aspects of Level 2 (Nexus of Personal and Treatment Issues), while Level 3 (Broader Systemic and Cultural Influences) issues remain primarily outside the scope of discussion except as they influence the general practice of counselors in a legal sense. As a final and comprehensive suggestion for changes in pedagogical practices for training counselors and supervisors, I believe the ISAT model offers a framework for integrating trauma training into counselor education programs. While the purpose of the ISAT model was created for trauma specifically, its three-level nested system incorporates relational concepts present in all types of counseling practice. By incorporating ISAT into counselor education programs, findings of this study that indicated deficiencies in trauma training and support could be remedied as follows:

- Level 1 Clinical Relationship Issues could be enhanced to include trauma-specific self-reflective training for counselors and supervisors along with basic information about trauma.
- Level 2 Nexus of personal and treatment issues could be expanded to include trauma-specific supervision as well as enhanced group experiences to highlight the importance of peer and collegial support in doing trauma work.
- Level 3 Systemic and Cultural Issues could be enhanced by emphasizing a deeper understanding of how these issues contribute to and affect the perpetuation of trauma in the culture, and how systemic flaws in the treatment and funding systems can hinder clients' recovery.

The importance of instituting pedagogical changes to counselor education programs as described in this section of the paper is underscored and supported by the data obtained during interviews with eight trauma counselor supervisors. Each of the eight participants contributed their lived experiences, their thoughts, and their suggestions for improving the complex journey from being a trauma competent therapist to becoming a trauma competent supervisor.

Bronfenbrenner’s (1979) Bio-ecological Model of Human Development provided a lens through which to view the transition process. Each of the systems identified by Bronfenbrenner were utilized in analyzing the themes identified earlier in this chapter and illustrated by relevant quotes from the participants. Viewing the lived experiences of the participants through this lens provided insight into the risks and protective factors that were inherent in the process.

Gregoire and Jungers (2007) summarize risk factors as those that have the potential to interrupt an individual’s developmental trajectory, while protective factors are those that serve to protect the individual from the influence of risk factors. In her study of master’s level counseling students, Ventura (2010) found that when dealing with traumatized clients in their practicums, the students had several risk factors. These included a lack of sufficient knowledge about trauma, lack
of understanding of transference and countertransference, a sense of being unprepared, lack of knowledge related to therapeutic alliance building, lack of adequate supervision, and a lack of understanding of how to be self-reflexive. All of these factors have been identified in counselor development literature as potentially damaging to clients and to counselors, along with the fact that graduate programs have not had a required specific focus on trauma (Lonergan, O’Halloran, & Crane, 2004; Chu, 1988; Alpert & Paulson, 1990; Pope & Feldman-Summers, 1992). The risks of compassion fatigue and vicarious trauma in counseling students have been well documented by Black (2008), Figley (1995), and Pearlman and Saakvitne (1995) and, as Ventura (2010) stated, “Reliance on supervision in trauma work, while essential, is not common.” (p.35)

Protective factors associated with the process of becoming a trauma counselor supervisor are similar to those outlined for counselor development, and include an emphasis on self-reflexive practices, such as IPR (Kagan, 1980), and knowledgeable supervision (Borders, 1994). Smith (2009) notes that clinical supervision for mental health professionals started out somewhat like an “apprentice” model used in other fields, though Falender and Shafranske (2008) documented that clinical knowledge and skills are not necessarily transferrable to supervisees through the process of observation and imitation, and that reflection on the counseling work, relationship, and supervision itself fosters counselor development. The data gathered from the participants in this study support Smith’s apprentice model observation, though ample supervision models exist and counselor education and supervision programs are becoming more numerous.
Further steps need to be taken in the interest of providing graduates of counselor education programs with the tools and training required to address the needs of traumatized clients – a need which has been woefully neglected to date. Through the implementation of trauma-specific models, such as Levers’ (2010) Integrative Systemic Approach to Trauma, counselor education programs could potentially send graduates of master’s and doctoral programs into the field personally and theoretically prepared to help the ever-growing number of individuals affected by trauma.

**Potential Hypotheses Generated from This Inquiry**

The following questions have resulted from the findings of this inquiry:

1. Do counselor education graduates leave their programs feeling prepared to work with traumatized clients?
2. Do graduates feel that they have adequate trauma-informed supervision at their jobs?
3. Do graduates of counselor education doctoral programs feel that their programs prepared them to supervise trauma counselors?
4. Do counselor education graduates of master’s programs feel prepared to supervise other counselors?
5. How do counselors with their own trauma histories feel about their preparedness to work with trauma?
6. How do counselors who are untrained in supervision develop a supervision style if promoted?
7. What feelings do counselor education students have about the prospect of learning about trauma?

8. What role do counselor education doctoral programs have in training supervisors to be trauma informed?

9. How do trauma counselor supervisors find support in their professional lives?

10. How can graduate programs foster and promote trauma-specific peer support models as professional resources?

**Limitations of this Study**

The eight participants for this study consisted of practicing trauma counselor supervisors known to the author locally, and the remainder were recruited from professional organizations in the United States, Canada, and Australia. Even though saturation of the data was reached prior to the eighth interview, generalizability to all trauma counselor supervisors cannot be assumed. Unlike quantitative designs, qualitative research does not require a large sample size to prove trustworthiness or reliability (Berg, 2009; Patton, 2002; van Manen, 1990). Measures utilized in supporting the trustworthiness of this study were described in Chapter 3.

The major limitation of this study was the uniformity of the sample. Six of the eight informants who volunteered to participate in the study were aged 60 and older. All were Caucasian and were of western cultural origin. The lack of diversity in age, cultural, and ethnic origin limits the generalizability of their experiences to other clinicians practicing as trauma counselor supervisors, particularly those in non-western cultures.
Due to my work in the Pittsburgh area as a trauma counselor supervisor, I knew the local participants, which could have influenced their responses during the study, though none were my current supervisors or supervisees. The informed consent procedure helped to assure confidentiality for the participants, as did their knowledge of my training in confidentiality as a clinician. Finally, because I was aware that my own biases around the subject of this study, I remained self-reflexive throughout the work of gathering information and analyzing the data obtained.

**Implications for Future Research**

This study generated several areas for potential future research, beginning with an extension of the current study using more purposeful sampling to ensure diversity in the age and ethnicity of the study population. The sample of this present study was self-selecting in response to queries placed to a professional organization and did not contain specifications for age or ethnicity.

A second area for potential research would be to query trauma counselor supervisors more specifically on the methods they used in supervision, whether or not they had specific training. Although some of the participants in this current study mentioned this information, the question was not included in the original semi-structured interviews. Exploring this area in greater depth would be important to understanding the differences between trained and untrained supervisors. This present study, for example, noted that only Participant #8 had had a semester-long supervision course that included use of self-reflexive learning. Participant #3 reported having taken an online supervision course, but could not remember the details and its value to her was in the certificate obtained. Whether or not elements
presented in the course were utilized in her supervision work could not be determined within the scope of this study.

Finally, based upon the thematic results in this study, an area for potential research would be to further explore the role of feminist influence on the process of becoming a trauma competent supervisor. Several of the participants in this study reported that they learned about trauma early in their careers because they were working in rape crisis centers or had been influenced by women’s studies courses where trauma was named and acknowledged, while for others the process was more circuitous.

Conclusions

The purpose of this study was to explore the lived experiences of trauma counselor supervisors. The findings revealed the lived experience to be a process that started with learning about trauma in order to become trauma competent, followed by being thrust into supervisory roles with little or no training in how to be a competent supervisor. The participants in this study described their supervisory challenges in detail, confirming that specific supervisory-related risk and protective factors following Bronfenbrenner’s model (1979, 2005) were applicable both for themselves and for their supervisees. The study findings indicated that the process of becoming a trauma counselor supervisor was long and complex due to lack of education about how to treat traumatized clients, followed by lack of training in how to supervise trauma counselors effectively. Analysis of the themes that emerged during this study revealed that participants felt that, though trauma is ubiquitous, they had to learn about trauma through immersion or “trial by fire”; that
they became supervisors by default or convenience for an agency; that they needed training and education; and that trauma counseling and supervision work requires the support of a community of peers.

Following the completion of the eight participant interviews, no new data points emerged and it was clear that the data had reached saturation. The results obtained were analyzed in accordance with literature on trauma and supervision. Conclusions reached as a result of this study indicate that basic education and training in dealing with traumatized clients is needed for students in counselor education and counselor education and supervision programs.

The study findings supported Ventura’s (2010) observation that lack of trauma training and education is a problem that extends beyond the master’s level:

As noted in Chapter 1, master’s level students who matriculate into doctoral level programs or enter into the field at the master’s level may not have been exposed to trauma theory in their academic programs. Still, these practitioners are charged with supervising trainees on cases dealing with simple or complex trauma. This ethical dilemma may be exacerbated further if the supervisors are not able to accurately assess or even conceptualize trauma. Ultimately, this situation can be harmful to clients who end up being re-traumatized by “therapeutic” interventions that ignore the most essential aspects of their existential crises. (p. 177)

This study also partially addressed one of Ventura’s (2010) suggestions for future research, in which she wondered about the lived experiences of supervisors at training sites, and whether they endorsed the countertransference observed by
informants in her study. The present study asked about countertransference as part of the lived experience of trauma counselor supervisors in a variety of settings, including agencies and private practice. Some participants gave detailed accounts of their own countertransference, while all endorsed the presence of countertransference as a part of the parallel process between client/therapist and therapist/supervisor dyads. The ability to observe and report on these processes seems to be an indicator of the ability to self-reflect, and to instill the use of these processes in those who are being supervised through methods such as IPR (Kagan, 1980).

In conclusion, Ventura’s (2010) research into the need for a pedagogy that includes enhanced supervision, understanding of trauma, and self-reflexive learning for master’s level counseling students supports Brown’s (2008) observation about trauma competent multicultural counseling:

...just as cultural competence is of importance in working with clients so that psychotherapists can hear and know the multiple meanings of their trauma experiences in light of their various identities, so such competence is a necessary component of responding to vicarious traumatization in themselves. (p. 253)

Brown’s statement reminds us that effective psychotherapy is performed by counselors who are both self and other-aware. Such awareness, as the results of this current study have indicated, requires equally well-prepared supervisors to support the counseling profession’s tradition of multicultural competence in providing competent and sensitive therapy to the most wounded among us in our society.
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Appendix A

Semi-Structured Interview Guide

Prior to the interview, the participants were asked to sign a consent form that presented all of the pertinent information about the participant's consent to be part of the study. Such information consisted of the title of the study, the investigator's name and contact details, the advisor of the co-investigator, the rationale for conducting the study, the purpose of the study, the risks and benefits, the lack of compensation, confidentiality, the right to withdraw, the summary of results, and the meaning of the voluntary consent. The following protocol questions were designed as open-ended prompts to elicit information about the phenomenon under investigation:

**Protocol Questions**

How does the concept of trauma fit into your experience of being a counselor?

*Describe your feelings when working with traumatized clients.*

*Tell me a story about how you learned to treat trauma survivors.*

*What particular issues did you notice that arose in treating trauma survivors?*

Describe your experiences in going from clinician to supervisor.

*What were the circumstances that led to your becoming a supervisor?*

*Describe how it felt to be both a clinician and a supervisor.*

As a supervisor, what were your supervisees’ needs in working with trauma?

*How were these needs different from working with non-trauma clients?*

*What did you notice about transference and countertransference?*

*What supervisory challenges stood out for you?*
What impact did cultural differences play in your supervision?

   How did they impact the client/therapist dyad?

   How did they impact the therapist/supervisor dyad?

What experiences prepared you for supervising trauma counselors?

   What was your education like?

   What helped you to learn to supervise?

What experiences or support do you wish you had had to prepare you?

   Would education in trauma and/or supervision have helped?

What ideas, concepts, or practices help to support you in your work?
Appendix B

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: The Lived Experiences of Trauma Counselor Supervisors

INVESTIGATOR: Nancy Fair (PhD Candidate)

ADVISOR: Lisa Lopez Levers, PhD
School of Education
(412) 396-1871

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the Requirements for the doctoral degree in Counselor Education and Supervision at Duquesne University.

PURPOSE: You are being asked to participate in a research project that seeks to investigate the lived experiences of counselors who have at least one year of experience as supervisors for other counselors who work with traumatized clients, and who have completed a master’s or doctoral level education in any of the professional therapeutic disciplines (Counseling, Psychology, Social Work, etc.). Gaining information about trauma counselor supervisors’ experiences may help the counseling profession assess current curricula in counselor and supervisor training for effectiveness in preparing counselors and their supervisors for dealing with trauma. You have been identified as a key stakeholder in the counseling community because of your professional work in the area of trauma counselor supervision. Participants are asked to meet with the researcher for 45 to 75 minutes (in person, by telephone, or via Skype or other electronic application) during which you will be asked a series of open-ended questions about your professional experiences learning about trauma and about your work as a trauma counselor supervisor. The meetings will be recorded on audiotape only, following which they will be transcribed by the researcher. A written transcript of the audiotape will be provided to you for review as to accuracy and fidelity. These are the only requests that will be made of you.

RISKS AND BENEFIT: There are no risks greater than those encountered in every-day working life for a trauma counselor
supervisor. While there are no direct benefits to you, the information collected in the study can be of benefit to future counselor supervisors.

**COMPENSATION:**

There will be no compensation for participation in this study. However, participation in the project will require no monetary outlay on your part.

**CONFIDENTIALITY:**

Your personal identity will never be revealed to anyone who reads the research. The information that you may provide to the researcher during the individual interview will be kept confidential and not reported in connection to your identity in any way. Informants who choose to participate via Skype or other electronic application will be aware that confidentiality via those application cannot be guaranteed. Each participant will be given a number in the final written analysis. All raw audio materials will be destroyed after transcription and review. All written data, including consent forms will be kept in a locked file cabinet in my home and password secured on my computer for at least five years after completion of the research.

**RIGHT TO WITHDRAW:**

You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time.

**SUMMARY OF RESULTS:**

A summary of the results of this research will be supplied to you, at no cost, upon request.

**VOLUNTARY CONSENT:**

I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project. I understand that should I have any further questions about my participation in this study, I may call Nancy Fair or Dr. Lisa Lopez Levers at (412) 396-1871, and Dr. David Delmonico, Chair of the Duquesne University Institutional Review Board at (412) 396-4032

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Participant’s Signature

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Date

________________________
Researcher’s Signature

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Date