Supervision and Vicarious Trauma

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Counsellors often find themselves working with clients who have experienced trauma. When that trauma impacts counsellors professionals tend to talk about burnout or countertransference, compassion fatigue, and vicarious trauma. In the following pages, vicarious traumatization is defined and explored as it exists in counselling contexts.

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Supervising Counsellors for Vicarious Trauma

All counsellors regardless of their work setting will find themselves working with clients who have experienced trauma. From the time that trauma effects were recognised the impact of working with those who had experienced traumatic events was noted. Historically the adverse reactions of counsellors to client trauma were viewed as burnout or countertransference (Figley, 1995). In many cases burnout, compassion fatigue, and vicarious trauma were conflated as secondary traumatic stress (Figley, 1995; McCann & Pearlman, 1990). However, studies have since identified differences between these concepts, and vicarious traumatization (VT) is now seen as a separate theory based construct with observable symptoms (Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a, 1995b).

Understanding Vicarious Trauma

Vicarious traumatization is defined "as the transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with clients' trauma experiences and their sequelae" (Pearlman & Mac Ian, 1995, p. 558 emphasis added). We know from research on the therapeutic alliance that the bond or connection between therapist and client is integral to a successful therapeutic outcome (Bordin, 1979).

Difficulty has surrounded the formulation of a universal definition of empathy. Goleman defined empathy as "the ability to know how another feels" (1996, p. 98). Looking at a scaffolded development of empathy from infancy, the concept of empathy was proposed as being composed of two forms, an affective, and a cognitive form of empathy (van der Graaff et al., 2014). Goleman also proposed a third type that he called 'empathic concern'(2007). In neuro-scientific study Decety and Yoder (2008) distinguish between empathic mimicry and true empathy, noting that true empathy allows for an understanding that the emotions are external to the self, and derived from the other's experience of their environment and the meaning they make of that interaction. Decety and Yoder have framed empathy as "a multifaceted construct used to account for the capacity to share and understand the thoughts and feelings of others" (2016). The neuroscience of empathic functioning derives from a number of mechanisms within the brain such as mirror neurons.

Mirror neurons are a mechanism involved in observational learning with Ramachandran referring to them as a "subset of motor neurons" that perform a "virtual reality" (2011). Further discussions have raised the perspective of two differing systems; one system is involved in the sharing of experience (empathy), and the other system involves cognitively understanding what it might be like to have that experience (Bloom, 2016). Bloom argues that these two systems represent the concepts of communion and agency, and speaks of 'unmitigated communion' (2016, p. 140) in connection to individuals who experienced a form of chronic empathic distress.

Although much of the writing on VT revolves around mental processes, thoughts and awareness, it must be emphasized that individuals also experience the world through their bodies (Herman, 2015; Rothschild, 2003, 2006, 2014; Van Der Kolk, 2014). Studies in neurodevelopment (Jean Decety, 2010) demonstrate that empathy connects and interacts with various neural regions, as well as the autonomic nervous system and the neuroendocrine processes that are involved in emotional states and social behaviours (Jean Decety, 2010). Walker (Walker, 2009) described how working with clients who have experienced abuse can physically effect the counsellor, while Rothschild (Rothschild, 2006) referred to these experiences as 'somatic countertransference' where the action of mirror neurons

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together with body mimicry can result in a 'contagion' of affect that manifests itself physically, emotionally, and cognitively. A study of 35 counsellors over a six-month period showed that 70% experienced sleepiness, muscle tension, unexpected shift in the body, yawning, and tearfulness. Among some of the other effects experienced were headaches (54%), stomach disturbance (41%) loss of voice (32%), nausea (23%), and numbness (29%).

Pearlman and Mac Ian (1995) noted "just as PTSD is viewed as a normal reaction to an abnormal event, we view vicarious traumatization as a normal reaction to the stressful and sometimes traumatizing work with victims" (p. 146). With what seems to be a therapeutic imperative to establish a therapeutic alliance through empathic engagement (Bordin, 1979; J. D. Safran & Muran, 2000; J. D. Safran, Muran, J.C., and Proskurov, B., 2009) coupled with the difficulty to anticipate the level of empathic distress that may be experienced by therapists, it seems therapists are caught in a paradoxical dilemma.

The key distinguishing characteristic of VT is its transformative nature (Pearlman & Mac Ian, 1995). Exposure to the trauma stories of clients can alter the perceptions of therapists, changing the way they view themselves, other people, and the world (Figley, 1995; Pearlman, 2012; Pearlman & Saakvitne, 1995b). These cognitive distortions (McCann & Pearlman, 1990) can impact on the psychological functioning of the therapist. VT has been conceptualised as being worsened by, possibly even based in, the therapeutic connection or empathic engagement with the client that is inherent in all counselling (Pearlman & Saakvitne, 1995b; Saakvitne, Gamble, Pearlman, & Tabor, 2000).

Constructive Self-Development Theory

Since VT is described as a progressive and an adaptive process Constructive Self Development Theory (CSDT) (McCann & Pearlman, 1992) is useful in understanding this progression. CSDT frames the changes in counsellor's cognitive schemas as being pervasive, across all spheres of the counsellor's life, and cumulative, with each traumatised client contact providing reinforcement to these changes. Saakvitne and Pearlman (1996) proposed that distorted beliefs and VT reactions arose out of five areas. These areas are outlined as i) frame of reference, ii) self-capacities, iii) ego resources, iv) psychological needs, and v) cognitive schemas (Saakvitne & Pearlman, 1996). The individual's sense of self and their perception of reality are developed out of these five areas (Saakvitne & Pearlman, 1996). The combination of perceived self and perceived reality provides the individual's context or framework for viewing the world. It is within these five areas that the vulnerability to adaptation, as a result of clients' stories, can result in disruptions and disorientation, and an emergence of VT in counsellors.

The CSDT model is also helpful in the development of strategies to deal with VT (Saakvitne et al., 2000). As VT is framed as an adaptive process it can be viewed as being on a continuum, based not on the accumulation of client trauma stories, but on the shifts that occur in the adaptive process. Saakvitne et al's suggested approach (2000) is to anticipate and prepare, address signs as they arise, and to transform the pain of VT.

It becomes the responsibility of counselling supervisors to provide a VT-informed service to counsellors that is knowledgeable, supportive, and VT-preventative.

VT-Informed Supervision

Using the CSDT model Saakvitne et al. (2000) suggested taking the following approach to working in an VT informed manner: Anticipate and prepare, address signs of VT, and transform the pain of VT.

Anticipate and Prepare. Each individual therapist needs to be cognizant of their own unique protective factors and their risk factors. Understanding of the interplay of these factors allows for an informed construction of a self-care plan that is specific and unique to the individual. Supervisors can facilitate these understandings by having conversations that allow the counsellor to identify their own unique personal risk, and protective factors, such as:

- Personality and coping style.
- Current life circumstances.
- Personal history.
- Social supports.
- Work style.
- Spiritual connection and resources.

Some studies have found that engaging in any coping strategy recommended for reducing distress did not have an impact on immediate trauma symptoms, and cautioned that focusing on the use of individual coping strategies might imply that those who feel traumatized may not be balancing life and work adequately by not be making effective use of leisure, self-care, or supervision, thus in effect blaming the victim (Bober, 2005; Bober, Regehr, & Zhou, 2006). Rather than constructing a generic work/life balance self-care plan the informed counselling supervisor can facilitate an understanding of the specific risk factors for an individual counsellor, and assist in the identification, reinforcement and employment of the counsellors unique protective factors.

Working with protective factors includes examining the meaning-making of the counsellor around their work and clients and the usual personal intersecting issues that may arise. Working with CSDT the counselling supervisor can explore:

- Frameworks utilised by the counsellor to interpret experience.
- Abilities that enable the individual to maintain a sense of self as consistent and coherent across time and situations; intrapersonal
- Abilities that enable the individual to meet psychological needs and to relate to others; interpersonal.

Meaning-making is particularly affected by long term, continuous exposure to trauma stories. With empathic engagement the counsellor has a narrowed focus on a single, identified individual. Work in the cognitive sciences has acknowledged that such a singular focus can skew moral judgements and ethical decision-making (Bloom, 2016; Zaki, 2017). Checking in with the counsellor on the meaning they place on the work that they do; the stories that they hear; the therapeutic interventions they choose; will assist the supervisor to detect the subtle changes to the counsellors point of view or frame of reference. Encouraging the counsellor to be cognitively aware of their frame of reference, and any movements or changes promotes the management of vicarious trauma symptoms. The facilitation of choice in ways of working with changes involves activating coping and managing strategies and the utilization of resources.

The domains that CSDT note of particular importance to meeting psychological needs and supporting existing cognitive schemas are:

- Safety
- Esteem
- Trust/dependency
- Control
- Intimacy

Regular self-reflection and the development of a capacity for personal insight are protective factors for VT. Awareness around cognition and meaning-making coupled with a preparedness to work openly with vulnerability is necessary for the counsellor and supervisor to work in this area.

Promoting counsellor awareness of body sensations arising during counselling sessions will assist the supervisor to address body state countertransference. A number of mindful interventions are now incorporated into therapeutic modalities for trauma symptoms. The awareness of body sensations arising can be developed and supported through a variety of mindful meditation/awareness techniques. Counsellors should be encouraged to develop sufficient skill in conducting a body-scan on themselves, to the point of being able to easily check-in on themselves intermittently through their working day.

Rothschild strongly recommends a sense of calm detachment when working with clients trauma stories (2014) and a strong recommendation for therapists to be aware of motion within the therapeutic space. The body mimicry that results in postural mirroring links to how the action of mirror neurons may result in unconscious automatic somatic countertransference.

In Egan and Carr's study of trauma counsellors (2008) they noted a correlation between the "degree to which a therapist reports experiencing countertransference at the somatic level in response to their clients and the amount of sick leave they need to take" (p. 5).

Supervisors may also find themselves hearing about organisational issues, and how the environment impacts the counsellors' capacity to delivery therapeutic services. Conversations regarding the environmental/organisational contexts are also a source to identify the risk and protective factors that are inherent within the counsellors work context. The three work areas of concern for vicarious trauma risk factors are:

- The organisational environment.
- Working with clients.
- Counsellor experience.

The organisational environment expresses the policies and procedures applied by the organisation. The organisation may have a mission statement that aligns with the counsellor's however it is in the application that values conflicts may arise. Some organisations have a required number of client sessions per day. Other organisations may not have any such requirement, however the workload balances maybe a problem. When an organisation is funded to deliver services to a particular client demographic the counsellor may find they only ever see clients who have been severely traumatised. Community attitudes to the client demographic as well as the availability of community resources can place added stress on the counsellor. Supervisors of clients not in general counselling need to be particularly aware of the inherent risks in the delivery of therapeutic services within single demographic funded projects.

Inadequate training may also be viewed as a VT risk factor for counsellors. Again, counsellors trained for general practice may find themselves working within a specific field of counselling for which they feel ill equipped. It is important not only for the ongoing learning process of counsellors to be offered appropriate training, but also to the meaning-making the counsellor makes regarding the value and meaning in their work as well as their beliefs around their own competency.

Address the Signs of VT. In 1996 Saakvitne and Pearlman developed a Self-Assessment Scale to aid workers in addressing their self-care needs (Saakvitne & Pearlman, 1996). Other scales and assessment tools have been developed for use, i.e. Traumatic Stress Institute Belief Scale (Pearlman, 1996), the Trauma and Attachment Belief Scale (Pearlman, 2003), and the Secondary Traumatic Stress Symptoms (Bride, Robinson, Yegidis, & Figley, 2004). It has been suggested that using the self-assessment tool periodically might assist in tracking changes (Quitangon & Evces, 2015) in counsellors exposed to trauma stories.

Counsellors working with trauma may find themselves caught in a state of preoccupation with the trauma stories their clients bring to them. They may find themselves caught in a state of constant arousal as a result of repeatedly being triggered by these trauma stories, or they may become numbed. When a counsellor is caught in the cognitive and physical tension of their responses to the traumatic experiences of others it can impact not only their professional life, but also their physical and emotional health, and their relationships with friends and family.

In such instances counsellors will question their frame of reference, world-view or spirituality. The domains of safety, esteem, trust/dependency, control, and intimacy will all be disrupted. Belief in self capacity will be diminished; challenging the counsellors ability to have view of a positive self, their ability to self modulate, and to maintain a strong sense of connection to self.

Counsellors may present with doubts regarding their work, low motivation, avoidance of trauma clients, over involved in details, lack of flexibility, critical of colleagues and withdrawing from community and training activities. They may feel under-valued or that their work makes no difference. Such changes to professional performance and functionality may lead to errors in judgement. A reluctance to work collaboratively can also lead to isolation and withdrawal from colleagues and may result in job changes or poor quality work.

On a personal level the same feelings of hopelessness, anger, apathy, negative perception and low self image may lead the counsellor to reject any personal or emotional support available from friends and family. This detachment comes in the form of isolation, poor communication and conflictual relationships.

All of the above and more are signs and symptoms of vicarious traumatization. They may manifest in varying degrees of seriousness. Since we understand VT to be a cumulative and transformative phenomenon then it is possible to view it as being on a continuum.

Taking a continuum viewpoint fits with the approach of anticipate/prepare, manage, and transform. Along the continuum are a number of decision or action points that can provide the braking and/or reversing of an identified progression of vicarious trauma that without action will lead to a full effect experience of vicarious trauma.

Within the therapeutic environment strategies to employ include:

- Balance the level of empathic engagement. Make empathy conscious and disconnect from traumatic experiencing.
- Employ somatic and mindful awareness interventions. Break the mirroring process, moderate arousal, and work on grounding, centering and boundaries.
- Strengthen resilience working through the five domains detailed in CSDT.

Outside of the therapeutic environment it may also be necessary to consider the contribution of the workplace. For the health and wellbeing of the counsellor framing vicarious trauma as an occupation health and safety issue may assist in identifying workplace practices that are increasing counsellor risk factors. Organisational change may not be possible, however the supervisor may facilitate a discussion with the counsellor regarding what they may be prepared to raise with their coordinator/manager, such as reduced client hours, or changing one to one counselling with some psycho-educational group work.

A review of the existing self-care plan of the counsellor may also be due, to further assess which needs are being met and those that need more support. Personal replenishment activities will vary, and it may be necessary for the counsellor and supervisor to consider personal therapy as a safe option for facilitated self-examination of the counsellor's thoughts and feelings.

The informed counselling supervisor who has worked with the counsellor on anticipation and preparation for VT need only identify the signs/symptoms, to implement the coping and managing strategies that will address that particular manifestation for that particular individual. There is no magic one size fits all solution to something as complex as vicarious trauma, experienced by someone as unique as any human being. The response needs to be crafted to suit the signs/symptoms and the individual and their context.

Transform the Pain of VT. The full range of the effects of vicarious traumatization is spread across five categories; emotional, behavioural, physiological, cognitive and spiritual:

- Emotional – feeling unsafe, experiencing anxiety or grief, feeling angry or irritable. Distraction and changes in mood and/or sense of humour can also be felt.
- Behavioural – isolation, changes in eating or sleeping habits, increase in alcohol or substance use. Difficulty separating work and personal life, increased workloads, and sometimes engagement in risky behaviours may also be present.
- Physiological – depletion of physical well being may be evidenced in headaches, rashes, ulcers or heartburn as well as more serious physical complaints.
- Cognitive – difficulty concentrating, changes to negativity or cynicism in points of view, and difficulty separating from the trauma experienced by clients.
- Spiritual – disconnect from others and the world, loss of hope, decreased sense of purpose and feelings of unworthiness.

Untreated this constellation of symptoms can become very debilitating, and a need for a combined mental and physical health approach maybe required. As the revised criteria for PTSD in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) has been expanded to include "repeated exposure to aversive details" of a traumatic event some of those suffering from vicarious trauma may be diagnosed with PTSD. Therapy is definitely recommended in such cases.

Summary

All counsellors will be exposed to the risks of vicarious trauma in their working life. For some those risks will be balanced by protective factors that are intrinsic to them or structurally available through their work organisation (such as supervision) or safety plans. For others, though a more fraught journey on the vicarious trauma continuum is experienced. The message is that vicarious trauma is not some random phenomenon that may or may not occur. Through the intervention of aware supervisors counsellors can be empowered to construct a practice that acknowledges the possibility of being effected by symptoms of vicarious traumatization, and goes on to structure strategies to cope with risk factors, strengthen protective factors and monitor movement on the continuum initiating braking strategies where necessary.

There is a need to recognise that the transformative effect of vicarious traumatization is not only cognitive but also somatically expressed. The development of mindful awareness of self – bodily sensations, emotions and thoughts is a strong protective factor for all in the field.

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