A PHENOMENOLOGICAL STUDY OF THE EXPERIENCES OF SUPERVISORS WORKING WITH CRISIS COUNSELORS

A Dissertation

Presented to

The Faculty of the Department of Counselor Education

Sam Houston State University

In Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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August, 2017

A Phenomenological Study of the Experiences of Supervisors Working with Crisis Counselors

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ABSTRACT

Tran, Quoc Dung V. L. *A phenomenological study of the experiences of supervisors working with crisis counselors*. Doctor of Philosophy (Counselor Education), August, 2017, Sam Houston State University, Huntsville, Texas.

A phenomenological study was conducted at a Southwestern United States University to examine the experience of nine supervisors who work with crisis counselors. This study examined the training, topics, and difficulties experienced as they sought to support and perform their supervisory duties. Nine themes emerge and described as *Learning the job, Crisis topics, Effective Communication, Skills development, Maintaining flexibility, Setting boundaries, Maintaining support, Stress, burnout, and self-care,* and *Balance.* Best practices were identified by supervisors to build resiliency and promote growth for both supervisors and their supervisees. Implications for practice and research are included to further enhance effective supervision of crisis counselors.

KEY WORDS: Crisis, Supervision, Trauma, Trauma informed supervision, Vicarious trauma.

ACKNOWLEDGEMENTS

Special thanks to my family for supporting me through this journey. You have always believed in me and held me to the highest standards. I could not have done this without you. I also thank my colleagues for supporting me throughout this process. Your friendship, professionalism, and moral support is sincerely appreciated. And also my sincerest gratitude for my professors at Sam Houston State University. Your passion, professionalism, and guidance has allowed me to accomplish this monumental achievement. And of course to my cohort at Sam Houston State University and all those that took part in this study.

TABLE OF CONTENTS

Page

ABSTRACT iii

ACKNOWLEDGEMENTS iv

TABLE OF CONTENTS v

CHAPTER I: INTRODUCTION 1

Statement of the Problem 5

Purpose of the Study 6

Significance of the Study 7

Definition of Terms 9

Cultural Trauma Theory 11

Multi-Cultural Supervision 12

Limitations and Delimitations 12

Assumptions 12

Organization of the Study 13

CHAPTER II: REVIEW OF THE LITERATURE 14

Crisis and Trauma 14

Traumatization of Counselors 19

Traumatic Growth 22

Supervision 23

Supervision Models 24

Crisis and Trauma Informed Supervision 31

Emerging Research 32

Summary 40
CHAPTER III: METHODOLOGY 43
Transcendental Phenomenology 43
Participants 50
Summary 56
CHAPTER IV: RESULTS 57
CHAPTER V: CONCLUSION 79
REFERENCES 88
APPENDIX 102
VITA 110

CHAPTER I

Introduction

The focus on crisis-based and trauma informed counseling has grown exponentially within recent years (James & Gilliland, 2013; Quiros & Berger, 2013) and is becoming a necessity due to the increased rate in occurrence of natural and anthropogenic disasters and other crisis. Notable disasters that have caused significant distress for a large numbers of people include the terrorist attacks in New York City on September 11, 2001, Hurricane Katrina in 2005, and most recently, the San Bernardino social services building shooting in December 2015. In addition to natural and anthropogenic disasters, interpersonal traumas such as intimate partner violence, sexual abuse, or random acts of violence may also trigger physical and psychological illnesses in both survivors and helping professionals.

Professionals working with clients who are experiencing a crisis are at risk of shared trauma. Traumatic events may significantly impact mental health professionals as they are often called on to respond and support survivors immediately following first responders and after a crisis (Faust, Black, Abrahams, Warner, & Bellando, 2008). The prevalence of PTSD has been found in up to 75% of anthropogenic disasters survivors and 60% of natural disasters survivors (Galea, Nandi, & Vlahov, 2005). A sample of New York City social workers working with victims of the terrorist attacks in September 2011 found that 25% reported symptoms consistent with PTSD (Boscarino, Figley, & Adams, 2004). Stress associated with crisis counseling may not only lead to post traumatic stress disorder through vicarious trauma, but it may also lead to compassion

fatigue and burnout, which have been identified as occupational hazards within the mental health profession (McAdams & Keener, 2008).

The Diagnostic and Statistical Manual of Mental Disorders 5 (APA, 2013) specifies four major symptom areas for individuals with PTSD including a) persistent re-experiencing of the traumatic events or cues related to the trauma; b) persistent avoidance of stimuli or cues related to the traumatic event; c) persistent symptoms of increased arousal such as hyper-vigilance and exaggerated startle response, d) negative alterations in cognitions and mood. Victims have also been found to be more likely to report somatic symptoms such as depression, anxiety, headaches, chronic pain, difficulty sleeping, and asthma (Iliffe & Steed, 2000).

Just as disasters and other crises are traumatic events that may cause significant physical and mental health problems with survivors including post-traumatic stress disorder (PTSD**),** counselors may also experiences similar cognitive and physiological symptoms following prolonged exposure to the recollections of the traumatic event described by client. The transmission of physiological and psychological distress has been referred to as secondary trauma or vicarious trauma (Pulido, 2012). The symptoms of vicarious trauma and PTSD are nearly identical in the clusters of symptoms as described in the DSM 5 (APA, 2013).

Vicarious trauma refers to the transformation that occurs as a result of empathic engagement and is often a result of listening to graphic descriptions of disturbing events or re-enactment of traumatic experiences (Pearlman & Saakvitne, 1995). Pearlman and Saakvitne (1995) further describes vicarious

trauma as a change that therapists experiences that parallels their client's symptomology including feelings of shock, despair, helplessness, hopelessness, irritability, and hyper-vigilance. These changes in world views can cause significant disruptions in the belief of self, others, and of the world for helping professionals.

Clinicians experiencing vicarious trauma may lead to crisis situations for these helping professionals. A common symptom of vicarious trauma that significantly impacts helping professionals is secondary traumatic stress (STS). STS includes intrusive thoughts and flashbacks of the traumatic event that results in hyper-arousal and hyper-vigilance (Leverich & Post, 2006). Vicarious trauma and STS may in turn lead to changes in cognition and behaviors due to the negative views of personal safety, trust in others and of the world, and in self-esteem (Howlett & Collins, 2014). Vicarious trauma is distinguished from STS as it tends to be associated with pervasive and cumulative effects of exposure over longer periods of time. Secondary traumatic stress is associated with more critical situations that occurs over shorter periods of time. Furthermore, vicarious trauma tends to be associated with chronic trauma that is repetitive and pervasive while STS may be associated with a single event (Jordan, 2010).

A secondary result of counselors working in crisis settings may be compassion fatigue. Compassion fatigue is a unique occupational hazard for those working with crisis and trauma situations and has been used to describe vicarious or secondary trauma in the literature (Figley, 1995; Bride, Radey, & Figley, 2007). The core symptoms of compassion fatigue and vicarious trauma are similar and include flashbacks, nightmares and intrusive thoughts (Galek, Flannelly, Greene, & Kudler, 2011). Compassion fatigue however specifically identifies the helping professional's inability to be empathetic to the

client. If left unattended, compassion fatigue may lead to harm for both clients and counselors including ethical violations and premature exit from the profession (Merriman, 2015).

Burnout, like compassion fatigue is also a result of stress of interpersonal interactions, usually in crisis (Figley, 1995). Burnout is described as psychological strain due to feelings of inadequacy or incompetence as a result of working with difficult populations (McCann & Pearlman, 1990; Maslach, 2003). Chronic interpersonal distress that leads to emotional exhaustion, depersonalization, and feelings of ineffectiveness or lack of accomplishment are the hallmark features of burnout (Thompson, Amatea, & Thompson, 2014). Although working with victims and other difficult populations does not guarantee that burnout will follow, continued exposure in addition to emotional drain, professional isolation, and ambiguous successes have been found to confound the susceptibility of burnout (Maslach, 2008; McCann & Pearlman, 1990).

Clinical supervisors play a fundamental role in providing support to counselors working with clients in crisis. Effective clinical supervision have been recommended to mitigate the risks of crisis counseling including vicarious trauma (McAdams, & Keener, 2008). Effective clinical supervisors can help assess clinicians' vulnerabilities in order to build effective coping skills. Clinical supervisors also address job related stress to support their supervisees in addition to training and teaching of theoretical and clinical knowledge necessary for clinical work. Effective supervisors further provide a professional but safe environment that allows counselors to identify and express symptoms of

secondary traumatization or defense reactions such as denial and dissociation, further mitigating the effects of vicarious trauma, compassion fatigue, and burnout. Lastly, supervision has been found to not only prevent, but can also heal vicarious trauma (Cohen & Gagin, 2005; Pulido, 2007).

Supervision theories and interventions such as developmental models (Stoltenberg & McNeil, 2010; Ronnestad & Skovholt, 2003), social models (Bernard, 1997) and theory based models (Bernard & Goodyear, 2014; Miehls, 2010**)** have been explored, but exposure to crisis issues are rarely addressed (Bernard & Goodyear, 2014). On the rare occasions crisis supervision has been addressed, the studies have explored crisis from the supervisee's perspective (Depre, Echterling, Meixner, Anderson & Kielty, 2013; Somner, Cox, 2005; West, 2010). There is a paucity of research in the field of crisis and trauma-informed supervision with even greater scarcity of research from the supervisor's perspectives.

Statement of the Problem

Crisis counseling is a growing field that deals with situations which may cause significant harm to helping professionals. The risks of vicarious trauma are real and have been well documented in previous research (Howlett & Collins, 2014; Knight, 2013; Bell & Robinson III, 2013). Supervision has been identified as an integral practice that can mitigate the negative factors of crisis and trauma counseling which includes vicarious trauma, compassion fatigue, and burnout (Pearlman & MacIan, 1995; Sommer, 2008). There is however, a lack of detail on crisis supervision guidelines and practices. The paucity of research in this field indicates a significant need for further research to assist supervisors working with counselors who see clients that experience crisis and trauma.

Supervisors, through effective supervision, enhance counselor's self-awareness and self-efficacy which then promote positive outcomes for clients (Wheeler & Richards, 2007). Exploration and identification of effective supervision skills and techniques when supervising counselors working with crisis clients can therefore increase the efficacy of therapy (West, 2010). Increasing the quality of supervision can promote greater acquisition of skills for counselors, resistance to vicarious trauma, and enhance the overall well-being of supervisors, crisis counselors, and of clients (Dupre, Echterling, Meixner, Anderson, & Kielty, 2013). The dangers counselors experience when working with crisis clients are real and include both physiological and psychological distress. Ineffective supervision may lead to counselors and supervisors experiencing vicarious trauma, burnout, and emotional fatigue; endangering clients as well as counselors. Exploring, identifying, and sharing the experiences of supervision of crisis counselors needs to be a priority to ensure safe and effective practices and clinical efficacy.

Purpose of the Study

Given the importance of the supervisor's experience in providing supervision, the purpose of this phenomenological study is to explore the lived experiences of supervisors of counselors working with crisis clients. The *lived experiences* specifically in this study refers to the thoughts, feelings and behaviors crisis supervisors experience as they provide supervision to crisis and trauma counselors. This study will explore the phenomenon of clinical supervision from the supervisor's perspective as they engage in supervision with supervisees. This

study is designed to answer the research question, *What are the experiences of supervisors of counselors working with crisis clients?*

Significance of the Study

Previous research in crisis supervision (Morris and Minton, 2012) noted that counselors frequently encounter high-risk clients in crisis but are inadequately prepared in counselor education programs. The lack of research, knowledge, and clear guidelines in the field of crisis supervision exposes clinicians, their supervisors, and their clients to a myriad of hazards. The purpose of this study is to expound on the existing literature and to empirically identify significant factors in supervision as experienced by supervisors that could affect crisis therapists, supervisors, and therapeutic interventions. Results may also contribute to the literature concerning how supervisors perceive and work with counselors in crisis and trauma settings. Identification of supervision skills, techniques, and supervisor self-care may further enhance teaching and resiliency for clients, counselors, and supervisors.

Research on the negative effects of vicarious trauma has grown significantly in recent years in relation to the increased need for these services. Social workers responding to disasters have reported significant levels of intrusive unpleasant thoughts and depressive symptoms (Cohen & Gagin, 2005; Collins, Coffey, & Morris, 2010). Sexual violence counselors also have been found to experience elevated levels of trauma symptoms (Pack, 2013). Similarly, Iliffe and Steed (2000) reported increased levels of symptomology such as nausea, headaches, and exhaustion in conjunction with psychological distress including feelings of horror and intrusive imagery.

Novice counselors have been found to frequently encounter high-risk crisis clients but often report lack of adequate crisis training within their counselor education programs (Morris & Binton, 2012). The lack of preparedness puts counselors at high risk for vicarious trauma and trauma symptoms. Exploration of the crisis supervisor's experiences can identify common issues and symptoms reported in supervision, and inform educators on enhance preparation for counseling students.

Trauma informed supervision has been shown to mitigate the negative effects of vicarious trauma for counselors working with crisis clients. Sommer and Cox (2005) found that effective supervision that addresses vicarious trauma influenced the effects of secondary traumatic stress on direct care providers and their abilities to cope. There is limited research however, on trauma informed supervision, and no qualitative research have been found that focused on the supervisor's perspective with licensed professional counselors. Understanding and exploring crisis counselor's perspectives and experiences can identify best supervision practices so that effective supervision can be promoted in order to decrease the risk of vicarious trauma.

The lack of knowledge and guidelines for effective crisis supervision further exposes clients, counselors, and supervisors and their families to hazards such as vicarious trauma, compassion fatigue, and burnout (Newell & MacNeil, 2010). Failure to provide effective crisis supervision also increases the risk for reprimand and possible litigation for supervisors who are legally responsible for the training and supervision of supervisees (Corey, Haynes, Moulton, & Muratori,

2010). As clinical supervision has been recommended to promote resilience and mitigate the risks and negative outcome associated with crisis work (McAdams & Keener, 2008), exploring and sharing the experiences crisis supervisors have is integral to the health and efficacy of crisis counselors.

Definition of Terms

Burnout

Burnout is defined as a psychological response to chronic emotional and interpersonal stress. Burnout is characterized by emotional exhaustion, depersonalization, and feelings of ineffectiveness or lack of personal accomplishment (Thompson, Amatea, Thompson, 2014).

Clinical supervision

Clinical supervision is a reflective process to examine the clinical work of practitioners to enhance personal and professional growth. Typically the supervisor is a senior professional who guides, offers feedback, models, and evaluates the process to allow supervisees a safe environment to gain competence within the profession (Quiros, Kay, & Montijo, 2013).

Compassion fatigue

Compassion fatigue is a response to the stress of interpersonal interactions specifically with traumatized clients (Thompson, Amatea, Thompson, 2014). Chronic use of empathy by helping professionals in addition to stressful bureaucratic responsibilities can lead to the experience of physical and emotional drain generally termed as compassion fatigue (Newell & MacNeil, 2010).

Crisis

Crisis is identified as heightened distress associated with psychiatric disorders (Dupre, Echterling, Meixner, Anderson, & Kielty, 2013). Crises are critical incidents that are troubling, disturbing, and potentially destabilizing.

Disasters

Disasters include natural and anthropogenic disasters. Natural disasters include but are not limited to geological, hydrological, meteorological disasters, fires, health disasters, and space disasters. Anthropogenic are human-made disasters that includes intentional and unintentional events such as industrial, ecological, and transportation accidents, war, civil strife, ethnic and religious conflict, violent mass gatherings and demonstrations and acts of mass violence such as terrorism (American Counseling Association, 2011).

Trauma

Trauma for the purpose of this study, is defined as psychological distress following exposure to a traumatic or stressful event (Diagnostic and Statistical Manual of Mental Disorders 5th ed., 2014). Results of psychological trauma may include altered views of oneself and of the world, sense of security, thinking, and feeling, and inadequacy in handling stress.

Trauma Informed Practice

Trauma informed practice focuses on a system of care to address the needs of traumatized clients. Trauma informed practice relies on basic assumptions of safety, trustworthiness, choice, collaboration, and empowerment within the practice of counseling and supervision. (Quiros & Berger, 2013).

Vicarious Trauma

Vicarious and secondary trauma in this study are used interchangeably and are defined as shared physiological and/or psychological distress as a result of an empathic connection that occurs due to knowledge of a client's trauma (Bell & Robinson III, 2013).

The following section introduces several theories that will inform the proposed study.

Cultural Trauma Theory

Freud proposed that trauma is the result of painful experiences that have not been fully integrated into the personality (Halberstadt, 1996). Cultural Trauma Theory originates from Freudian psychoanalysis but has progressed to include a more inclusive definition of trauma that acknowledges vicarious trauma. Trauma today is still defined as painful remembering of an experience (Visser, 2011) with the inclusion that trauma is not dependent on primary experiences alone (APA, 2013). The Diagnostic and Statistical Manual of Mental Disorders (APA, 2013) includes the diagnostic criteria for trauma which includes exposure to actual or threatened death. This exposure can result from direct experiences of the traumatic event leading to crisis, witnessing the traumatic events in person, learning of the traumatic event occurring to a close family member or friend, or experiencing first-hand repeated or extreme exposure to aversive details of the traumatic event (APA, 2013).

As counselors working with clients that have experienced trauma, they may themselves experience the negative emotions associated with the crisis. Knowledge and experience in both theories and the process of working with crisis counselors in

supervision is essential for the well-being of all parties involved including supervisors, counselors, and clients.

Multi-Cultural Supervision

A second theory that will be integrated and used in this research is multicultural theory of supervision. As supervisors need to be aware of counselor's and client's diversity, multicultural competence is critical in both the supervisory relationship and the supervisee's relationship with clients. Multicultural supervision involves awareness, knowledge and skills of appropriate interactions within the therapeutic and supervisory process and is a key component in effective psychotherapy training, clinical supervision, and cultural competency (Bernard & Goodyear, 2014).

Limitations and Delimitations

There are several limitations to this study including the possibility of sampling errors due to the qualitative design that will be used. The sample group that will be used in this study may not be an accurate representative of the population. Also, as supervision varies in style and complexity, the variation in theories and techniques used in the supervision process may affect transferability to other situations. A necessary delimitation is the researcher's attempt to limit the sampling to crisis counselors and supervisors.

Assumptions

Basic assumptions in this study are that all participants will be truthful in their reports and that analysis of the data are represented accurately. As the

researcher and coders are clinicians working in crisis settings, bracketing was used with the knowledge that attempts to eliminate researcher bias.

Organization of the Study

This study is divided into five chapters. Chapter I includes the background of the study, statement of the problem, purpose of the study, significance of the study, definition of terms, conceptual framework, research questions, limitations, delimitations, and assumptions of the study. Chapter II will present a review of the literature identifying past research on trauma and supervision. In Chapter III, The methodology is described including the research design, description of participants, data collection and analysis. Chapter IV will include the results of the study. Chapter V will summarize the results and include discussions as well implications and recommendations for future studies.

CHAPTER II

Review of the Literature

This review of the literature describes research that has focused on the supervision process for clinicians that work with crisis clients. In addition to discussing trauma and related issues (e.g., vicarious trauma, burnout, compassion fatigue, and PTSD) research pertaining to intimate partner violence (IPV), sexual assaults, wars, and terroristic threats also will be presented as they have been identified as high risk events that precipitates crisis and trauma. Of particular importance, this review will address supervision and supervision models including theory based, developmental, and process models. Trauma informed supervision, specifically with clinicians working in crisis and trauma settings will also be discussed.

Crisis and Trauma

Counselors and supervisors working in any setting will likely work with clients who are survivors of some form of crisis leading to trauma. Trauma is defined generally as some form of exposure to actual or threatened physical well-being (APA, 2013). In addition to domestic violence, sexual abuse, or random acts of violence, trauma can be precipitated by human created tragedies such as war and terrorist attacks. Furthermore, counselors may work with a variety of events including earthquakes, hurricanes, tsunamis, tornados, and various other natural disasters (Sommer, 2008). Counselors working in a domestic violence shelter, Veteran's Administration hospital, or any other agency that has a focus on crisis have an extremely high likelihood of working with clients with trauma related issues (Sommer, 2008). The following sections will focus on specific crisis that may lead to trauma including intimate partner violence, sexual

assaults, and wide scale natural impact events such as wars, terroristic threats, and natural disasters. Exposure to each or all of these experiences can produce post-trauma symptoms to varying degrees that disrupt clients' lives (Kessler et al., 1995).

Intimate Partner Violence

Intimate partner violence (IPV), commonly known as domestic violence, is the infliction of physical, sexual, or emotional harm to a current or former partner with the intent of establishing control (Centers for Disease Control and Prevention, 2005). IPV is a term that is used to describe violence between heterosexual couples as well as LGBT couples. The term *intimate* does not imply the necessity of sexual intimacy but also can occur in dating or marital relationships (Jackson-Cherry & Erford, 2014). IPV may include rape, physical violence, and/or stalking.

Intimate partner violence (IPV) is a major public health concern that affects both men and women. The Centers for Disease Control and Prevention (CDC) (2011) reported that approximately 18.3 % of women and 1.4% might recheck this percentages as the one for females seems very high and too low for men of men have experienced severe physical violence by an intimate partner. More than half (51.1%) of female victims of rape reported being raped by an intimate partner and 40.8% by an acquaintance. More than one third (35.6%) of all women and more than one quarter (28.5%) of all men in the United States have experienced rape, physical violence, and/ stalking by an intimate partner in their lifetime (Centers for Disease Control and Prevention, 2011).

IPV affects women and men in all racial ethnic, socioeconomic, and religious groups, but disproportionately affects women. Approximately 1 in 5 Black and White

(18.8%) and 1 in 7 Hispanic (14.6%) women in the United States have experienced rape at some time in their lives. Over 1 in 4 women who identified as American Indian or Alaska Native (26.9%) and 1 in 3 who identified as multiracial (33.5%) reported being a victim of rape in their lifetime (Centers for Disease Control and Prevention, 2011).

The physical, emotional, and social consequences of IPV have been well documented in the past. Nearly two million injuries and 1300 deaths can be attributed to IPV in the United States alone (Centers for Disease Control and Prevention, 2011). Men and women who experience IPV are more likely to report frequent headaches, chronic pain, difficulty sleeping, activity limitations, poor physical health, and poor mental health than men or women who did not experience these forms of violence (CDC, 2011). Women who experienced IPV are also more likely to report asthma, irritable bowel syndrome, and diabetes (Centers for Disease Control and Prevention, 2011).

Sexual Assaults

Sexual assault is defined as an attack or attempted attack involving unwanted sexual contact (Bureau of Justice Statistics, 2012). An attack does not have to be completed and can be either forcible or non-forcibly committed and still be considered and assault. Furthermore, cases where consent cannot be given due to intoxication, being mentally incapacitated, or below the age of legal consent, any sexual contact under these circumstances would also be considered sexual assault.

The DSM-5 (APA, 2013) includes four paraphilic disorders that fit the definition of sexual assault: frotteurism, pedophilia, sexual sadism, and voyeurism. Frotteurism is defined as the act of touching, fondling, or rubbing someone without their consent. Pedophilia is sexual focus and activity with a minor under the age of 16 by an adult at

least five years older than the victim. Sexual sadism is sexual excitement gained at the expense of another's mental or physical torment. The final disorder is voyeurism, the attainment of sexual satisfaction from observing others in the nude or in the act of intercourse.

The effects of sexual assault can be immediate and lasting. Burgess, a psychiatric nurse, and Holmstrong, a sociologist, conducted research with women who presented after having experienced a rape. They first coined the term *rape trauma syndrome* to describe the collection of symptoms reported (Burgess & Holmstrom, 1974). They described two distinct phases of women's response to sexual assault: the acute phase, and the reorganization phase. The acute phase can last from several days to multiple weeks and experiences a heightened level of stress. The reorganization phase was a long term process of integration where the victim regains a sense of control over life. Burgess and Holmstrom found symptoms in rape trauma syndrome to be consistent with post-traumatic stress disorder (PTSD). They found that victims experienced intrusive thoughts about the sexual assault, decreased involvement in their environment, sleep disturbances, hyper-vigilance, guilt, impaired memory, and fears about reoccurrence of the sexual assault.

Wars and Terroristic Threats

Following the attacks on September 11, 2001, the United States deployed over 2.1 million troops during Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Military service members of the Gulf War were exposed to a high degree of combat exposure resulting in increased risks of mental health problems (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Common diagnoses include post-traumatic

stress disorder (PTSD), depression, and suicidal ideation (Kieran, 2014; Kinney, 2012). Studies continue to show a steady increase in the rate of mental disorders in this population (Kang & Hyams, 2005; Kinney, 2012).

Within the U.S. Veterans Administration (VA), at least 121,130 of the 2.1 million troops who served in OEF and OIF between fiscal year 2002 and fiscal year 2010 had PTSD (Shiner, Drake, Watts, Desai, & Schnurr, 2012). Between 2001 and 2008 the rate diagnosis of PTSD had increased from 0.2% to 21.8% within the VA (Seal, Metzler, Gima, Bertenthal, Maguen, & Mannar, 2009). Continued multiple deployments and deployment intensity also increase the risk of developing PTSD (Shen, Arkes, & Pilgrim, 2009). Furthermore, the length of deployment, hostile environment, and unusual work demands for military personnel also contributes to high rates of co-occurring disorders (Hoge, 2011).

The rates of suicide has increased dramatically in numerous studies (Bruce, 2010). The VA has expanded its outreach programs and developed a system of suicide prevention coordinators for veterans (U. S. Department of Veterans Affairs, 2011). Suicide rates for service members however, continue to rise with at least 5% of all service members considering suicide and 2.2 % reporting attempting suicide in 2005 (Bray et al., 2009). The reported rate of suicide for OEF/OIF male veterans is 38.0 per 100,000 persons and 36.0 per 100,000 female veterans. The rates of suicide in the U. S. is significantly lower with 24.1 per 100,000 for men and 6.1 per 100,000 in women (Centers for Disease Control and Prevention, 2012).

Traumatization of Counselors

The focus on crisis based counseling has increased recently as counselors are increasingly called on to work with survivors of trauma (James & Gilliland, 2013). Situations that counselors commonly encounter include post-traumatic stress disorder (PTSD), sexual assault and other intimate partner violence, and school and workplace violence (James & Gilliland, 2013). Terroristic attacks, fires, floods, car accidents, and other crisis such as being in a war or disaster may also be a subject of trauma for clients. Personal disasters often include divorce, domestic violence, job loss, homelessness, and grief which may predicate trauma. Although counselors working with survivors of trauma are not directly experiencing trauma, the retelling of the trauma and its effects on the client may vicariously lead to adverse consequences (Abassary & Goodrich, 2014). Constant exposure to crisis and disaster based situations in clinical practice have been shown to lead to increased levels of stress, anxiety and trauma with clinicians. Continued exposure may lead to burnout, emotional fatigue, and vicarious trauma (Abassary & Goodrich, 2014).

Burnout

Burnout is defined as a persistent negative state of mind towards work (Thomas, Kohli & Jong, 2014). It is at least partially a result of stress due to continuous physical and emotional exhaustion. It often is a result of negative job attitudes, negative self-concept, and a loss of concern or feeling for clients and accompanied by distress, reduced effectiveness, decreased motivation, and dysfunctional attitudes and behaviors at work (Cahalane & Sites, 2008; Rosenberg & Pace, 2006).

Compassion Fatigue

Counselors that work with clients in crisis for prolonged periods of time also can be susceptible to emotional fatigue (Abassary & Goodrich, 2014). Emotional fatigue, sometimes termed compassion fatigue, can be identified by a loss of enjoyment in the profession, decreased sense of personal accomplishment, increased cynicism at work, physical and emotional exhaustion, and a loss in the ability to be empathetic towards clients (Mathieu, 2009). Compassion fatigue may also lead to high turnover rates and early departure from the field, as well as serious harm to the client or the therapeutic relationship (Simpson & Starkey, 2006). The loss of empathetic skills can lead to counselors minimizing client risk of underlying trauma that may be present. Counselor's engagement with secondary trauma can further lead to reactions such as countertransference. Emotional fatigue can occur with counselors and lead to a loss of emotional coping capacity (Abassary & Goodrich, 2014). Burnout and emotional fatigue are not the only dimensions of the dangers of vicarious trauma. Hearing client's story of trauma over long periods can also lead to changes in personal and professional identity and manifest as vicarious trauma (Culver, McKinney, & Paradise, 2011).

Vicarious Trauma

A number of terms have been used to describe the effects experienced by counselors who provide services to clients affected by traumatic stresses. McCann and Pearlman (1990) were the first to use the term vicarious traumatization (VT). Other researchers prefer the term secondary traumatic stress disorder (Catherall, 1999; Kassam-Adams, 1999). Regardless of the term, VT is a major concern for counselors and client's alike and needs to be continually examined.

Counselors exposed to extreme stressors are at a high risk of developing post-traumatic stress disorder (PTSD) (Galea, Nandi, & Vlahov, 2005). The Diagnostic and Statistical Manual of Mental Disorders (APA, 2013) defines PTSD as (a) persistent re-experiencing of the traumatic event in the form of flashbacks, dreams, and other unwanted recollections as well as persistent psychological or physiological distress with exposure to cues related to the trauma; (b) continued and persistent avoidance of stimuli or cues related to the traumatic event; and (c) persistent symptoms of increased arousal such as hyper-vigilance and amplified startle response.

Past literature examining vicarious trauma (VT) has presented conflicting results. Researchers have found inconsistencies in past literature which indicated that counselors with personal experiences of past trauma, higher caseloads, and fewer years of experiences are at higher risk of VT (Kassman-Adams, 1999; Way, VanDeusen, & Cottrell, 2007). Although most research has found negative effects of VT, psychological growth has also been found following vicarious exposure to trauma (Arnold, Calhoun, Tedeschi & Cann, 2005).

Anecdotal reports of vicarious trauma (VT) include symptoms synonymous with post-traumatic stress disorder (APA, 2013; Bride, 2007; Figley, 1995). Clinicians with vicarious trauma may also experience signs of depression, anxiety and other symptoms similar to that of the client (Culver, 2011). Symptoms may include sleep disturbance, intrusive images, and changes in core beliefs about trust, intimacy and control (McLean, Wade, & Encel, 2003). Clinicians with vicarious trauma may also develop a biased worldview and cause disruptions in personal and professional circles (Pearlman & Ian, 1995). Counselors working with domestic violence victims for instance, may begin to

assume that all intimate partners are violent. Further, counselors suffering from vicarious trauma may lack the empathic abilities necessary for therapeutic work (Dill, 2007). Also, defense mechanisms including numbing, avoidance and denial can interfere with the ability to build and maintain a therapeutic relationship (Jordan, 2010).

Traumatic Growth

Not all clients and counselors exposed to trauma experience the same effects. Although research literature has revealed counselors are at a risk of burnout, compassion fatigue, and vicarious trauma with symptoms similar to that of clients with PTSD, positive changes may come from these experiences. Clients who suffer from life threatening events such as the death of a loved one, physical ailments, and other life-threatening events may move towards a healthier attitude toward life, spiritual transcendence, and an appreciation of life (Calhoun & Tedeschi, 2013). Counselors may similarly experience a personal sense of meaning after working with those that have experienced hardships. Counselors may additionally gain sensitivity, compassion, insight, tolerance, and empathy (Tedeschi & Calhoun, 1996).

Organizational support including supervision has been shown to lessen the impact of indirect trauma (Brockhouse, Msetfi, Cohen, & Joseph, 2011, Collins, Coffey, & Morris, 2010). Multiple researchers have found collaborative supervision that addresses vicarious traumatization and a supportive work environment enhance counselors' abilities to cope (Brockhouse, Msetfi, Cohen & Joseph, 2011; Sommer, 2008).

In summary, trauma is a complex and serious matter that is increasingly becoming a cause of psychological and physiological concern. Intimate partner violence, sexual assaults, wars, violence, and natural disasters are common issues that may create

symptoms commonly associated with post-traumatic stress disorder. Counselors working with this population for extended periods of time without adequate support are at risk of vicarious trauma (VT).

Supervision

Supervision has traditionally been used in the healing professions as a method of transmitting knowledge and skills from experienced practitioners to students (Schulman, 2010). The supervisor typically offers feedback and guidance, evaluates, and models the process to allow the student or novice clinician to acquire skills in a safe environment where ethical and professional boundaries are maintained (Quiros, Kay, & Montijo, 2013). Supervision also allows the opportunity to examine the clinical growth of practitioners to enhance personal and professional growth and ensure competence (Berger & Quiros, 2014).

Supervision has been recognized by regulatory boards, professional credentialing groups, and accrediting bodies as a critical part of counselor training and is required part of the educational process (Berger & Quiros, 2014). Clinical supervision involves mentoring by a professional to integrate theory into practice, master clinical skills, and build a professional identity (Bernard & Goodyear, 2014; Todd & Storm, 2003). Professional entities such as the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) have established guidelines for preparation of counseling students through supervision. The American Counseling Association Code of Ethics also requires the integration of study and practice as counselor educators are required to establish education and training programs integrating academic and

supervised practice (ACA, 2014). Similarly most state licensing boards require up to 1800 hours of supervised practice prior to licensure (NBCC, 2014).

Supervision Models

Supervision models tend to follow counseling in terms of theoretical development, professional development, and key issues (Bernard & Goodyear, 2014). As counseling models are continually devised and older models refined, so are supervision models introduced and refined. I will attempt to describe in the next section, the most influential and widely used models of supervision. Supervision models include theory, developmental, and process models of supervision.

Psychodynamic Approach to Supervision

Clinical counseling supervision originated within psychoanalysis and developed as a continuation of training analysis (Bomba, 2011). Freud's psychodynamic conceptualization of personality and motivation includes the role of drives, emotional relations, pleasure principles, neurosis and dream analysis as well as a multitude of other theoretical conceptualizations. Although there are a myriad of therapies founded on psychodynamic principals, there appears to be two commonalities; the significance of the unconscious and the importance of the therapeutic process (Bomba, 2011).

Psychodynamic supervision, in its infancy, focused on the client (Bernard & Goodyear, 2014). Supervision was focused on the client's dynamics and the supervisor was an uninvolved expert in theories and techniques. Starting with Ekstein and Wallerstein (1972), psychodynamic supervisors gave more attention to the supervisory dynamics but continued to employ the supervisor as an uninvolved expert. A relational model of supervision was proposed by Sarnat in 1992 and further developed by Frawley-

O'Dea and Sarnet in 2001, ultimately leading to the practice of supervision that focuses on the supervisee relational process (Sarnet, 2012).

Frawley-O'Dea and Sarnat (2001) proposed three dimensions for psychodynamic supervision. The first dimension identifies the nature of the supervisory relationship in both the traditional practice as an uninvolved expert as well as the importance of the supervisory relationship itself. In the traditional role, the supervisor helps the supervisee understand the patient and identify the correct technique to use. The supervisor also is involved in the relational process and uses appropriate self-disclosure and open discussions of countertransference. The first dimension is based on the supervisor's focus. The supervisor can focus specifically on the client, the supervisor, or the relationship between supervisor and supervisee. Dimension three is the supervisor's primary mode of participation. Here the supervisor can take on different roles such as a teacher, reflector of affect, or asker of questions (Bernard & Goodyear, 2014). The inclusion of the importance of the supervisory relationship was a precursor to other forms of supervision including humanistic oriented supervision.

Humanistic Oriented Supervision

Supervision was identified as an integral aspect of training for Humanistic-Relational Oriented Supervision and its most notable theorist Carl Rogers. Rogers believed the conditions of genuineness, empathy, and warmth were necessary for both supervisees and clients (Rogers, 1942). Person centered supervision therefore, relies on the therapeutic alliance in the context of the relationship. The person centered supervisor trusts in the supervisees' ability and motivation to learn, grow, and explore both the therapeutic situation and themselves (Rogers, 1942). The supervisor takes a collaborative

stance, one that cultivates skills in use of counseling to support and encourage client's change (Farber, 2012).

Rogers was among the first to use accepted tools such as electronic recording devices and transcriptions in supervision (Bernard & Goodyear, 2014). Rogers concluded that students that had direct access to the content of their interviews could better identify their tendencies and allow supervisors to share advice or provide teaching. Furthermore, Rogers emphasized the importance of modeling during supervision, the attitudes towards human nature, change, and towards the self.

The impact of the client-centered approach to supervision was profound and has been combined with many different skills and techniques. The modalities and interview skill-building approaches developed by Rogers are still used in counseling training programs today. Procedures to teach attitudes and procedural skills have further been operationalized (Carhuff & Truax, 1965) and are taught within virtually all mental health training programs (Bernard & Goodyear, 2014). This blending of multiple theories and constructs continues with behavioral and cognitive theories.

Cognitive-Behavioral Model of Supervision

Cognitive Behavioral Supervision is based on three separate theories including behavioral, rational, and cognitive principles. Behavioral theories focus on classical and operant conditioning based on observed behaviors. Rational and cognitive therapies focus on modifying client's thoughts. The blending of these three theories, now commonly known as Cognitive Behavioral Therapies (CBT), is the most widely researched and developed theory of therapy and supervision (Milne, 2008; Milne, Aylott, Fitzpatrick, & Ellis, 2008; Reiser & Milne, 2012).

CBT is based on the assumption that all behaviors, both adaptive and maladaptive, are learned and based on irrational or unhelpful thoughts (Bernard & Goodyear, 2014). Negative emotions are the result of these unhelpful thoughts, and can be addressed as part of the supervision. Each supervision session has an agenda, and homework is assigned to focus on helping supervisees identify these assumptions. A common structure for CBT supervision includes checking-in, agenda setting, bridging from previous supervision session, review of homework, discussion of agenda, assigning of new homework, supervisory summary, and feedback from supervisee (Bernard & Goodyear, 2014).

In addition to changing negative or irrational thoughts through discussions and homework, CBT supervisors also often implement the use of recording devices (Newman, 2010). Supervisors can listen to all or part their supervisees' sessions to assess needs and decide on interventions. CBT supervisors therefore, are often involved in the dual role of teacher and supervisor. They are seen as at least partially responsible for supervisee training and are often seen as experts. They focus on the extent to which supervisees master techniques congruent with cognitive behavioral therapies.

Developmental Approaches to Supervision

The integrated developmental model (IDM) is the most widely used developmental model of supervision (Stoltenberg & McNeil, 2010). The IDM is an integration of Hogan's (1964) model of supervisee's progression in stages and Harvey, Hunt, and Shroeder's (1961) model of progression in levels (Stoltenberg, 2010). Stoltenberg's model purports that counselors develop in four stages, each of which consists of three levels, Awareness, Motivation, and Autonomy.

In the first stage, novice counselors focuses on their personal needs and on skills and interventions they are learning within the integrated developmental model (IDM). Most novice counselors are highly motivated and want to learn quickly to get past performance anxiety and evaluation apprehension (Stoltenberg & McNeill, 1997). Supervisors are often seen as experts during this stage while trainees will ask for advice and guidance.

As counselors acquire confidence, knowledge, skills, and experience, they will move onto the second stage of development (Stoltenberg & McNeill, 1997). Focus moves onto that of the client and they are able to more effectively empathize and conceptualize their clients' problems. Anxiety is lessened as novice clinicians gain confidence but motivation also decreases which may at times lead to ambivalence. At this stage, counselors also tend to shift between dependence and independence when working with supervisors.

The third and final stage of counselor development within the integrated IDM follows successful resolution of issues found in level one and two. Trainees in this level are confident, insightful and self-aware. They also can effectively empathize with and understand the client’s perspectives and needs. Supervisees in level three often exhibit a strong sense of autonomy as they have developed a strong professional identity. Supervision is less directive and more consultive in this stage. Level three therapists are able to utilize information presented by clients and provide effective responses in sessions based on theoretical and empirical information (Bernard & Goodyear, 2014).

Stoltenberg (2010) further identifies eight general domains that clinicians focus on as they transition from stage to stage within integrated developmental model. The

eight stages including intervention skills competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences, theoretical orientation, treatment goals and plans, and professional ethics are characterized. As beginner counselors gain competence of specific domains, they move to higher levels of competence.

Discrimination Model of Supervision

The final category of models of supervision is the process model. Process models focus on the supervision process itself whereas other models focus on either a theoretical approach or the learning process of the supervisee. These models emerged from the vantage point of supervision as an educational process and the process of a relationship. The Discrimination Model (DM), developed by Bernard (1979), is one of the most accessible and often the first model of clinical supervision supervisors encounter (Bernard & Goodyear, 2014).

The developmental model (DM) identifies three supervisory roles (teacher, counselor, and consultant) as well as three foci (intervention, conceptualization, personalization). Supervisors may work out of three separate roles depending on supervisees' needs, and respond in one of nine different ways (3 roles X 3 foci). The Teacher role is assumed when the supervisee needs structure and instruction, feedback, or modeling. The second role, the Counselor, provides opportunities to reflect and enhance understanding. Supervisors within the Consultant role assume a collegial position and provides an avenue to discuss ideas in an appropriate and professional manner (Bernard & Goodyear, 2014).

Supervisory roles are determined based on the supervisee's abilities and needs within one of three focus areas including intervention, conceptualization, and personalization. Supervisors during supervision can focus on any or all foci. Intervention is identified generally as observable behaviors provided during the counseling process and how well these interventions are delivered. Supervisors can also focus on conceptualization; that is how the supervisee understands the occurrence within the counseling session. Supervisees' counseling styles are taken into account and fit within the personalization focus. It is in this focus that personal issues and countertransference are processed.

Supervisors must be prepared to use all roles with supervisees at any level (Bernard, 1997). Supervisors, for instance, are more likely to use the teaching role with novice counselors and a consultant role with advanced practitioners. They are also likely to focus primarily on intervention and conceptualization skills. More experienced counselors would likely be expected to focus on personalization issues (Bernard & Goodyear, 2014).

In summary, supervision is an integral aspect of counselor training and development. Multiple models of supervision have been developed including theory, developmental, and process models of supervision. The most commonly used theories for supervision include psychodynamic, humanistic, and cognitive-behavioral models. Other models commonly used includes the IDM and the Discrimination Model within the field of clinical supervision (Stoltenberg, & McNeill, 1997; Stoltenberg, McNeill, & Delworth, 1998)

Crisis and Trauma Informed Supervision

Supervision of therapists working in specific areas such as trauma also has grown to focus on tasks associated with specific individual client issues (Lendrum & Syme, 2004; Roche, Todd, & O'Connor, 2007). As well, supervision has been recommended as a means of support and self-care for clinicians to mitigate the effects of secondary trauma and promote resilience (Brockhouse, Msetfi, Cohen, & Joseph, 2011; Collins, Coffey, & Morris, 2010; McAdams & Keener, 2008). Furthermore, supervision for trauma work has been shown to provide positive outcomes for clients and clinicians (Berger & Quiros, 2014). In this study, crisis supervision and trauma informed supervision will be used interchangeably.

Trauma informed supervision combines knowledge of supervision and trauma and the interrelationship between the counselor, the therapeutic relationship, and trauma (Etherington, 2009). Parallel to the principles of trauma informed counseling, safety, trustworthiness, choice, collaboration, and empowerment should be exercised in trauma informed supervision (Berger & Quiros, 2014). Safety must be attained not only in the physical sense, but also emotionally. Environments that are consistent and comfortable can contribute to supervisee's readiness to share trauma related information (Berger & Quiros, 2014). This level of comfort may also help build the therapeutic alliance with supervisors. Just as in in treatment of trauma survivors, supervisors must establish clear boundaries and expectations to instill trust so supervisees can share trauma related reactions and received feedback.

Choice, collaboration, and empowerment are also hallmarks of trauma-informed supervision. Choice and collaboration occurs as supervisors work with supervisees to

choose the most effective intervention. The collaborative relationship allows for knowledge and skills from both professionals are shared honored equally. Collaboration that leads to success and validation can further empower supervisees (Daniel & Quiros, 2010).

Emerging Research

The phenomenon of crisis supervision from the supervisor's perspective is not well understood. Although supervision have been shown to be an effective method of training, professional development, and well-being (Berger & Quiros, 2014), little research have been conducted to examine this experience. An extensive review of the literature found three studies specifically involving supervisors of clinicians in crisis settings. Of these three studies, two were focused entirely on supervisors and their perspectives and provides insight on the need for continued research in this field.

The first of the three studies found was a phenomenological study conducted by Dupre, Echterling, Meixner, Anderson, and Kietlty (2013) exploring supervision experiences in situations requiring crisis counseling. Thirteen counselor were selected (3 men, 10 women) and interviewed in two rounds of semi-structured, open-ended interviews that lasted approximately 60 minutes. Participants were asked to recall a single time in their career when they provided crisis counseling and to reflect on their experience of crisis supervision during the time. Five major themes emerged including: (1) counselors confront several types of crisis situations; (2) crises are clinically, systemically, and culturally complex; (3) counselors experience positive and negative outcomes from crisis counseling; (4) crisis supervision is essential, beneficial, and

potentially harmful; and (5) professional counselors want and need post-licensure clinical supervision.

The first of five themes reported by supervisees included the likelihood of multiple types of crisis situations including acute exacerbations of long-standing difficulties, behavioral emergencies, and unexpected tragic events. Long standing difficulties reported included struggles with "frustration, disappointment, and suicidal ideation" due to client's personal struggles. Behavioral emergencies include suicidal behavior, acts of violence, and interpersonal victimization. One client further reported having to deal with violent deaths of a student's parents.

The complexity of crises was the second major theme in this study (Dupre, Echterling, Meixner, Anderson, & Kietlty, 2013). All 13 counselors reported significant behavioral and psychological problems as well as challenging life circumstances. Cultural and linguistic issues were also major factors within the framework of clinical practice. One counselor in particular noted the difficulty in distinguishing "between the elements of culture, psychosis, and intoxication (pg. 88).

The third theme involved the impact of crisis counseling. Participants expressed intense feelings including fear, powerlessness, anger, resentment, envy, compassion, and shock when providing crisis counseling. When crises were extremely challenging, counselors reported high levels of stress, countertransference, vicarious trauma, destabilization, and symptoms of post-traumatic stress disorder. Three participants specifically reported high levels of anxiety, exaggerated startle response, and hyper-vigilance. This supports previous research that vicarious trauma may lead to symptoms congruent with post-traumatic stress disorder (Culver, McKinney, & Paradise, 2011).

They also reported positive feelings of compassion, optimism, gratitude, and joy when celebrating positive changes in therapy. These feelings are consistent with past research that vicarious exposure to trauma may have positive outcomes (Calhoun & Tedeschi, 2013).

The fourth theme was counselor's supervision experience during a crisis. Every participant reported the benefits of crisis supervision as an essential tool for success when working with crisis clients. This theme revealed supervisor's role as a guide, witness, and role model. Counselors used phrases such as "help me not get sucked in" and "walked through stuff with me" as well as "validate me." Crisis supervisors helped counselors normalize situations and offered practical advice and instill hope in supervisees. Effective supervision was reported by participants include immediate and specific feedback, clear guidance for dealing with the crisis, debriefing, and discussions on countertransference.

Not all participants reported positive supervisory experiences throughout the crisis however. Five participants reported no clinical supervision was provided during the crisis. Supervision itself was further reported by some participants as the cause of trauma leading to the counselor to have feelings of betrayal. One counselor described the supervision experience as "horrible."

The final theme identified the importance of clinical supervision even after licensure. All participants agreed that post-licensure supervision was beneficial and necessary. They noted that some may feel post-licensure supervision is a sign of incompetence or unrealistic. Although post-licensure supervision is not required, participants promoted the want and need for continued supervision. Counselors noted

that supervision "stretches me" and that it allows them to "be the best kind of counselor I can be."

The second study (West, 2010) was specifically focused on the perspectives of supervisors who were experienced in working with trauma in adulthood. This study was conducted in the United Kingdom and was published in the British Journal of Guidance and Counseling. A Delphi technique was used by West to identify supervision issues that requires attention in clinical supervision. As experts were needed, purposeful sampling was conducted which included provisions of at least five years' experience as a practitioner and two years' experience as a supervisor. Data was collected using three rounds of questionnaires emailed to respondents. Questionnaires were sent every four weeks and given two weeks to complete in order to mitigate fatigue. Fifteen counselors were identified to have met the criteria for participation and eleven agreed to participate in the study.

Three goals were identified for this study. First, the research aimed to elicit experienced supervisor' views of supervision for counselors working with trauma. Second, the research sought to identify themes and key concepts from views of a panel of experienced supervisors. Lastly, the researcher attempted to identify the main areas of consensus and contention among experienced supervisors when considering supervision issues for therapists working with trauma.

Data analysis included both qualitative (first and second questionnaire) and quantitative (third questionnaire) approaches. The primary purpose of the qualitative questionnaires was to identify themes consistently reported by the participants. Thirty-six themes emerged from 422 statements presented from the first two rounds of

questions. The main themes that emerged from data analysis that were identified as significant focused on training and experience of both supervisee and supervisor, the educational aspects of supervision and trauma intervention, the consideration of organizational factors, and the impact of trauma work on the supervisee.

The aim of the third questionnaire was to present a perspective of consensus and contention. The data was analyzed to produce statistical summaries of the mean and standard deviations for each of the 36 themes that emerged in addition to the minimum and maximum ranges for each question. Themes with a SD of less than 1.5 were seen as having the greatest consensus, and those with a SD of more than 3.0 was seen as having the most disagreement.

The themes of training, experience, and education when working with trauma appeared regularly throughout the questionnaire. Supervisors expressed the importance of assessing the experience and training of supervisees in the first meeting (SD = 1.08, mean = 9.00) and also of education as a function of supervision in order to ensure competence (SD = 1.48, mean = 8.43). They also expressed the importance of trauma specific training to protect clients (SD = 1.22, mean = 8.29). A link between VT and education was also found as supervisors felt a lack of training and experience may lead to disillusionment, burnout and VT. Furthermore, panel members felt it was essential for supervisors to have substantial knowledge and training in psychological trauma (Statements 29 b [SD = 1.40, mean = 9.21], 34 [SD = 1.54, mean = 8.93] and 34a [SD = 1.44, mean = 8.86]).

Knowledge and training were themes that emerged with supervisors. Specifically, knowledge about dissociation (SD = 0.67, mean = 8.93), physiological experiencing (SD

= 0.80, mean = 8.86) and arousal levels (SD = 1.12, mean = 8.50), and the body (SD = 2.02, mean = 8.21) were found to be integral to successful supervision. The development of knowledge and skills for both supervisees and supervisors and the commitment for continued professional development in general were emphasized.

Panel members also agreed on the importance of identifying counter-transference (SD = 0.81, mean = 8.71) or lack of involvement when supervising therapists working with trauma. The development of resiliency and management of their own fears when working with trauma to prevent negatively impacting clients was also of particular importance. The panel also identified that the awareness of parallel process (SD = 0.87, mean = 8.00) was important and could help with recognition for vicarious trauma.

Organizational issues were found to impact trauma work depending on the level of experience and awareness of trauma issues. Supervisors identified the importance of discussing with supervisees the possible impact of working with trauma and the possible impact in therapeutic work (SD = 0.53, mean = 9.43). Data also identified the importance of the organization's understanding of vicarious trauma and offer support (Statements 3d [SD = 1.57, mean = 8.93] and 25a [SD = 1.22, mean = 8.00]).

Supervisors in the study identified awareness and prevention of VT noted that VT should be a fundamental component of trauma counseling supervision. They felt the possibility of VT should be considered throughout each supervision session starting with the first meeting. There were polarizing opinions however on the need to know counselors' past history as personal history may affect supervisee's work and may lead to re-traumatization (SD = 4.26, mean =. 4.71). While some supervisors felt it was necessary to be aware of supervisees personal history (SD = 0.65, mean = 9.00), others

believed the emphasis should be on supervisee's awareness of their own issues (SD = 1.04, mean = 9.21).

The theme of maintaining balance also was found in the study for both supervisees and supervisors. Supervisors highlighted the importance of a balanced workload between trauma and non-trauma clients (SD = 1.96, mean = 8.00). Additionally, supervisors felt clinicians should have multiple resources on which they can rely (SD = 0.98, mean = 8.93). Lastly, participants felt supervisors should have a balance within the various functions of supervision including education, supportive and restorative functions (SD = 1.89, mean = 8.14).

The third study reviewed was conducted by Berger and Quiros (2016) who sought to identify best practices for training trauma-informed practitioners. This qualitative study consisted of semi-structured interviews with 12 masters level social workers. In this study, ten participants were reported to be female with eight white, two Latinas, and two black. Participants also reported to be working in community and hospital based agencies that serves clients with a myriad of traumatic issues.

The researchers identified three main themes including factors that shaped supervision for trauma-informed practice, challenges in providing trauma-informed practice, and perceived effective strategies in providing trauma-informed supervision. Each main theme were then factored into specific characteristics as described by the participants. Characteristics identified included personal as well as professional factors including cultural orientation, training, theoretical approach, perceptions of challenges and support, skills, personal traumatic experiences, history of the agency and in supervision, vicarious trauma, and clinical skills. What was also found to be especially

important was the degree in which the supervisees experienced the changes in their own worldviews following the traumatic experience of working with survivors of trauma.

Formal training and practical experience was identified as major factors in the shaping of trauma informed practice. Supervisors with familiarity with multiple models of trauma-informed practice tended to have higher quality of care for their supervisees. Furthermore, personal features including modesty, cultural humility, and acknowledgement of limitations were qualities that enhanced supervision.

The supervisory relationship was further identified as a critical factor in effective supervision in this setting. Trauma-informed supervisors were supportive and readily available and met with their supervisees consistently. They emphasized a balance of attentiveness, gentleness, supportiveness, and nurturing while challenging and encouraging personal growth.

The remaining factors identified include contextual aspects including the population served and agency variables. The degree of stigmatization including history of oppression and exposure to traumatic experiences affected supervision. Agency variables including the organizational structure, cultural, autonomy, conceptualization of services, and intervention model, and teamwork were also factors affecting supervision.

The second theme identified was divided into three challenges including complexity of client situations, involvement of clients, and resources limitations. Client's situations may involve nonclinical factors such as legal problems that disrupts the healing or teaching process. Client in these situations may not have the ability to be fully involved and immersed in clinical work further complicating treatment. Last, resource

limitations such as lack of funding to train or hire staff may lead to challenges in providing supervision for trauma informed practice.

The final major theme emerged as perceived effective strategies for providing supervision for trauma-informed practice. The authors reported that supervisors who encouraged supervises to be empowered through validation and allowing them to be active participants in the supervisory process led to effective sessions. Attending to the supervisor-supervisee relationship further enhanced supervision. Lastly, attending to parallel processes, emphasizing knowledge, and advocating self-care was also identified as effective strategies.

Summary

Clinical supervision is an essential component of professional practice and a method of choice for helping novice counselors acquire knowledge and skills (Berger & Quiros, 2014). Supervision impacts counselors' theoretical development, self-efficacy, and self-awareness within the helping professions and specifically within the counseling field. Trauma and is a field that specifically deals with crisis situations that may cause physiological and psychological harm to helping professionals through secondary trauma. Trauma informed supervision, specifically in crisis settings, has been overlooked by researchers in the past. In order to adequately train and protect current and future counselors, it is essential to understand the dynamics of trauma informed supervision. Increased knowledge and awareness of trauma informed supervision can enhance the abilities of practitioners to provide services and to decrease the risks for vicarious traumatization.

The purpose of this study is to explore the supervision experiences of supervisors of counselors working with crisis clients. Although the three major studies presented in this literature review have components that directly relate to supervision in crisis counseling, none are focused specifically on the supervisors' perspectives as they engage in clinical supervision with licensed professional counselors here in the United States. Dupre et al. (2013) study did focus on crisis supervision and identified some major themes. These issues identified in crisis counseling include the idea that counselors confront several types of clinically complex crisis situations that can both negatively and positively impact counselors. The authors also identified the benefits of trauma informed supervision as well as the need for post-licensure clinical supervision. West (2010) interviewed 11 clinical supervisors in the United Kingdom and identified several major themes. She first noted the importance of training, experience, and education and its impact on counselor efficacy and well-being. She also identified the role of the organization and its impact on vicarious trauma. Last she identified the importance of having a balanced workload that included crisis and non-crisis clinical work. Quiros and Berger (2016) conducted a qualitative study giving voice to masters level social workers and identified factors that shaped supervision including characteristics of supervisees, supervisors, and their relationship. Challenges identified were the complexity of the client situations, involvement of clients with other systems, and resource limitations. Effective strategies included empowering supervisees, attending to the supervisory relationship, ensuring safety, attending to parallel processes, emphasizing knowledge, and advocating for self-care.

Although all three studies focuses on clinical supervision, only West's (2014) and Quiros and Berger's (2016) studies focused specifically on clinical supervision from the supervisor's perspective. West's participants however, were sampled from the UK where training, licensure and cultural differences likely exist. Quiros and Berger's study were limited to masters level social workers and did not include any license professional counselors. The current study intends to help bridge the gap between the UK and the US as well as between masters level social workers and licensed professional counselors by identifying similarities and differences in the supervision experiences of trauma supervisors. This study will also add to the paucity of information on the major themes that are addressed in crisis supervision as well gain insight on supervisor's thoughts and ideas on the best practices for clinical crisis counseling, supervision, and self-care.

CHAPTER III

Methodology

The purpose of this study is to explore the lived experiences of supervisors of counselors working with clients experiencing trauma due to crisis. This study is designed to answer the research question, *What are the experiences of supervisors of counselors working with crisis clients?* A qualitative approach was used to address the experiences of supervisors working with clinicians in crisis settings. A transcendental phenomenological study was identified as an effective method of study as it describes the common meaning for several individuals of their lived experiences of the phenomena (Cresswell, 2014). In this chapter, the eight steps of transcendental phenomenological approach will be described, including determination of the research approach, phenomenon of interest, philosophical assumptions, data collection, questions, data analysis, textural and structural descriptions, and essence. The participant section immediately follows and addresses trustworthiness and credibility which includes sections on rich data, respondent validation, discrepant evidence, triangulation, numbers, and comparison. A chapter summary is also included.

Transcendental Phenomenology

A phenomenological study describes the common meaning in a person's lived experiences of a concept or a phenomenon (Creswell, 2013). Phenomenologists attempt to describe what all participants have in common as they experience a phenomena. Transcendental phenomenology approaches requires the researcher to take a fresh perspective “as if for the first time” (Moustakas, 1994).

Determination of the Research Approach

The first step for conducting phenomenological research is to determine if the research problem is best examined using a phenomenological approach. Creswell (2013) notes that a phenomenological approach is best used when it is important to understand several individuals' common experiences. As this research attempts to understand the experience of supervision of clinicians that work in crisis and trauma settings, this approach is well suited to answer the research question.

The researcher interviewed multiple individuals that are currently employed in a supervisory position in a trauma setting. Although each setting may have unique problems and procedures that requires the use of different supervisory techniques and skills, they likely will also have a common experience of supervision and trauma. That is, all participants will be focused on the experience of supervision of counselors who work in crisis or trauma settings.

Phenomenon of Interest

Identification of the phenomena of interest is the second step identified in a phenomenology study. The phenomenon of interest in this study is supervision. Specifically, the researcher is interested in the experiences of supervision of clinicians working with crisis or trauma clients as experienced from the supervisors' perspective.

Philosophical Assumptions

The primary assumption of a transcendental phenomenological study is the researcher's influence on the study. Transcendental means "to perceive freshly, as if for the first time" (Moustakas, 1994). This practice of suspending all judgments is commonly termed *bracketing* or *epoche* (Creswell, 2013). By setting aside any

preconceived biases, values or judgments about supervision or crisis, the researcher will be better able to examine that phenomena as if for the first time. As the primary researcher as well as the two coders are licensed clinicians who primarily works with trauma clients in crisis environments, past experiences and presuppositions must be suspended in order to achieve a fresh perspective. In order to mediate the human element of the researcher, a rigorous investigation of the self will be applied to data gathered during orientation as well as prior to data analysis by all coders.

Data Collection

A semi-structured interview was conducted for each participant in a natural setting as agreed upon by the participant and investigator. Interviews were completed face-to-face as researchers agree this is a desirable method of data collection in qualitative research (Creswell, 2013; Maxwell, 2013). Data were collected through multiple sources including a demographics questionnaire, individual semi-structured interviews, and direct observations. The demographics questionnaire included age, gender, race/ethnicity, type crisis center/setting currently employed, number of years in the supervisory role, and the percentage of time the clinicians they supervise perform in crisis situations. To ensure anonymity, the demographic questionnaire also included a space for a pseudonym to be used during the interview. All interviews were recorded on a digital recording device to assist with the transcription process. Audio recordings were then transferred onto a password protected computer in a separate folder. Any identifying information have been deleted from transcriptions and only pseudonyms will be used.

Grand Tour Questions

Following consent and the completion of a short demographics form, five open ended questions were asked to examine the supervisor's experiences. All questions are grounded in past literature reviewed on the topics of counseling, supervision, and trauma work as well as the primary investigator's experience working in crisis (Dupre, Echterling, Meixner, Anderson, & Kietlty, 2013; Quiros & Berger, 2016; Tran & Henriksen, 2016; West, 2014). Grand tour questions were further developed to identify specific areas of supervision including educational components, relevant topics in supervision, and self-care practices. These questions were included to help facilitate identification of the overall experience of supervision of crisis counselors. Follow up questions to the grand tour questions were asked to obtain additional clarity. Shiva's circle of constructivist inquiry developed by Crabtree and Miller (1992) will be used to guide the cycle of inquiry. Although Moustakas (1994) identifies only two grand tour questions, I have included three additional questions as they help to provide an understanding of the common experiences of the participants. The grand tour questions include 1) *What training or preparation did you have prior to obtaining this position? 2) What have you experienced in terms of supervision of clinicians working in this setting? 3) What situations have typically influenced or affected your experiences in supervision? 4) How has working in this setting affected or changed you? 5) What do you do for self-care as a supervisor?*

Data Analysis

A modified approach of the Stevick-Colaizzi-Keen method by Moustakas will be used for data analysis (1994). Data was first recorded on a digital device

and stored in a password protected file. The interview was then transcribed verbatim and grouped into themes by each individual coder. The statements were then clustered into themes or *meaning units*. Quotes that help to provide an understanding of the experience are identified in a step called *horizontalization* (Moustakas, 1994). A textural and structural description including the quoted words of the participants can then be developed. Bracketing, the process of putting aside one's own beliefs (Creswell, 2013) about the phenomenon was employed in order to ensure validity of the study. Specific steps to analyze the data and ensure validation are described below.

Data analysis was completed by a coding team. The team consisted of the primary investigator and two additional coders for the purpose of inter-rater reliability and accurateness of analysis. An orientation of both volunteers were conducted prior to coding. During orientation, the coders were instructed to bracket their experiences as mental health clinicians. The first coder and primary investigator identifies as a doctoral candidate, licensed professional counselor, and licensed chemical dependency counselor working in a crisis residential program. He also has experience working in forensics as well as psychiatric emergency settings. The second coder is a licensed professional counselor as well as a licensed marriage therapist. Although she does not currently supervise or work in crisis settings, she identified as a doctoral candidate with prior experience as a crisis clinician in a psychiatric hospital. The third coder is a masters level clinical social worker who works in a residential crisis treatment facility. She also has a history of working in multiple crisis settings.

The practice of using a semi-structured interview with a set of open-ended leading questions focused on the research aim was employed as suggested by researchers (Chan,

Fung & Chien, 2013). The semi-structured interview included probing follow up questions as to allow participants to freely describe their experiences and allow potential new rich data to be acquired (Chan, Fung & Chien, 2013). This helps to bracket the interviewer's past experiences from influencing the data.

Strategies for bracketing during data analysis were also completed. Prior to analyzing the data, all three coders assessed their own world views on crisis supervision. The coder's thoughts, opinions, and knowledge of the phenomena of crisis supervision were discussed. All coders identified being in crisis in the past and have had effective and ineffective supervision. Furthermore, the primary investigator is a licensed professional supervisor currently working as a crisis clinician as well as is supervising masters level students. Once possible biases were identified and discussed, each coder then agreed to adopt an attitude of curiosity and philosophy of objectiveness as if we were hearing and experiencing supervision of crisis clinicians as if for the first time.

Specific instructions were given during orientation to highlight and record on a chart relevant statements made by participant from each interview. These statements were then clustered into themes by each coder individually. Overarching themes were then reported and compared with all coders and discussed to ensure a textural and structural understanding of the experience. This process was repeated for each participant and their verbatim transcription.

Textural and Structural Descriptions

Following data collection and initial data analysis where the themes, or "textural description" were formed, a description of the context (structural

description) or setting is also created. A summary of themes, that is the structural and textural descriptions, were reviewed by each participant for the purpose of member checking (Creswell, 2013) to ensure the analysis is representative of the participants' experiences. All nine participants agreed with the analysis of the data; however one participant pointed out that a particular statement identified could be taken out of context and construed. The primary investigator noted the participant's meaning and reworded the statement to better reflect the actual meaning. Specifically, the statement "Common crisis factors include deaths by homicide and suicide or car accidents." Was changed to "Some crisis events encountered by staff may include deaths by homicide, suicide or car accidents."

Major overarching themes were determined by a majority. That is, only themes identified by the majority of participants were included as an overarching theme. As there were nine participants, at least five of nine participants must have identified the topic in order to be included as a major theme. Additional notable themes will be discussed in discussions following data analysis.

Essence

A textural-structural description of the meanings provide an understanding of the experiences of the participants related to the phenomenon of crisis supervision (Moustakas, 1994). From the structural and textural descriptions, the essence of the phenomenon is created. This passage, or essence, identifies the common experiences of the participants. The underlying structure of the common experiences should allow the reader to better understand the experience of supervision of crisis clinicians.

Participants

Upon approval of the Institutional Review Board (IRB), the primary investigator identified potential participants from a list of available mental health providers found in the greater Houston Area. Eligible crisis providers included any rape/trauma/crisis care centers and psychiatric hospitals as well as public and private entities.

The researcher contacted potential participants by telephone and email to request participation. All participants were voluntary and were informed of ability to request to withdraw from the study at any time. Purposeful sampling was administered as this study is focused on crisis supervisors. Maxwell (2013) identifies three main goals for purposeful sampling that meets the criteria for this study. The primary goal of purposeful sampling is to achieve representativeness of the setting, individuals, or activities selected. As this study is directly related to counselor supervisors or clinicians that work with trauma or crisis settings, each participant in the study must fit this specific criteria. Only if the criteria of being a supervisor that provides supervision for trauma or crisis counselors are met will the data accurately represent the set guidelines.

The second goal of purposeful sampling is to establish a comparison to illuminate differences between settings or individuals. Although all participants are counselor supervisors, they practice in a myriad of settings. Because there may be differences in settings, any similarities between responses of participants promotes credibility.

The last goal that purposeful sampling can achieve is that only this method of selection will allow the research question to be answered accurately. The research question is focused specifically on counselor supervisors working with trauma clinicians. For the purpose of this study, participants must provide supervision for counselors that have at least one year of supervision experience and must provide supervision for crisis situations at least 50% of the time.

Between 3 and 25 participants were used as suggested by researchers (Creswell, 2013; Polkinghorne, 1989) in a phenomenological study. The number of participants will be determined by saturation; that is, when new data does not lead to additional information. In order to achieve the desired number of participants, the researcher asked potential participants to help with the recruitment process in a method known as snowballing.

Data was collected through multiple instruments during the initial contact and during the informal interview. Following identification of possible participation in this study, the primary investigator contacted each volunteer in person or by phone in order to identify eligibility of criteria for participation. During that interview, three questions were asked including a) Do you supervise counselors that work with crisis clients? B) Does at least half of the counselors you supervise work in crisis situations? C) Are you willing to consent to this research study? In order to ensure anonymity and confidentiality, participants were asked to use a pseudonym which was recorded in the demographics form.

Individuals that met the criteria for participation were met at a location mutually agreed upon by the participant and primary investigator. During this interview, the

Consent for Participation in Research was reviewed in detail. Individuals that agreed to participate in the study signed and was given a copy of the consent. Following consent, a short demographics form that included a request for a pseudonym to be used during the interview to ensure confidentiality was completed. Demographics information on the form included age, gender, race/ethnicity, setting of counseling work provided, years of experience as a supervisor, and approximate percentage of crisis counselors participants currently supervised. All demographics questions were write-ins except for the last question where the approximate percentage of crisis supervisees were identified by circling a range of options from 10%-100% with intervals of ten percent each. Following completion of the demographics form, the primary investigator asked five grand tour questions which may also include a number of follow-up questions to further analyze the experience of supervision.

Trustworthiness and Credibility

Within the qualitative context, the terms credibility and trustworthiness have been used as equivalents to internal and external validation, reliability, and objectivity in quantitative studies (Maxwell, 2013). Validation in qualitative research is identified by researchers as an attempt to assess accuracy of findings (Creswell, 2013; Maxwell, 2013). The term validation is used by these authors to emphasize a process rather than a method of verification of truth.

The researcher is a direct participant in this study and has been described as an integral component for data collection (Creswell, 2013). Researcher bias may threaten trustworthiness and credibility of qualitative studies (Miles &

Huberman, 1994) by unwillingly or unknowingly selecting data that fits into their existing theories, goals, or preconceptions. The investigator's influence on the setting or participant, also known as reactivity, can further influence validity of studies. For this reason, researchers suggest using multiple validation techniques in qualitative research to establish trustworthiness (Creswell, 2013; Marshall & Rossman, 2011).

Maxwell (2013) identifies eight strategies to increase credibility of phenomenological studies. This study will integrate six of the eight strategies to help ensure credibility and trustworthiness of the data. The remaining two strategies, intensive long term involvement and interventions will not be implemented as only one interview will be conducted and no interventions will be used in this study. The six strategies are discussed below.

Rich Data

Intensive interviews gathering detailed data from interviews can provide full and revealing information from participants (Maxwell, 2013). Obtaining this rich data will help to ensure that the words and meanings of the participants are accurate. Verbatim transcripts were obtained from the interviews and noted to search for richness in this study. Using the participants' statements helps to provide a full and revealing picture to ensure that the clients' experiences are accurately represented. In addition to the participants' statements, direct observation will also provide rich data. Concrete events that are observed by the researcher were noted and provides context or significance. Providing detailed statements and observations of the participants further helps to increase the credibility of the data.

Respondent Validation

Ensuring the actions and words of the participants are recorded and interpreted accurately is a fundamental necessity for qualitative research. One of the most effective methods of ensuring accuracy is through respondent validation, or member checks (Maxwell, 2013). The researcher contacted each participant and solicited feedback about the data collected. The conclusions formulated by the investigator was confirmed as accurate by participants in this study. This helped to eliminate the possibility of misinterpretation and ensure the perspectives of the participants are accurately represented. Respondent validation further helped the researcher identify biases and misunderstanding of what was observed during the interviews (Maxwell, 2013).

Discrepant Evidence

Identifying and analyzing discrepant data is a vital part of qualitative research (Maxwell, 2013). Participants' reports that are not easily accounted for or explained must be analyzed to determine if there are flaws in the interpretation or method. Examination of both supporting and discrepant data can help validate the conclusions established from the data. Any discrepant data will be addressed and reported in this study.

Triangulation

Triangulation is the process of collecting information from a diverse range of individuals and settings using multiple methods (Maxwell, 2013). This strategy helps to reduce the risk of biases and promote credibility. Triangulation in this study will be established through the use of multiple sources as well as

multiple coders. Triangulation of individuals include using multiple coders to identify clusters of meanings and themes form the transcriptions. The use of participants from multiple settings and backgrounds including hospitals, jails, private practice, agency and community settings will further to promote validity of the study. Triangulation of sources include obtaining information through interviews, demographic questions, and direct observations.

Numbers

The use of numbers in qualitative research can help to validate conclusions as well as provide credibility to data collected (Maxwell, 2013). Participant's reports that are prevalent will be reported to help bring credibility to the theme or behaviors present. Ideas and statements that are rare will be also be reported as discrepant data. Further, Quasi-statistics was also used to report demographic information from the participants including age, gender, race/ethnicity, and number of years in the supervisory role. Quasi-statistical analysis, sometimes called manifest content analysis, allows the investigator to search for themes specified following transcription.

Comparison

The participants may provide supervision in various settings including hospitals, clinics, educational settings, or private practices. Similarities and differences in each setting will be compared as it may affect the overall experience of supervision. Furthermore, the type of crisis clinician's deal with may also influence the supervisory experience. These differences must also be taken into account and reported in the study. Last, the personal supervision styles of each supervisor will be compared. Any

similarities across these settings provides credibility to the conclusions drawn from the data.

Summary

In summary, a transcendental phenomenological approach was determined as the best research approach for this study as it allows the researcher to understand several individuals' common experiences. This approach allowed the researcher to explore and understand the experience of supervision of clinicians who work in crisis and trauma settings. Participation selection was discussed which includes the method of sampling and target population. Data were collected through multiple sources including a demographics questionnaire, individual semi-structured interviews, and direct observations. Data analysis was conducted through a modified version of the Stevick-Colaizzi-Keen method to find themes following verbatim transcription of the interviews. The essence of the phenomenon was created following exploration of the themes to explore the experience of supervision of crisis clinicians. The results of the analysis is provided in Chapter IV. The conclusion, implications, and future research suggestions are presented in Chapter V.

CHAPTER IV

Results

In this study, nine participants were included although saturation was found after four interviews and data analysis. That is, no new meaningful themes were identified outside of the overarching themes already found. As the primary investigator wanted to include data from multiple sources and settings, interviews continued until nine were completed.

The interviews conducted for this study ranged from twenty eight minutes and thirty eight seconds to forty five minutes and twenty three seconds in length (M = 00:42.32). All interviews were recorded on a digital recorder and transcribed by the primary investigator. All digital recordings were kept on a password protected file on a computer and transcripts were also kept separately from the audio recording except when used to verify accuracy of the transcriptions. Eight females and one male with ages ranging from thirty two years of age and fifty seven years of age (M = 42.66) met the criteria set forth by the primary investigator. Seven participants identified as being “W” or “White” and two identified as being “AA” or “African American.” Seven participants holds licensure as a professional counselor (LPC) and two holds licensure as master in social workers. Participants verbalized between 3 to twenty years supervision experience. Five participants reported that 100 percent of masters level supervisees they supervise works with crisis clients and four participants reported 90 percent of their masters level supervisees work with crisis clients. Settings were described by participants as field/community based (5), private practice (1), residential (1), forensics (1), and Mental Health Crisis Service (1).

Following analysis of the data, nine overarching themes were identified that answered the research question, *What are the experiences of supervisors of counselors working with crisis clients.* The following five grand tour questions were used to help facilitate identification of the experience of supervision of crisis counselors. 1) *What training or preparation did you have prior to obtaining this position? 2) What have you experienced in terms of supervision of clinicians working in this setting? 3) What situations have typically influenced or affected your experiences in supervision? 4) How has working in this setting affected or changed you? 5) What do you do for self-care as a supervisor?* From the statements found in the transcription to be relevant by the coders, nine themes were identified including: Learning the job, Crisis topics, Effective communication, Skills development, Maintaining flexibility, Setting boundaries, Maintaining support, Stress, burnout and self-Care, and Balance.

Learning the Job

Learning the job was the most prominent theme identified by all nine (of nine) participants. All participants reported that they had received some formal training through academic work, conferences, and trainings in subjects such as leadership, safety, and documentation. Five of the interviewers reported that they held supervisory positions and had practical experience supervising clinicians prior to working in their current position. The remaining four participants identified this as their first supervisory position. All participants however specifically shared that they had to continue learning and refining their supervisory skills through the experience of supervision as well as ongoing and continuing education.

A participant who identified herself as Care Coordinator" shared:

> "I have been in the mental health field for 24 years and so the first 10-12 of them, I just worked my way up through. I've worked in residential dual diagnosis programs, in a field based clinical setting, I've worked for mobile crisis outreach teams and until I finished graduate school, I was working in case management type jobs. I feel like I was in the trenches and understand how it is. I…take different things from supervisors that I really valued and carried that into when I got my first supervisory job…It's always a learning experience. No matter how many years you have you're always going to learn something new in this kind of service."

Kelly, a supervisor who works in a crisis residential program, adds the importance of having to learn on the job due the demands of crisis work. Although she reported having ten years of experience supervising, she identifies the ongoing challenges of supervision.

> "So working in a crisis field, things come up that you can't train for. Some of the things that happens I can't always show you so with that, whenever someone experiences one of those things, then it always becomes a different training."

Dot, a supervisor in private practice shares her method of gaining and imparting knowledge to her supervisees. She states,

> "I love training. I love conferences. For me, that's the only way you stay relevant and knowledgeable as a counselor. I feel as a supervisor I can't teach them anything that I don't know; so it's mandatory that I go so I can then share with them."

Lilly shared her training experiences in multiple aspects of supervision.

> "I have been supervising in the mental health field for ten years now. A lot of agency provided training, a lot of conflict resolution training, and a lot of human resources type of oriented training focused on being able to work with people from many diverse type of backgrounds; and more importantly being in a supervisory role, being able to lead individuals who can be quite different from you…And then on my personal side, just my curiosity. Just a lot of informal reading about management, about debriefing. I read quite a lot and I continue to read quite a lot about how do you help a clinician who provide direct care contact. How do you help them process it at the end of the day…Trauma informed type care when it comes to self-care. Lots and lots of training on self-care."

Crisis Topics

Crisis supervisors experience a myriad of situations on a daily basis. All participants (nine of nine) identified suicidal ideation or other forms of self-harm, homicidal ideation, psychosis, and substance abuse as common crisis topics in supervision. At times, personal issues such as familial or interpersonal and relational difficulties may also be the cause of stress and requires supervisory support. Clinical supervisors provide training with skills development in counseling, conceptualization, and assessment skills as well as interpret guidelines and help set boundaries in critical issues for their supervisees. Supervisors may also be asked to advocate for their supervisees.

When asked to describe concerns brought up by crisis counselors during supervision, Belle states

> "Somebody who's suicidal with a plan, homicidal with a plan, who is hearing voices and are going into psychosis that are actively directing them to hurt themselves or somebody else. Severe anxiety where they feel they cannot be left alone. Possibly severe alcoholism, you know where we may have to intervene and call the police of the ambulance. What it comes down to is if the person is safe and not leaving them where they are. When they (supervisees) get crisis calls, they staff those cases with us and we help them determine what hospitals they go to, or if they need to go to a hospital. We also coordinate if our doctors can see them because our goals are to avoid hospitalizations or jails so if we can get them in then we could reduce the time they are in crisis. We'll see if they can use some coping skills so that they don't need to go. A lot of them (supervisees) come with substance abuse problems. I enjoy it but some of them will be very frustrated with it."

Kelly shared how crisis work, specifically trauma, is experienced in supervision.

> "Suicide, that's always something that's discussed. Trauma, that's a big issue that we need to stay on top of; especially second hand trauma that my therapists and my masters level people goes through. And that's when it comes to those supervision sessions turns into counseling sessions. Sometimes that opens up old wounds for them, but there are lots of trauma that our clients goes through that they have to deal with. So those are the three big things. Suicidal ideation or attempts, trauma, and substance use."

Care Coordinator also identified crisis situations that may include events such as deaths by homicide, suicide, or car accidents. She further added that personal issues may confound the dangers of working in crisis settings.

> "Staff has to drive their own cars and they have to drive people in their cars and so staff sometimes have difficulties with that. They have their own lives, their own issues, and cars they have to maintain, their family to worry about… Some people are single parents so if a child is sick or if there is a problem there may not be anyone to take care of them. They're trying not to disappoint the people they're working with."

Lilly shares her focus on helping her supervisees process crisis work to help mitigate the effects of vicarious trauma.

> "You hear a lot of sad stories about a lot of broken lives and as a person, clinician, individual, you have to be able to process that at the end of the day. So sometimes as a supervisor, I get to do a lot of the processing piece. Helping kinda figure out how does this patient fit into this conceptualization that you've provided me and how do you make sense out of them and what was the process like for you. Kinda like checking in and making sure the clinicians are OK…A lot of times when you supervise with clinicians in a crisis setting, you have to debrief them. Depending on the type of work they do, the kind of experiences they have, on a daily basis based on their patient contact…How do you teach your employees what self-care is and how does it apply to their setting?"

Dot shares the challenges of supervising crisis counselors with the focus on advocating for and teaching her interns to advocate for themselves.

> "Right now I have seven (supervisees), and of the seven, six work in psychiatric hospital settings and one work in an outpatient clinic. In a psychiatric hospital, all kinds of stuff comes up. Of course you have suicidality of clients that often comes in that are highly acute. One of the big things we deal with though, and this has been repeatedly is, facility management issues that impact their work. For example, you'll have directors of programs that does the scheduling…you have a unit that have 25 clients and you've got one therapist on a weekend that's supposed to run four to five groups, do individual therapy, do family therapy, and do patient family orientation, and do notes. It is impossible. And you've got somebody that's suicidal on the unit…I've had to advocate for my supervisees and teach them how to advocate for themselves."

Effective Communication

Participants (5 of 9) identified effective and empathetic communication as critical to crisis supervision. The stress of crisis work may lead crisis clinicians to require some additional support. Support may come in multiple forms including consultations, guidance, suggestions, and at times, counseling. Supervisors who are able to overcome differences in communication styles due to age differences as well as cultural differences appear to identify with successful supervision

Anne Mayer stated,

> "Our staff has changed. Millennials working…it's a different culture from when I was coming up…it's been a learning experience for both of us…Communication

style to me are very different. You know, come sit and talk to me. No they want to text you. They want to email you. No come sit down and talk to me. So that's been a struggle with them."

When asked about strategies to help bridging the communication gap, Anne Mayer shares,

"Well, (I) just try to understand when they don't want to come in here and talk to me, it's not a personal thing, it's the way they communicate. It's just their style and culture. It's not that I don't want to see you. I'm afraid of you or anything like that; just adapting my understanding."

Salted Caramel states,

"Our team meets every other week for staffing so we kind of give them an opportunity to discuss whatever they need in a team or a group setting. And then me plus my supervisor, the program director, we both have an anytime you need to talk policy. Whether its call us, show up, I don't care what time of day or night it is. Let us know so that we can help you and support you…If they need an hour, they get an hour. If they need two hours they get two hours. Sometimes they just need to vent and get it out and have someone that understand and just listen. And maybe sometimes I add a little bit of guidance and suggestions."

Hillary shared that to be an effective supervisor, one must "be someone they can talk to. Because you go through a lot of stuff so if your door is always closed, it's a problem. So be available."

Cormac McCarthy shares

> "I think I've always responded well to people who are willing to talk about a situation and not direct me what to do. I feel like when we discuss a situation as opposed to it being a one sided situation its more productive. We both come up with better ideas and how to resolve it. And it didn't feel so much as they're just telling me to do something or just do your job as opposed to actually feeling like a collaboration between the two of us and we were able to reach a better understanding to resolve the situation. So that's something I always try to utilize. Listen to what other people have to say; respect their input. Certainly I have my own view of how to do something but so do they; and theirs is just as valuable. They're educated and licensed people so there's no reason to feel like my opinion and my direction is the only way to do it. I think it's much healthier to have both people involved come up with a resolution."

Skills Development

Development of counseling skills during supervision was also a commonality among the participants (5 of 9). Identifying symptoms, conceptualization, and particularly important was documentation. Belle states that in supervision, "Our LPCs have me and I meet with them at least once a month…Sometimes they need more help with documentation…"

Lilly identifies specific deficits her interns face.

> "I work with a lot of clinicians who are working on obtaining their full license, so provisionally licensed staff. So a lot of times just basic educational components may pop up. A lot of teaching (of) how to clinically document, how to be able to

identify symptoms and how it leads and connects to documentation, treatment planning, that kind of thing. So lots of the logistical and educational piece of what each notes needs to have and how do you need to conceptualize and document it."

Cormac McCarthy adds the importance of consultation of specific cases as well as helping his interns with assessment and diagnosis skills.

" Most of the time it's just addressing particulars of cases. There are certain issues with the case they may come to me for clarification or making a diagnosis or something like that. Sometimes just staffing a case, just to see what direction they should go in; to see if it's somebody that's appropriate for this program."

Although the majority of Salted Caramel's supervisees are "seasoned," she shared that she has to provide assessment training for her clinicians.

"We took a chance and we did hire a very green person and um, I have had to do a lot of training and we've had to have a lot of conversations that I haven't necessarily have had to have with other people… Sometimes you have to dig deeper to know what going on and when it's appropriate to get police involved; when it's appropriate to bring someone to the hospital versus just talk about it for an hour."

Hillary shared how training can be conducted with multiple aspects and can be accomplished in multiple methods.

"We do a lot of specific skills development. So right now, one issue for example is we're focusing on is safety planning…We've always been ok, pretty good at safety planning but based on some really highly validated cases that's come

through recently, we wanted the team to feel empowered and the team has every available piece of information so that they know how to do safety planning effectively, especially within our unit. So we changed some communication software. We've created some really nice face to face groups, mini trainings that we're getting ready to start right now."

Maintaining Flexibility

Being flexible was a factor that showed up in 5 of 9 interviews. Supervisors identified that individual crisis counselors have a myriad of needs. Some require constant supervision and come in as interns. Others are more seasoned but continue to require support. Individual needs and different levels of support requires supervisors to be extremely flexible.

Lilly shared the importance of diversity and flexibility when supervising crisis counselors

> "You have to be able to be very diversified in your approach. People are different and everybody has different styles; everybody has different approaches. So if you're trying to make your supervisory approach fit every employee you may have some difficulty with that. So a lot of patience, a lot of willingness to kinda change your own approach to fit that employee so that they can hopefully get the best out of whatever you're trying to teach, or help them improve, or help them process. So in a sense you have to be willing to change when you supervise individuals. Cause if you get stuck in your ways and it may not fit all the employees that you have. It just doesn't work. People will either not do a good job or people will end up leaving."

Kelly K also identified flexibility as essential to being successful in crisis work.

> Being flexible. Flexibility. Being open to constructive criticism. Being adaptable to change. Those are some key things that I notice those people last longer. If you have someone that's very structured, sometimes it a little hard because with crisis, things changes every day. You come in, you have your schedule set, you know what you're going to do and you get here and gosh dern it, nothing goes the way its supposed to. So having someone that comes in very open minded. I want you to have your skeleton schedule laid out… but you have to be open to change because it changes quick."

Due to the constant changes and challenges in her setting, Hillary shared the importance of flexibility and the ability to think critically in order to make sounds decisions in crisis work.

> "We talk about flexibility, we talk about being laid back…We talk about needing to have good critical thinking skills and we talk about people who don't need everything to be specific. I hate saying it but it's not black or white. You know things are not black or white here, everything is gray, you have to decide. You can have 20 different people that you talk to and have 20 different ways that people present and there is no script. There is no template. You just have to figure it out."

Supervisors that are forced to be rigid in their treatment can lead to ineffective work and lead to burnout. Belle describes her experiences in her past and current position.

> "What kept me in the crisis realm is that we get to be creative here. (In my previous position) I couldn't be as creative as the curriculum would let me and

> that was frustrating. I see the clinicians being frustrated as I was as a supervisor as well…The demand and intensity of that increases the clinician's ability to learn."

Anne Mayer spoke about embracing change as the workforce changes. She identifies the challenges she faces but also realizes the strength that younger crisis counselors bring.

> "We have a lot of millennials working for us. It's been a learning experience for both us and them. They're more resourceful, creative, kinda you know, willing to do whatever. It's a shift in learning how to work with them in the style that they're comfortable with. That I'm comfortable with. I feel like I'm talking about a different species but it's been different. I mean it's not bad, it's just different. There's just a different way of doing what they do and sometimes it's a lot more efficient than the old way."

Setting Boundaries

Setting appropriate boundaries appear to be a major concern among supervisors (5 of 9) of crisis counselors. Boundaries between appropriate risks and behaviors as well as whether or not a traumatic topic should be addressed or not in crisis.

Belle shares her concerns with safety due to physical threats her supervisee's experiences and her priority when supervising crisis clinicians.

> "My one thing I ask my staff about is your safety has to come first. Because they forget since they get so comfortable with the chaos of the situations we deal with. We have had swat teams pull up behind us. We've had you know, swords or machetes pulled out; all kinds of different things. You are taking them to the

hospital and they crawl to the back seat. We handle a lot of situations, we handle all kinds of negative consequences."

Care Coordinator shares concerns with safety and understanding boundaries and roles of crisis counselors. She emphasizes her supervisee's involvement in treatment and how quickly situations can escalate.

> "A lot of times it's about a care coordinator being so invested on working with this person with every single need. But sometimes they do need that boundary that are beyond their job roles. They can't be everything to everybody. I have one person that I can think of…he's working with (a client) and the drug dealer think the guy owns him money and the drug dealer guy shows up and he's (care coordinator) talking to the drug dealer. That's beyond what he's supposed to do…we just try to reinforce safety and boundaries."

Salted Caramel shares causes of frustration which can lead to burnout with her supervisees.

> "Well, I deal with a lot of folks who, well my staff gets frustrated fairly easily because we deal with chronic clients so you know a lot of them have their chronic mental illness alone, and some of them have the chronic mental illness with substance abuse. You know we think we know what is best for the person and we know what the best decision is and we see the actual decision being made and we can't force the client to make the right one. I see a lot of frustration dealing with that. A lot of our folks, sometimes are learning to manage themselves. I have a lot of conversations about self-care, setting boundaries, not burning yourself out. How you know, you're supposed to be the person you know, you come in, you're

calm, you know, it's not your problem. You're just there to facilitate and navigate and hopefully the problem gets resolved."

Dot shares that a part of her job is to help her supervisees determine what issues to address and what issues to not address based on specific situations such as time, setting, and degree of support and services available.

> "Because in five days you don't want to open a can of worms you can't close back up. You get somebody else to do that. So helping them to decipher the difference. So I can see they have this sexual abuse. Yes, we're not going to deal with that. Not right now. Because you can't close that in 3-5 days. Um so you know how to give them resources, talk to the family so they understand what their role is in helping them… a lot of them do groups too so in the group setting, how to manage with relaxation techniques, how to help them manage their anxiety, ptsd... So helping them structure groups that makes sense for the clients that they see."

Maintaining Support

Five of (5 of 9) participants identified the importance of being part of a community in crisis work. The challenges of crisis work and physical as well as emotional strain leads clinicians to lean on each other for support. This sense of camaraderie is nurtured by supervisors within their clinical team to further enhance resilience.

Cormac McCarthy

> "It's a pretty close knit unit. People who come to work on this unit I think like it. And they tend to stay because it's laid back and we all watch out for each other. I

think we're all very aware of what's going on around the unit. We have cameras, we listen for each other, we have plans in place on how to respond if there are situations that are involve aggression or things like that so you know…Ways of getting everyone involved."

Salted Caramel shares how efficiently crisis clinicians can work if they have support from their supervisors and their teammates.

"The teams kinda run themselves and support one another; and me be back up if necessary…we'll go out to lunch frequently as a team and if it's not the whole team, the I'll go out with each person and we'll sit down and have lunch and chit chat…it's just a huge feeling of togetherness and that they can count on each person."

Dot shares that interns are able to learn with each other and from each other. These relationships may last through internship and continue to supervisees' professional careers.

"Even though my group may have five or six interns or less depending on the days, we really get along well. We all, they get along with each other very well, they've become friends. They collaborate on things. They even work with me on other projects you know, related to counseling stuff so it's become like this little family I guess."

Kelly K. recognizes the importance of a strong sense or togetherness and provides team building exercises outside of the work place. She specifically focuses on building that relationship.

> "We try to work on team building. We attempt to have some type of camaraderie where we do something…we go somewhere; maybe go bowling or shoot pool or something that we can kinda de-stress. Squeeze the fun out to say the least."

Anne Mayer shares the stressful circumstances her clinicians go through and her experiences with supervising and supporting crisis workers.

> "They've literally seen people shot to death, people who have had their heads cut off, six months old babies in the freezer, completed hangings, car wrecks, all kinds of trauma that clinicians usually aren't exposed to; so we had to figure out how to deal with that. And the best way that we have found for them to deal with it is support from within their program because no other clinician have the same experiences they do….you know encounters. So they have a pretty tight knit. It's pretty informal but its peer to peer support counseling. Because nobody understand them like somebody that's been in that experience…in most of my programs, the staff just kinda help each other out…you know how the military only want to talk to the military, it's kinda the same thing with the program. So far it's worked. We haven't had anybody leave necessarily because of the trauma of the burnout or anything because they feel so supported…I think the fact that having that support, having someone, their peers, to talk to has been, has worked very well in that program in particular… (there's) a lot of camaraderie because they all know what the other is experiencing because they've been there. I don't think it happens naturally. I think it's a mutual respect among staff and I think it's like a relationship building that's developed over time."

Stress, Burnout, and Self-care

Seven of nine (7 of 9) supervisors identified the risks of burnout and the importance of self-care for themselves as well as their supervisees. Lilly shares:

> "(the) Mental health field is a very, can be a very stressful and demanding field in a sense that your skill is you. You give a lot of yourself in treating people who may need a lot of support. So making sure those people (clinicians) understand that self-care is needed and it's not a sign of weakness if you're struggling with something. For some reason a lot of times in mental health field we see that we can't take our own advice. You know, as a therapist you teach your clients you teach your patients all these wonderful skills they can use to help their lives and then we don't use it for our own lives. So I think a lot of time schools focus on the academic piece, theoretical piece. And then I think the real life experience, real world experience piece speaks a lot to the crucial importance of healthcare and knowing how to manage your well-being as you're trying to help people regain their well-being. I think it goes a long, long way. Cause when you burnt out, you really can't be of much help to anybody but yourself."

Salted Caramel identifies the importance of self-care, particularly in crisis settings. She also shares situations that she have experiences that leads to negative repercussions of crisis clinicians that are in distress.

> "Self-care is huge. And dealing with some of the crisis that we've seen. I have one person in particular, she's scared to death that she's going to see her client, waking in, dead one day. And we've had that happen in the past. And some people are better at handling that and some people are not; and she's one who's

> just, every day that she has to go visit this person, she'll call and ask you "come with me because I'm scared that this is what I'm going to find.""

Cormac McCarthy promotes self-care and well-being by sharing information and regularly assessing his crisis counselors for signs of burnout and secondary trauma.

> "I (also) try to make sure staff take care of themselves too and in our staff meetings, I will give them handouts and guidelines on self-care and the likes so they can manage their stress as well. Because they're on the front lines every day. They're working with people all day long who really can wear you down; and dealing with that that constantly. So I think we all try to practice good self-care, at least self-awareness of when we need to just step back. I kinda take inventory of where you're at before burnout and too much stress."

Hillary shares her experiences as well as multiple avenues to mitigate burnout and trauma.

> "Well, it's really stressful. Working on this environment is very stressful. Not for me specifically, but I think, I guess, for the team. I'm always very concerned for the team. You never know when we're going to get a bad call, we've very fortunate that we have not had, I think we've had two deaths that we know of on the phone…So you know, really managing for those very difficult situations; to try to make sure that the staff person who's taking those calls are safe. In situations like this supervision time with clinical team leaders, self-care in the quiet room, helpline, EAP, time off the phones."

Care Coordinator shares a case where burnout can possibly lead to premature exit from the field.

> "I do definitely know there's burnout. There is one particular person that I know that's working on getting her license and she is having more and more difficult cases and she started to say "I'm starting to wonder if I even want to be in this field anymore. And I try to encourage her to take some time off too, and take some mental health days when needed, mini vacations, and I also try to help her realize that there are so many other things you can do with our license. "You've come so far, don't throw it all away because there are so many other things you can do with our license. Because it can be too much."

Kelly K focuses on her duties as a supervisor to constantly monitor her supervisees on their levels of stress and provide necessary support to ensure they continue to be able to continue with the demands of crisis work.

> "We definitely talk about how to relieve stress…I have one person that, whenever they're starting to burn out, their talk changes. And so I ask so are you going to take a week off? I've looked at your time. You have enough hours. You can take a couple days off. What's going on? Well, its time. And usually a week off for that person gets them back and re-centered. Um, I also in staffing, I give him that safe place that we can talk about anything. Let's leave it in here though. We're going to talk about how we're going to help the clients. We're going to talk about your frustration with working with the clients. And this is a safe place at work that you can do that."

Balance

Seven (7 of 9) participants identified having a balance in professional and personal life as a defining factor in effective crisis counselors and supervisors. Supervisors are cognizant of their own needs and continually monitor the needs of crisis counselors they supervise. Dot shared:

> "We talk about it in supervision. My question is, how balanced is your life? Social, intellectual, productivity, and spiritually. And if they're like um, Dot, I was way off on that I didn't do these things spiritual, I didn't do anything social, I just work, work, work. So then what's the goal…I set boundaries too, I think that it's important but I teach my interns that as well. Just because we're servants to the public doesn't mean that we don't have pride ourselves and have boundaries. So there's times I'm off the grid in the sense that when they need me, then they can always text me and I'll respond. Creating boundaries is part of myself care with my time and my space. Other self-care things, just having fun. You now, being silly. I'm silly. I'm a goofy person. When I'm with them we crack jokes, we laugh. To me that's self-care too….and we don't try to create this façade like everything I ever done worked very well and all this kinda stuff. So, for me, I think that helps in that environment. And this is being who I am as part of me taking care of me. I don't have to pretend. Being genuine. That's it. That's all I can do. And for me that works."

Hillary shares the importance of being able to compartmentalize and separate work and personal life. Although her department provides training for stress and trauma informed-care, she identifies the need to balance professional and personal needs.

> "We do training about stress management and trauma informed care; and everybody creates a safety plan when they start working here. But part of that is we're very big on when you're done with your shift, you're done with your shift. Nothing carries over. When you walk out that door, all your follow-ups are assigned, you have trust within the system that it's gonna get done. You don't have to worry about it. Go home. Do whatever you do. Go run, hangout with kids, play with your dog, or whatever. So I do the same thing. I'm very much about like, there is no martyr culture…When you're here you bust your butt but when you go, you play."

Lilly shares strategies she employs to help with stress and burnout. She is able to separate her personal and professional duties, but also seeks support herself from other professionals.

> "I work very hard to daily, leaving work at work. Little things like I have to have my phone on because we, I have the beautiful job of being on call 24/7, but what I've done is I've turned off notifications for example. So unless my phone rings, I don't look at it…you find yourself always being on; even when you're supposed to be at home relaxing. So a lot of leaving work at work. And then basics, spend time with my family, spend time with my dog. Relaxing…Consultations. I do a lot of consultations…predominantly self-care in my mind is knowing the balance of work life and work stops and life begins."

CHAPTER V

Conclusion

In this study, supervisors of crisis counselors described a multifaceted experience that identified powerful growth but also potential for physical as well as psychological harm. Overall, supervisors reported supervision was a beneficial and necessary part of clinical work, especially with clinicians in crisis settings. They identified the need to be present and available for their supervisees and provide individualized care whenever support is needed. In addition to continually obtaining and sharing knowledge of complex systems involved with crisis work to their supervisees, supervisors also identified the parallels of needing their own needs met in order to be successful clinicians and supervisors. Like their supervisees, they too need to have support from colleagues as well as personal support from outside of their profession.

The findings in this study support past literature concerning supervision and trauma informed practices. McAdams and Keener (2008) highlighted the importance of supervision to mitigate the vicarious trauma and enhance resiliency with counselors who work with survivors of trauma. Berger and Quiros (2014) also noted that supervisors examines the effects of trauma work to "monitor the type and amount of interventions by the supervisee (pg 299)," to ensure safety and deter re-traumatization. Supervisors who participated in this study verbalized the positive impact supervision had on their supervisees, particularly with difficult and stressful situations. Strategies such as debriefing were used to promote reflective learning by participants and by past researchers (Cheng, Eppich, Grant, Sherbino, Zendejas & Cook, 2014; Raemer, et al, 2011). They identified the value of creating a "safe place" where supervisees could

process their vicarious trauma and provide and maintain support to better cope and build resilience to crisis work.

The importance of continuing education as well as knowledge of trauma informed practices was found to be essential to effective supervision in crisis settings. Specifically, the theme of *skills development* mirrors Quiros and Berger's (2016) findings that empowering supervisees by meeting their educational needs encourages growth." Participants in the current study reported the necessity of personally and professionally staying abreast of topics relevant to supervision. Increasing knowledge of subjects such as current trends, theories, practices, and techniques is an integral factor in trauma informed supervision. Supervisors must also be educated about vicarious trauma symptoms in order to provide effective guidance to clinicians under their supervision (Bledsoe, 2012; Pearlman & Saakvitne, 1995). This theme is further supported by licensing boards for a myriad of professions including marriage and family therapists as well as licensed professional counselors where continuing educational credits are required for licensure (ACA, 2014).

Dangers associated with working in the field were identified as concerns with which crisis clinicians and supervisors struggle. Crisis clinicians are often asked to meet with clients at their homes or neighborhoods where the environment cannot be reasonably secured. As researchers have noted a strong positive correlation between urban and lower income residential areas and increase in violence and mental illness (Ochodo, Ndetei, Moturi & Otieno, 2014, Vijaylakshmi, Ramachandra, Reddemma & Math, 2014), safety is a priority for supervisors as well as their supervisees. Constant work in possibly hazardous conditions may lead to normalization of these working conditions and

minimizing clinicians' need for safety. Setting and maintaining appropriate boundaries were identified as crucial for the safety of crisis counselors.

The high risk lifestyles of clients including drug abuse sometimes lead to dangerous situations that are outside the scope of practice for crisis clinicians. Crisis clients may find themselves entrenched within conflicts between their clients and potentially violent individuals. A history and possibly current drug seeking behaviors may further put both clients and crisis clinicians at risk. The complexity of client situations including the involvement of dangerous and possibly life threatening situations that arise when working with this population should be continually monitored so appropriate *boundaries* can be maintained.

Physical boundaries were not the only dangers identified in this study. Psychological dangers were also noted for clients, crisis clinicians, and supervisors. Organizational limits such as time restraints, lack of resources, or poor scheduling may lead to unmet needs of clients. Frustration due to noncompliance or inability to see positive changes can then lead counselors to experience burnout and compassion fatigue. For that reason, crisis supervisors must ensure their supervisees are provided with a physically and emotionally safe location to process their own trauma. Genuiness, empathy, and warmth provides a sense of safety that can reduce the feelings of uncertainty and mitigate compassion fatigue and burnout (Berger & Quiros, 2016).

Crisis clinicians and crisis supervisors who conduct clinical work are also prone to vicarious trauma (Berger & Quiros, 2014; Jordan, 2010). For that reason, crisis supervisors must be diligent in practicing and promoting self-care with their supervisees in order to manage stress and burnout. Supervisors must ensure that crisis clinicians have

the skills necessary to be effective counselors, ensuring each clinician has sufficient time off, and that they are able to effectively cope with the stressors of crisis work.

The major theme of *balance* have been supported in past research. Having a balance between work and personal life was found to be a key to self-care and resiliency when supervising crisis counselors (Berger & Quiros 2014). Support can come from supervisors and peers as well as from personal relationships outside of the professional setting. Relationships with friends and family outside of work for instance, helps crisis supervisors to maintain a sense of balance and purpose (Jordan, 2010). Maintaining general self-care activities through hobbies such as camping, reading, drawing, and cooking were all identified by participants in this study as helping to promote balance and is supported in past literature (Hesse, 2001). Maintaining physical health through exercise, sleep, and adequate nutrition was also identified. Last, maintaining spiritual connections through meditation, yoga, or volunteer work can enhance balance and promote overall well-being.

Other methods of coping with crisis work includes being emotionally secure through a sense of togetherness, family, and camaraderie. Participants in this study identified a strong sense of camaraderie with their peers that strengthened both counselors and supervisors resiliency. These findings and the theme of *maintaining support* are congruent with past findings that identified evidence that the existence and level of support from professional colleagues and supervisors decreases the effects of professional burnout (Lakey & Cohen, 2000; Ray & Miller, 1994). Supervisors may choose to nurture a sense of camaraderie and teamwork to promote a sense of wholeness.

Peer to peer support at the clinical and managerial level was described to be helpful as it promotes normalization of thoughts and feelings and promote innovative ideas to support crisis clients. Supervisors would benefit from continual consultation with their peers who work in other crisis programs serving similar populations.

Effective communication is a hallmark of supervision in any field, but it is particularly necessary in the counseling field; and even more essential with crisis counseling. Participants reported that building a strong therapeutic bond between supervisors and supervisees was seen as integral for effective supervision. These findings are congruent with past research (Farber, 2012; Quiros & Berger, 2016; West, 2010) and again reinforces the importance of the humanistic qualities of counseling and supervision. *Effective communication* further builds a sense of trust and camaraderie which strengthens resiliency and reduces burnout (Lakey & Cohen, 2000; Ray & Miller, 1994). This feeling of support and care throughout the clinicians' personal and professional life coincides with professional growth in trauma practice (Calhoun & Tedeschi, 2013).

Although the study was designed to report on major themes, that is, ideas that were described in supervision with a majority of supervisors (at least 5 of 9), relevant minor themes were also identified that reflect concerns of supervisors of crisis counselors. Supervisors reported that effective crisis clinicians were passionate about their occupation and enjoyed helping people. Supervisors identified the many struggles crisis clinicians face including moderate pay, dangerous and stressful situations, and lack of resources. Clinicians that are passionate were identified as often being able to overcome obstacles and continue working in a field that at times, appears hopeless.

Although the inclusion of “passion” is not found in literature related to counseling, compassion has been identified as a hallmark of effective counseling (Figley, 1995). Compassion-fatigue and burnout are directly correlated with ineffective care (Thompson, Amatea, Thompson, 2014); passion therefore, would be inversely correlated and could be seen as a factor in effective counseling and supervision.

Implications

The findings from this study have important implications that apply to supervision across diverse fields. Factors such as the necessity for ongoing and continuing education, understanding and setting appropriate boundaries, effective communication, and self-care were themes universally seen as helpful for all supervisors. The specific topics identified by crisis supervisors and the severity of the situations reported however, are unique to practitioners in the helping fields.

This study offers several implications for supervisors, crisis clinicians, counselor educators, and researchers. First, the importance of clinical supervision was identified as being an essential component of crisis work as supported by past research. (Anderson, & Kielty, 2013; Berger & Quiros 2014; Tran & Henriksen, 2016; Dupre, Echterling, Meixner, 2013). Crisis/Trauma-informed supervisors must not only teach, train, and support their supervisors in contextual knowledge, but they must also be aware of any vulnerabilities due to working with critical clients. The complex situations and needs of crisis clients, along with limited successes and resources available, can often lead to vicarious trauma for counselors. Providing crisis counselors with the skills necessary and the support personally and professionally can help to mitigate the effects of compassion fatigue, burnout, and premature exit from the professional. Congruent with humanistic

models of supervision, when supervisors are able to build a trusting supervisory relationship with their supervisees and support their supervisory needs, growth can be obtained. (Farber, 2012; Tran & Henriksen, 2016).

Specific crises topics were identified by supervisors including self-harm, substance abuse, and psychosis in this study. As these subjects were universally agreed upon as common issues in crisis work, strategies to educate and train mental health practitioners to be effective in assessing, diagnosing, and treatment are essential. Teaching institutions, mental health agencies, and clinical counseling supervisors may wish to not only include ongoing specialized training on topics such as multiculturalism, techniques, and theories as required for licensure and accreditation, but also should include training in crisis work and crisis topics such as self-harm, psychosis, and substance abuse and dependence. As crisis is an increasingly regular phenomenon, counseling educators may further wish to integrate these subjects into their core curriculum to enhance preparedness of their clinicians.

Another important implication of the research findings include the importance of flexibility, balance, and self-care as features associated with resiliency for both supervisors and clinicians working with crisis counselors. Supervisors can promote resiliency by individualizing supervision session to meet the needs of their clinicians. Within each supervision session, supervisors can help supervisees establish a realistic role in their crisis work and create appropriate physical and emotional boundaries. Furthermore, supervisors can play a larger role in helping crisis clinicians be more aware of their own limitations and find alternative methods to build resiliency and promote post-traumatic growth.

Limitations and Future Research

Several limitations to this study are identified and may limit transferability. First, transferability and generalization of these findings are limited due to the small sample size of nine participants. The participants were purposefully limited to supervisors currently supervising master's level crisis clinicians in the Southwestern region of the United States. Although only data from nine participants were analyzed, the small number is not uncommon in qualitative research (Guest, Bunce, & Johnson, 2006). Furthermore, saturation was reached at four interviews. Five additional interviews were conducted, analyzed, and included as the primary investigator attempted to include participants from multiple settings.

A second limitation related to transferability is due to the inherent needs of crisis supervision. As many of the participants were required to be available 24/7, some interviews were interrupted as their supervisory services were necessary. Although none of the participants had to end the interview prematurely, the disruption may have caused the supervisors to stop their train of thought and not report a critical aspect of their supervisory experience.

The final limitation is based on the foundation of qualitative research in that it is designed to accurately represent the experiences of its participants (Tran & Henriksen, 2016). Although the researcher attempted to capture the essence of supervision of crisis counselors, this analysis is based on the participants' abilities to accurately represent their experiences. Furthermore, although three different peer reviewers were used to analyze the data, their own personal experiences may have limited their accuracy. Although all three coders that analyzed the data went through an orientation process that included

bracketing to ensure inter-rater reliability and accuracy of research, the data generated is subject to some bias. To further limit bias and promote accurate representation of the data, the primary investigator attempted to include participants with gender, age, experience, and crisis settings that reflected current trends in clinical mental health care. The resulting sample however may not be representative of all supervisors working with crisis counselors, and generalization of these results should be done on a case by case basis.

Qualitative research allows for a detailed description of an experience however it does not allow for causal effects limiting its use in certain settings (Creswell, 2013). Future research can attempt to identify specific factors and its influences on traumatization as well as traumatic growth (Barrington & Shakespheare-Finch, 2013). Identification of these factors can help counselor educators and clinical supervisors to better prepare their clinicians for crisis work while mitigating any negative effects. Future research should also include more participants in a wider variety of settings to ensure more accurate data and transferability. A final area of research could identify specific guidelines for crisis and trauma-informed supervision so that accreditation boards, academic institutions, mental health agencies, clinical supervisors, and ultimately crisis clinicians can deter symptoms of vicarious trauma, burnout, and compassion fatigue, and promote resilience and growth.

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APPENDIX

Institutional Review Board
Office of Research and Sponsored Programs
903 Bowers Blvd, Huntsville, TX 77341-2448
Phone: 936.294.4875
Fax: 936.294.3622
irb@shsu.edu
www.shsu.edu/~rgs_www/irb/

DATE:	October 11, 2016
TO:	Quoc "Chance" Tran [Faculty Sponsor: Dr. David Lawson]
FROM:	Sam Houston State University (SHSU) IRB
PROJECT TITLE:	*A Phenomenological Study of the Experiences of Supervisors Working with Crisis Counselors [T/D]*
PROTOCOL #:	2016-09-31663
SUBMISSION TYPE:	INITIAL REVIEW—RESPONSE TO MODIFICATIONS
ACTION:	APPROVED
APPROVAL DATE:	October 11, 2016
EXPIRATION DATE:	**October 11, 2017**
REVIEW TYPE:	EXPEDITED
REVIEW CATEGORIES:	7

Thank you for your submission of your **Response to Modifications** for this project. The Sam Houston State University (SHSU) IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

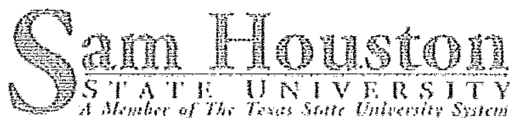
This submission has received **Expedited** Review based on the applicable federal regulation.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require each participant receive a copy of the signed consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure which are found on the Application Page to the SHSU IRB website.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Sam Houston State University IRB's records



Institutional Review Board
Office of Research and Sponsored Programs
903 Bowers Blvd, Huntsville, TX 77341-2448
Phone: 936.294.4875
Fax: 936.294.3622
irb@shsu.edu
www.shsu.edu/~rgs_www/irb/

appropriate reporting forms for this procedure. All Department of Health and Human Services and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

This project has been determined to be a Minimal Risk project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. **Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of October 11, 2017. When you have completed the project, a Final Report must be submitted to ORSP in order to close the project file.**

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact the IRB Office at 936-294-4875 or irb@shsu.edu. Please include your project title and protocol number in all correspondence with this committee.

Sincerely,

Donna Desforges
IRB Chair, PHSC
PHSC-IRB

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Sam Houston State University IRB's records

Sam Houston State University

Consent for Participation in Research

A Phenomenological Study of the Experiences of Supervisors Working with Crisis Counselors

Why am I being asked?

You are being asked to be a participant in a research study about the experience of clinical supervisors as they conduct supervision with crisis counselors. This study is conducted by doctoral student Chance QD Tran, MA, LPC and Professors, David Lawson Ph.D., Chi-Sing Li, Ph.D., and Sheryl Serres, Ph.D., at Sam Houston State University. You have been asked to participate in the research because you have been identified as a supervisor that supervises crisis counselors and may be eligible to participate. We ask that you read this form and ask any questions you may have before agreeing to be in the research.

Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future relations with Sam Houston State University. If you decide to participate, you are free to withdraw at any time without affecting that relationship.

Why is this research being done?

This research is being conducted in order to better understand the experiences of supervisors who conduct supervision with counselors of crisis clients. Counselor educators and future counselor students may benefit from this study.

What is the purpose of this research?

The purpose of this phenomenological study is to describe the experience of supervisors as they conduct clinical supervision of counselors or crisis clients. This study is designed to answer the research question, *What are the experiences of supervisors of counselors working with trauma clients?*

What procedures are involved?

If you agree to be in this research, we would ask you to do the following things:

1. Supervisors will be asked to contact primary investigator by email, in person, or by telephone for participation.

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2. Respondents will be asked to complete a consent and demographics form (5 minutes).

3. Volunteers will participate in a semi-structured interview (60 minutes).

4. Transcripts will be reviewed through a responded validation by phone or in person at the same location as original interview (10 minutes).

5. Results of the study can be issued to participants in person by primary investigator by request following completion of the study.

Approximately 13 participants may be involved in this research study.

What are the potential risks and discomforts?

No more than minimal risks have been identified for this study. If participant(s) experience any psychological discomfort, they may request counseling at the Sam Houston State University Jack Staggs Clinic in Huntsville, the Community Counseling Center at the Woodlands, or The Harris Center for Mental Health and IDD.

Are there benefits to taking part in the research?

There are no direct benefits to participating in this study. Counselor educators and future counseling students may gain valuable information as a result of this study.

What other options are there?

There are no other options other than the interview process.

What about privacy and confidentiality?

The only people who will know that you are a research participant are members of the research team. No information about you, or provided by you during the research will be disclosed to others without your written permission, except:

- if necessary to protect your rights or welfare (for example, if you are injured and need emergency care or when the SHSU Protection of Human Subjects monitors the research or consent process); or
- if required by law.

When the results of the research are published or discussed in conferences, no information will be included that would reveal your identity. If photographs, videos, or audiotape recordings of you will be used for educational purposes, your identity will be protected or disguised.
Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law.

Consent Form

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All interviews will be recorded and stored on a password protected computer. They will be transcribed and analyzed for themes. Participants may ask for a copy of the interview and transcriptions by request and will be issued in person by primary investigator. All personal information, research data, and related recordings will be coded and stored to ensure confidentiality. Pseudonyms will be used during all stages of this study and all documents and recordings will be destroyed three years after completion of this study.

What if I am injured as a result of my participation?

In the event of injury related to this research study, you should contact your physician or the University Health Center. However, you or your third party payer, if any, will be responsible for payment of this treatment. There is no compensation and/or payment for medical treatment from Sam Houston State University for any injury you have from participating in this research, except as may be required of the University by law. If you feel you have been injured, you may contact the researcher, Chance QD Tran at 832-594-1895.

What are the costs for participating in this research?

There are no costs associated with this research.

Will I be reimbursed for any of my expenses or paid for my participation in this research?

There are no anticipated costs or reimbursement for participation in this research.

Can I withdraw or be removed from the study?

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

Who should I contact if I have questions?

The research will be conducting by Chance QD Tran. You may ask any questions you have now. If you have questions later, you may contact the researchers at: Phone: (832-594-1895).

Research Chair Dr. David Lawson (936-202-5012; dxl028@*shsu*.edu.)

What are my rights as a research subject?

If you feel you have not been treated according to the descriptions in this form, or you have any questions about your rights as a research participant, you may call the Office of Research and Sponsored Programs – Sharla Miles at 936-294-4875 or e-mail ORSP at sharla_miles@shsu.edu.

You may choose not to participate or to stop your participation in this research at any time. Your decision whether or not to participate will not affect your current or future relations with the University.

Consent Form

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If you are a student, this will not affect your class standing or grades at SHSU. The investigator may also end your participation in the research. If this happens, your class standing or grades will not be affected.

You will not be offered or receive any special consideration if you participate in this research.

Agreement to Participate

I have read the above information. I have been given an opportunity to ask questions and my questions have been answered to my satisfaction. I agree to participate in this research.

Consent: I have read and understand the above information, and I willingly consent to participate in this study. I understand that if I should have any questions about my rights as a research subject, I can contact Chance QD Tran at 832-594-1895 or by email at qdt001@shsu.edu. I have received a copy of this consent form.

Signature: ______________________________ Date: __________________

As part of this project, an audio recording will be made of you during your participation in this research project for transcription purposes only. This is completely voluntary. In any use of the audio recording, your name will not be identified. You may request to stop this recording, review this recording, or to erase any portion or all of your recording at any time. This recording will otherwise be deleted three years after completion of this study.

Consent to audio recording of this interview: I willingly consent to being recording during this interview. I understand that if I should have any questions about my rights as a research subject, I can contact Chance QD Tran at 832-594-1895 or by email at qdt001@shsu.edu. I have received a copy of this consent form.

Signature: ______________________________ Date: __________________

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Recruitment Documentation

Recruitment Process:

Primary investigator (PI) will identify mental health care agencies that identifies as a provider of crisis services, through resources including APA and ACA publications, local phone listings and agency publications (phone book, resource publications, i.e. Houston Resource Guide), and the internet. PI will then contact supervisors of said agencies directly by phone, email, or in person to recruit for participation. If supervisors from those agencies refer PI to other possible participants, PI will also contact them directly by phone, email, or in person.

Script:

"Good morning/afternoon/evening. My name is Chance Quoc D Tran and I'm a doctoral candidate with Sam Houston State University. If you have a moment would you mind answering a few questions that will help with recruiting for a study that is being conducted?" (If yes, we will continue. If not, PI will request a time to contact possible participant in the future. If refused, or identified as not eligible due to research criteria, identified name will be stricken from possible participant list).

"You have been identified as a supervisor that supervises crisis counselors and may be eligible to participate in a voluntary study that may benefit educators and future counselors. This research is being conducted in order to better understand the experiences of supervisors who conduct supervision with counselors of crisis clients. Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future relations with Sam Houston State University. If you decide to participate, you are free to withdraw at any time without affecting that relationship. I have three questions in order to ascertain participation criteria."

> "Do you supervise counselors that work with crisis clients?"
>
> "Does at least half of the counselors you supervise work in crisis situations?"
>
> "Are you willing to consent to this research study?"

If participants meet all criteria, PI will set a meeting at a desired location set by participant which may include their place of employment, Sam Houston State University, or any other mutually agreeable location that may provide a confidential interview.

DEMOGRAPHICS

To ensure anonymity, you will be identified using an assumed name during this interview. What would you like your pseudonym to be? ____________________________

Age: ____________________

Gender: ____________________

Race/Ethnicity: ____________________

Setting counseling is provided: ____________________

Years of experience as a supervisor: (Please circle one or fill in other)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 other _____

Approximate percentage of crisis work clinicians you supervise: (Please circle one)

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

VITA

CHANCE QUOC DUNG V.L. TRAN
qdt001@shsu.edu; chance.316@gmail.com

LICENSES AND CERTIFICATIONS

Licensed Professional Counselor
Board-Approved Supervisor (LPC-S - 67871)
Licensed Chemical Dependency Counselor (LCDC - 12043)
National Certified Counselor (NCC-611565)
Certified Texas Educator

EDUCATION

Sam Houston State University
Ph.D in Counselor Education **Summer 2017**

Prairie View A&M University
M.A. in Counseling Psychology **Spring 2009**

Rutgers University
B.A. Psychology **Spring 2002**

TEACHING EXPERIENCE

Sam Houston State University

COUN 6374 01 Practicum in Group Counseling ***Summer 2015***
COUN 6374 02 Practicum in Group Counseling ***Summer 2015***
COUN 5112 02 Ethics for Counselors ***Summer 2014***
COUN 6376 01 Supervised Practice in Counseling **Fall 2014**

Cypress Fairbanks Independent School District

Frazier Elementary **2007-2008**
New Arrival Classroom (NAC)
Math and Science (2nd Grade)
M. Robinson Elementary **2008-2012**
Math and Science (4h Grade)

SUPERVISION EXPERIENCE

Board Approved Licensed Professional Supervisor
Triadic Supervision
Individual Supervision

CLINICAL EXPERIENCE

The Harris Center for Mental Health and IDD **2010 – current**
Crisis Residential Unit
Adult Forensics-Harris County Sheriff Office
NeuroPsychiatric Center

Houston Psychotherapists **2009 - 2010**
Clinician

Clinician Cypress Fairbanks Independent School District **2009 - 2010**
Counseling Intern

AtlantiCare Behaviorial Health
Case Manager/Program Director **2002 – 2007**

PRESENTATIONS

TACES Presents: An advanced Supervision Session on Trauma informed Supervision

Texas Association for Counselor Educators and Supervisors in Austin, TX (3/2/17)

Advising and Understanding Crisis Procedures

Texas Association for Counselor Educators and Supervisors in Austin, TX (3/2/17)

Substance Use, Addition, Harm Reduction, and Co-Occurring Disorders

University of Houston Graduate School of Social Work (7/13/2016)

Interactive Teaching Techniques for Counselor Educators and Supervisors

Texas Association for Counselor Educators and Supervisors in Austin, TX (1/29/16)

The Beginner Counselor's Experience of Transitioning from Academic to Clinical Practice

Texas Association for Counselor Educators and Supervisors. Austin, TX. (1/29/16)

Experiential Supervision Techniques for Counselor Educators and Supervisors

Texas Association for Counselor Educators and Supervisors. Austin, TX. (1/29/16)

Interactive Teaching Techniques for Counselor Educators and Supervisors.

Counselor Educators and Supervisors, Philadelphia, PA (10/8/2015)

The Experience of Transitioning from Academic to Clinical Practice

Counselor Educators and Supervisors, Philadelphia, PA (10/8/2015)

Using Experiential Activities in Group Supervision: Warm up, Action, and Sharing

Texas Association for Counselor Educators and Supervisors in Austin, TX (1/30/15)

Interactive Teaching Techniques for Counselor Educators and Supervisors

Texas Association for Counselor Educators and Supervisors in Austin, TX (1/29/15)

Techniques of Counseling

Sam Houston State University (3/26/14)

PUBLICATIONS

Tran, Quoc D., Henricksen, Richard (2016). Transitioning from Academic to Clinical Practice.

Retrieved from https://www.counseling.org/docs/default-source/vistas/article_5753f227f16116603abcacff0000bee5e7.pdf?sfvrsn=4

UNREFERRED PAPERS

A MULTIVARIATE ANALYSIS OF ALCOHOL, COCAINE, AND MARIJUANA AS PREDICTORS OF SUICIDE	**2014**
AN ANALYSIS OF STIGMA AS A BARRIER TO UTILIZATION OF MENTAL HEALTH SERVICES FOR ASIAN AMERICANS	**2014**
A COMPARATIVE ANALYSIS OF THE CENTER FOR EPIDEMIOLOGIC STUDIES DEPRESSION TWENTY AND SEVEN ITEM SCALES AND ITS CORRELATION TO SMOKING	**2013**

LANGUAGES

English
Vietnamese

MEMBERSHIPS

AMERICAN COUNSELING ASSOCIATION

Association for Counselor Education and Supervision
Southern Association for Counselor Educators and Supervisors
Texas Association for Counselor Education and Supervision
Chi Sigma Iota
National Board of Certified Counselors
***Former President of the Asian American Association of Atlantic County**

SCHOLARSHIPS

Provost Scholarship
Department of Counselor Education Scholarship