



Are We Looking After Our Trauma-focused Clinicians?

**A review of current supervision models and literature regarding the detection and prevention of vicarious trauma in supervision:
Is there room for improvement?**

Introduction of the presenter – Anna Elders

- Registered nurse – Mental Health
- Currently Clinical Nurse Specialist in Therapeutic Interventions at Tiaho Mai (adult inpatient unit in South Auckland)
- Cognitive Behavioural Psychotherapist
- Work history – CAMHS, prisons, inpatient units, day hospitals, trauma service (NZ and UK)
- Supervisor (RN's and other health professionals)

Interest in Vicarious Trauma and Supervision

- 2009 –Masters module in Clinical Supervision for Cognitive Behavioural Psychotherapists whilst working as a trauma psychotherapist in the UK

Focus of presentation

- What is Vicarious Trauma (VT)?
- What are the predominant generic functions of supervision?
- Do current models of supervision purposefully act to detect and prevent VT?
- How can supervision be enhanced to reduce the risk of development of VT in clinicians working with client trauma?

Definitions of Vicarious Trauma (VT)

- “a transformation in a therapist (or other worker) as a result of working with clients’ traumatic experiences” (Morrison, 2007, pg 2)
- The term was first coined by McCann and Pearlman in 1990
- VT symptoms first noted in emergency workers in the 70’s leading to exploration of its presence in other professional populations (police, solicitors, health professionals)

How does VT develop?

- Can occur cumulatively or immediately following exposure to empathic therapeutic work with client trauma
- Perpetuating factors include therapist engagement with;
 - both the details of the trauma (often explicit)
 - and the client emotions and cognitions resulting from it
- Differs to burnout, compassion fatigue, countertransference (symptoms, onset, severity)

My personal interest in VT and supervision

- Experience working as a trauma-focused clinician
- Experience providing supervision to trauma-focused clinicians and other colleagues
- Belief that we need to look after clinicians working with clients who have experienced trauma (almost all mental health professionals) as well as the clients themselves
- Acknowledgement and experience of the 'transference' of client 'symptoms' onto the clinician

VT research

- Minimal research available (including no identified studies within NZ)
- Bober & Reger (2006) study:
 - Sample of 259 therapists

Focus

- Locate primary predictors of development of VT in clinicians

Findings

- Main predictor is level of exposure to trauma work
- Years of professional experience or personal history of therapist found to be insignificant

How can VT present in supervisees?

Personal changes within the clinician

- Changes within cognitive schemas and belief systems
- Cognitive intrusions
- Feelings of shame and inadequacy
- Avoidant behaviour and hyper-arousal
- Changes in sense of identify
- Memory changes (autobiographical)
- Relationship difficulties
- Changes to affect, behaviour and overall functioning

(Trippany, Kress and Wilcoxon, 2004 & Morrison, 2007)

How can VT present in supervisees?

Professional changes within the clinician

- Avoidance of discussing certain session topics
- Changes in behaviour at work (withdrawal, collegial relationships)
- Reduced effectiveness within therapy e.g.avoidance of topics/tasks
- Therapeutic ruptures with clients
- Empathic withdrawal by the therapist in sessions

(Trippany, Kress and Wilcoxon, 2004)

- Symptoms are thought to 'parallel' those experienced by clients with PTSD (Morrison, 2007) and can present as more subtle features to distressing & disabling symptoms

Generic definition and functions of supervision (Milne 2007)

- Definition

“the formal provision by senior/qualified health practitioners of an intensive, relationship-based education and training that is case-focused and which supports, directs and guides the work of colleagues (supervisees)”

- Functions

- Quality control
- Maintaining and facilitating the supervisee’s competence and capability
- Helping the supervisee to work effectively

Review of supervision literature

- No reference to VT in generic supervision literature
- Definitions and generic functions often defined and described in similar terms to Milne's definition (2007)

What are the impacts of these definitions on the other important function of supervision; supporting and monitoring the wellbeing of the clinician?

Should supervision serve to detect and prevent VT?

- Trippany, Kress and Wilcoxon (2004) call for supervisors to “take an active preventative role” against VT
- VT literature often acknowledges the vital role of supervision in detecting and preventing VT
- Assumptions can be made that supervisees are in good psychological health to undertake their roles however this is not always the case (Armstrong & Freeston, 2006)
- Services have ethical & moral obligations to look after staff therefore should be actively protecting clinicians against VT

How could supervision serve this purpose?

- Helping to processing trauma material, emotions and cognitions following sessions (Cerney 2005)
- Helping clinicians 'disentangle' their lives from their clients experiences (Braehler, 2006)
- Increasing personal awareness and reflection in clinicians (Braehler, 2006)
- Peer supervision; normalising experiences and distress, connecting isolated clinicians with others undertaking similar work and helping to amend cognitive distortions (Trippany, Kress & Wilcoxon, 2004)

Current supervision models

■ The Holloway Model (1995)

Key themes:

- Learning orientated model
- Focus on the supervisee/supervisor relationship as the “container for the supervision process” (pg 57)

“the supervisor’s primary functions are to teach the inexperienced counsellor to foster their professional development” (pg 188)

Tasks of supervision:

- Enhancing therapist skills, conceptualising casework, monitoring professional role of the supervisee, increasing emotional awareness and reflection

Current supervision models

- **Milne , Aylcott & Fitzpatrick (no date)**

Key themes

- Supervisor & supervisee are the primary inputs
- style of therapy & context of learning influences supervision (moderators)

Tasks of supervision/supervisor

- Teaching, feedback, observing and goal setting (support learning)

These tasks support

- Experiential learning, reflecting, conceptualising and the supervisee 'experimenting' within future sessions with clients

Current supervision models

- **Proctor (1986)**

Key themes and tasks

- Formative (*education focused*; guides reflective learning process to assist development and incorporation of theory into practice)
- Restorative (*supportive*; explores impact of therapy on supervisee emotion & functioning, building stress management and coping skills for future use)
- Normative (*managing standards*; ensuring professional and organisational standards are met by supervisee including safety)

Dynamic movement between tasks as required giving flexibility to the session based on what issues are highlighted within the session

Current supervision models

■ General CBT specific supervision

Key Themes

- Content 'borrowed' from other modalities and models
- Echoes the design of typical CBT session (Lomax, Andres, Burruss & Moorey, 2005)
- Supervisor/supervisee collaboration a key feature of the process
- Supervisees encouraged to tape sessions for review in supervision

Key Tasks

- Client formulations lead supervision though opportunity to develop supervisee formulations when impasses/ruptures occur
- Moving client outcomes forward through the learning process that occurs with supervision

What have these models got to lend to the detection and prevention of VT in supervisees?

Model	Pros	Cons
Holloway (1995)	Focus on good relationship in supervision (protective factor), raising emotional awareness & reflective practice of supervisee	- Predominantly learning focused model - ↑ reflection & emotional awareness for client's benefit
Milne, Alycott & Fitzpatrick (no date)	Few noted	- Little focus on supervisee restoration or how client factors can impact
Proctor (1986)	Obvious restorative function for supervisee including monitoring of effects of therapy on emotion	No guidance or structure given as to how to help 'restore' the supervisee
CBT Models	Collaboration, 'check ins' & monitoring of supervisee affect & cogs, review of taped sessions (detection)	- No direct exploration into impact of therapy on supervisee - Client benefits of these tasks main focus (may miss vital Info)

Supervision vs Therapy

- Clear boundaries between supervision and therapy
- Sometimes the supervisee needs both
- Important to define how to manage issues that may arise at commencement of the supervisory relationship

What else may be required?

- Inclusion of more structure as to how to detect and prevent VT within supervision; specific tasks agreed upon at commencement of supervisory relationship
- Recognition of the additional risks that trauma-focused therapists have for development of VT by the wider health profession (including psycho-education for supervisee)
- Monitoring of changes in supervisee emotions, cognitions and behaviours in and out of sessions as a result of trauma work (particularly imaginal exposure) – use of rating scales

What else may be required?

- Specific opportunities within supervision sessions to process and reflect on difficult sessions with clients
- Creation of a safe environment to allow for disclosure of VT symptoms should they develop including an open forum with specific 'check ins'
- Supervision 'homework' that includes healthy processing of sessions, monitoring and management of caseload/types of client work being undertaken, ensuring breaks are utilised and overtime monitored

What else may be required?

- Provision of group supervision to help reduce isolation, allow for normalising/sharing of coping strategies and to assist in processing of session content
- Increased focus and discussion regarding VT as a phenomena by organisations and national bodies
- Further research into the impacts of VT and protective factors

Conclusions

- VT can have serious impacts on the supervisee (which will in turn impact on therapy delivered to clients)
- Supervision is considered a helpful tool in detecting and preventing VT in supervisees
- Many current supervision models lack focus on this task which may be reducing the potential protective factors of supervision for the trauma-focused supervisee
- Multiple identified avenues for assisting in VT detection/prevention however current lack of structure and direction at present
- Further research is required to explore VT prevalence in order to help highlight this serious phenomena to health services so that detection and preventative measures can be built into employee care

Questions or comments?

Handout of suggested enhancements for
Supervision available

For a full list of references or a copy of my paper email me;
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Thank you for your time!!

References

- Tarrier (Ed.) (2006) Armstrong, Freeston (2006) *Formulating Supervision, Case Formulation in Cognitive Behaviour Therapy*, United Kingdom. Routledge.
- Braehler, C. (2006) *Relationship Between Empathy and Professional Quality of Life in Psychologists Working with Older Adults*, October 2006, Empathy and ProQOL. Online.
- Bober, T. & Regehr, C. (2006) Strategies for Reducing Secondary or Vicarious Trauma: Do They Work? *Brief Treatment and Crisis Intervention, Brief Treatment and Crisis Services, Oxford Journals*, February 2006, **6** (1), 1 – 9.

References

- Cerney, M. (1995) *Treating the “Heroic Treaters”* in Figley, C.R. (1995) *Compassion Fatigue; Coping with Secondary Traumatic Stress Disorder in those that Treat the Traumatized*. Brunner/Mazel. New York.
- Holloway, E. (1995), *Clinical supervision; A Systems Approach*. United States of America, Sage Publications.
- Gabbard, G.O, Beck, J.S & Holmes, J (Eds) (2005) Lomax, J.W, Andrews, L.B, Burruss, J.W & Moorey, S. (2005) *Psychotherapy Supervision*. Oxford Textbook of Psychotherapy, Oxford, United Kingdom, Oxford University Press.

References

- Milne, D. (2007) An empirical definition of clinical supervision. *British Journal of Clinical Psychology*, **46**, 437-447.
- Milne, D. Aylcott, H. & Fitzpatrick, H. (no date) *How does Clinical Supervision Work? A Systemic Review and Experiential Model*. (Online) Last accessed 01/09. <http://www.ncl.ac.uk/nnp/myprofiles-linked/milne/rev%204.pdf>
- Morrison, Z. (2007) 'Feeling Heavy': *Vicarious Trauma and Other Issues Facing Those Who Work in the Sexual Assault Field*, ACSSA Wrap, **4**, Sept, Australian Institute of Family Studies. Online. Last accessed 01/09. www.aifs.gov.au/acssa/pubs/wrap/w4.html

References

- Pearlman, L.A. & Saakvitne, K.W. (1995a) *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors*. London. W.W. Norton
- Trippany, R.L, White, V.E, & Wilcoxon, S.A (2004) Preventing Vicarious Trauma: What Counselors Should Know When Working With Trauma Survivors, *Journal of Counseling & Development*, Winter 2004, **82**, 31 – 37.