Caring for the Caregivers: A Phenomenological Study of Supervisors and Vicarious Trauma

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Abstract

Trauma is prevalent in the world, leading individuals who have experienced trauma to seek counseling services. Counselors who listen to trauma narratives are at risk for experiencing vicarious trauma. Vicarious trauma is a term used to describe the negative effects of professional helping. The National Child Stress Network (2011) estimates that 50% of counselors are at risk of developing vicarious trauma with symptoms that can impact counselor effectiveness. Supervisors and Counselor Educators have an ethical responsibility to address vicarious trauma with the counselors they are supervising to prevent harm to clients (Sommer, 2008). Supervision has been documented as a protective factor against vicarious trauma; however, there is a paucity of research regarding supervisors' perception of the vicarious trauma phenomenon and how they approach vicarious trauma in supervision. This study aims to give a voice to supervisors' experiences of vicarious trauma within the supervision process. By giving a voice to supervisors and their perceptions of the vicarious trauma phenomenon, the results yield insight into the treatment and prevention methods of vicarious trauma through a supervisor's lens. Implications for counselor supervision best practices, counselor education and training, supervisor training, and clinician health in regards to vicarious trauma will be provided.

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has resonated with me for years. I revisit it when I become sad and frustrated with the world we live in at times and it provides me comfort. I hope you find comfort and motivation from it too.

The Starfish Story

A businessman was on vacation, walking along the beach, and saw a young boy.

All along the shore were thousands of starfish that had washed up from the tide, and were likely to die in the hot sun.

The boy walked along the shore and reached down here and there to pick up a starfish and toss it back into the ocean.

The businessman, so accustomed to efficiency, walked up to the boy to tell him about his nonsensical ways.

"I've noticed what you've been doing, son. You have a warm heart and I know you mean well, but there's so many starfish dying on the beaches all over the world. I'm sure you could do something better with your time. Do you really think you are going to make a difference?"

The boy glanced up at the man, and then looked down at a starfish by his feet. He picked up the beautiful starfish and tossed it back into the ocean, and said, "I made a difference to that one".

-Adapted from "The Star Thrower" by Loren Eiseley (1907-1977)

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Chapter 1

Introduction and Background

Traumatic events that impact people are prevalent. These events may include natural disasters, manmade disasters, sexual assault, personal assault, community based violence, war, domestic violence, grief, neglect, other violent crimes, and childhood trauma, just to name a few (Substance Abuse and Mental Health Services Administration, 2016; The National Child Traumatic Stress Network, n.d.). When traumatized persons seek counseling, counselors listen to and are exposed to explicit trauma narratives. Vicarious trauma occurs when counselors empathetically listen to client trauma narratives. Vicarious trauma is an occupational hazard of working with individuals that have experienced traumatic events (Pearlman, 1999). The symptoms can impede counselor effectiveness. It is an ethical responsibility of both the counselor and the supervisor to prevent and address vicarious trauma symptomology. Supervision has been documented to be a protective factor against vicarious trauma; however, there is a paucity of research identifying supervisors' ability to address, identify, and attend to vicarious trauma. A review of the literature on trauma, vicarious trauma, and supervision is provided. A recommendation for further research and counselor preparation strategies are explored.

Trauma is widespread in the world and traumatized persons may seek counseling services. According to the U.S. Department of Veteran Affairs National Center of PTSD (2015), trauma is not a rare occurrence, with about 6 out of 10 men and 5 out of 10 women experiencing at least one trauma in their lives. Trauma prevalence in the United States is additionally confirmed by the National Child Traumatic Stress Network (NCTSN) (2011), which states that

10 million children experience a traumatic event per year. Counselors are the individuals that empathetically listen to trauma narratives, thus experiencing indirect trauma exposure.

Vicarious trauma is a term used to describe negative effects of professional helping; therefore, it is considered an occupational hazard of providing counseling to traumatized persons (Merriman, 2015; Pearlman, 1999; Rank, Zaparanick, & Gentry, 2009). Studies indicate that up to 50% of counselors working with traumatized persons are at high risk of vicarious trauma (NCTSN, 2011). Vicarious trauma refers to the empathetic engagement with a traumatized client, which impacts the inner experience of the therapist. This may cause changes in the counselors self and professional cognitive frame of reference, affecting the personal, professional, and social aspects of the counselor (Adams & Riggs, 2008; Aparicio, Michalopoulos, & Unick, 2013; NCTSN, 2011; Saakvitne & Pearlman, 1996). Vicarious trauma manifests in symptoms similar to PTSD and often mirrors the client symptoms (Howlett & Collins, 2014).

Vicarious trauma can impact a counselor's effectiveness and be detrimental to a counselor's professional identity and success. Counselors experiencing unaddressed vicarious trauma can suffer from symptoms that impede their ability to provide effective treatment to clients (Vrklevski & Franklin, 2008). It is a counselor's ethical responsibility to monitor effectiveness under the American Counseling Association (ACA) Ethical Code C.2.d. and monitor for impairment under ACA's Ethical Code C.2.g. (ACA, 2014). However, for counselors-in-training, the ethical responsibility for monitoring this behavior also falls on the counselor educators and supervisors, who have a responsibility to monitor behaviors that might impede a counselor in training or indicate deficits. This is specified in the ACA Ethical code (2014), as well as the accreditation standards of Council for Accreditation of Counseling and

Related Education (CACREP) (Council for Accreditation of Counseling and Related Education, 2016).

Understanding the factors that impede counselors-in-training is critical to client well-being. This includes helping educators and supervisors understand the risk factors and signs of vicarious trauma. Some of the risk factors of vicarious trauma include: counselors who work directly with traumatized persons, counselors who identify as a women, new counselors (two years or less experience) or counselors-in-training, individuals who are highly empathetic by nature, counselors who have history of unresolved personal trauma, counselors with heavy caseloads, counselors with insufficient self-care strategies, and counselors who lack supervision, peer support, resources, and trauma specific training (Adams & Riggs, 2008; Jordan, K. 2010; NCTSN, 2011; Sommer, 2008; Vrklevski & Franklin, 2008). Protective factors include: counselors who practice healthy self-care strategies, counselors who have a supportive work environment, counselors with a reduced caseload of trauma clients, counselors with increased vacation and sick time, trauma-sensitive supervision, peer support, and trauma specific education and training (Merriman, 2015; Sommer, 2008; Vrklevski & Franklin, 2008).

Supervision is documented as a protective factor against vicarious trauma and as a way to address vicarious trauma symptomology; however, there is a rarity of research regarding whether supervisors are trained in trauma sensitive supervision and the ability to identify, attend to, and prevent vicarious traumatization (Merriman, 2015; Slattery & Goodman, 2009; Sommer, 2008). This study will aim to fill that paucity by researching supervisors' knowledge of vicarious trauma and recommendations for prevention of vicarious trauma.

Literature has provided evidence that trauma is rampant, which increases the number of individuals with trauma histories seeking mental health treatment; therefore, putting counselors

at a higher risk for experiencing vicarious trauma. Research indicates that counselors are experiencing and suffering from vicarious trauma symptomology, which can affect treatment effectiveness and the counseling experience for clients. Studies recommend protective factors and strategies to ameliorate vicarious trauma in counselors, with a heavy emphasis on organizational change within agencies, including clinical supervision. Trauma-sensitive supervision guidelines are available; however, there is a lack of research on the ability of supervisors to identify, attend to, and prevent vicarious trauma, as well as their perceptions of vicarious trauma. Supervision is an excellent screening and intervention tool for vicarious trauma; however, it cannot be effective if supervisors are unaware of the vicarious trauma phenomenon. This study aims to explore counseling supervisors' perceptions of vicarious trauma and understanding the phenomenon of vicarious trauma through the supervisors lens. By building the perception of supervisors' lived experiences of vicarious trauma the study will aim to fill the research gap.

Trauma Prevalence

Reviewing the literature on the pervasiveness of trauma is imperative to understanding the significance of this study of vicarious trauma. The Adverse Childhood Experiences (ACE) study demonstrated a link between average working Americans and high trauma rates, through a decade long collaboration and the largest scientific research study of its kind (Adverse Childhood Experiences, 2014). Dr. Anda of the Center for Disease control (CDC) and Vincent Felitti of Kaiser Parmanente began the ACE study in 1995 in response to finding that successful patients, who were terminating bariatric treatment early, had high rates of childhood trauma (Center for Disease Control, 2014). This large study captured data from 17,000 Health

Management Organizations (HMO) members on childhood trauma and behavioral and health outcomes in adulthood.

The ACE study revealed that trauma exposure was commonplace, even among a population of primarily Caucasian (77%) middle-class Americans that were college educated (72%). Even among this HMO population, which was not likely to have been exposed to neighborhood/street violence, extreme poverty, malnutrition, dislocation, or war trauma; 20% reported sexual abuse as a child, female participants reported 66% of domestic or family strife in childhood, and one in sixteen participants were exposed to four or more categories of adverse childhood experiences (ACE, 2014). The analysis of the data presented a link between health outcomes across bodily systems and gradient trauma exposure. Mental health and substance abuse outcomes such as depression, alcohol abuse, intravenous drug use, suicidal behavior, psychotic symptoms, and anxiety were also linked to trauma (ACE, 2014).

The ACE study blatantly reveals through consistent longitudinal evidence that incidents of trauma exposure are rampant in the general population and they are linked to physical and mental health outcomes. Other studies have similar findings, including statistics such as 90% of the population served in the mental health system have trauma exposure histories, most with multiple exposures, and 93% of adolescent psychiatric inpatients have trauma histories as well (Lipschitz, Winegar, Hartnick, Foote, & Southwick, 1999; Muesur, Goodman, Trumbetta, Rosenburg, Osher, Vidaver, et. al., 2004).

Additionally, the U.S. Department of Veteran Affairs National Center of PTSD (2015) reports that trauma is not a rare occurrence with about 60% of men and 50% women experiencing at least one trauma in their lives. Trauma prevalence in the United States is

furthermore confirmed by the National Child Traumatic Stress Network (NCTSN) (2011), which states that 10 million children per year experience a traumatic experience.

These studies provide overwhelming evidence that trauma is prevalent in the United States, as well as in the mental health care setting. It is a logical conclusion that mental health workers, including counselors, are exposed to client trauma narratives regularly in the course of their work. Counselors are the individuals that empathetically listen to trauma narratives, thus experiencing indirect trauma exposure. This type of exposure has been labeled as vicarious trauma.

Vicarious Trauma

In 1990, McCann and Pearlman developed a term to describe the impact of indirect exposure to trauma, specific to the counselor and the counseling relationship. The term vicarious trauma is used to describe and conceptualize the transformation that occurs within a cumulative process "through which the therapist's inner experience is negatively transformed through empathic engagement with the clients' trauma material" (Pearlman & Saakvitne, 1995, p. 280).

Similar to this definition, the American Counseling Association (n.d.) defines vicarious trauma as the "emotional residue of exposure that counselors have from working with people as they are hearing their trauma stories and become witnesses to pain, fear, and terror that trauma survivors have endured". Others have expanded this definition to clarify that empathetic engagement to clients' trauma material and increased stress resulting from working with traumatized persons sometimes leads to vicariously traumatized counselors (Adams & Riggs, 2008). Many counselors may be exposed to vicarious trauma, but not all will experience vicarious traumatization (Sommer, 2008).

While there appears to be some parallels in how this experience of emotional residue is defined, there have been differing opinions on what to label or call this experience. As noted earlier, it is frequently labeled as vicarious trauma. Other terms that label parallel or somewhat similar experiences include; compassion fatigue, secondary traumatic stress, burnout, or counter-transference; however, these terms are slightly different and cannot be used synonymously (Merriman, 2015). However, the term vicarious trauma has been used interchangeably with the aforementioned terms in the literature (Howlett & Collins, 2014; Jordan, 2010; Trippany, White Kress, & Wilcoxon, 2004). While the terms have some commonalities in their symptoms, counselors experience each differently (Figley, 2002).

Compassion fatigue has been defined to be long-term stress, including psychological and emotional strain of empathetic work that is cumulative in nature, resulting from empathizing with suffering clients (Tosone, Nuttman-Shwartz, & Stephens, 2012; Voss Horrell, Holohan, Didion, & Vance, 2011). Compassion fatigue is not limited to those working with trauma survivors which highlights the difference to vicarious trauma.

Figley (1995) defines secondary traumatic stress as the "natural and consequential behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other or client and the stress resulting from helping or wanting to help a traumatized or suffering person or client" (Figley, 1995, pg. 7). Secondary traumatic stress is unique to working with trauma survivors and has similar symptoms of Post-Traumatic Stress Disorder (PTSD) (Tosone, et al., 2012). Designating the difference between vicarious trauma and secondary traumatic stress can be challenging, as the definitions and symptoms are similar; however, the cause of the symptoms differs. For secondary traumatic stress, the counselor's symptomology is directly related to the client's experience of trauma and is case specific,

meaning it can occur suddenly and that it is not due to collective stress of professional helping (Tosone, et al., 2012). Secondary traumatic stress is in response to a specific case and client, while vicarious trauma can be a reaction to a specific case, but generally is a response to chronic exposure to numerous client's trauma narratives (Adam & Riggs, 2008; Aparicio, Michalopoulos, & Unick, 2013; Pearlman & Saakvitne, 1995; Tosone, Nuttman-Shwartz, & Stephens, 2012). Vicarious trauma symptomology extends further than anxiety, depression, avoidance, and hyper-arousal (symptomology of PTSD) by including a shift in the inner experience of the counselor, including cognitive schemas that influence the several aspects of the counselor's world, and can have permanent alterations on the counselor's life (Canfield, 2005; Pearlman & Saakvitne, 1995; Tonsone, Nuttman-Shwartz, & Stephens, 2012).

Burnout should not be confused with vicarious trauma. The distinction between vicarious trauma and burnout is clear. Burnout is specifically related to a high stress work environment and is not necessarily connected to client trauma narratives or the interpersonal interactions between the client and counselor (Harrison & Westwood, 2009; McCann & Pearlman, 1990).

Counter-transference is another term that needs to be distinguished from vicarious trauma. Clarification is made when considering that counter-transference is a short term response to the intrusion of the clinician's own unresolved history contained in a session with a client, thus confined within a therapeutic setting (Harrison & Westwood, 2009; Tosone et al., 2012). Vicarious trauma can have a long and/or short term impact on the totality of the clinician's life, both inside and outside of a therapeutic setting (Tonsone et al., 2012).

Vicarious trauma differs from the aforementioned terms due to it resulting from chronic exposure to client trauma narratives and a negative alteration of the counselor's cognitive schemas (Aparicio et al., 2013; Pearlman & Saakvitne, 1995). This phenomenon is a result of

cumulative exposure and not specific to any one client (Adams & Riggs, 2008). Specifically, vicarious trauma refers to the empathetic engagement with a traumatized client that impacts the inner experience of the counselor, such as changes in the counselor's self and professional cognitive frame of reference, influencing the personal, professional, and social aspects of the counselor (Adams & Riggs, 2008; Aparicio, et al., 2013; NCTSN, 2011; Saakvitne & Pearlman, 1996). Additionally, cognitive shifts influence identity, spirituality, and worldview, including changes in self-perception, ego, and psychological needs may occur when a counselor experiences vicarious trauma (Canfield, 2005; Pearlman & Saakvitne, 1995).

Additionally, vicarious trauma is diverse due to the involvement of "profound changes in the core aspects of the therapist's self" (Pearlman & Saakvitne, 1995, p. 152). Pearlman (1999) designates that vicarious trauma is "neither a reflection of inadequacy on the part of the therapist nor of the toxicity or badness on the part of the client. It is best conceptualized as a sort of occupational hazard" (p.52).

Vicarious Trauma Symptomology

According to Pearlman & Saakvitne (1995), vicarious trauma can cause significant changes in the core traits of the counselor, including the way the counselor views themselves, others, and the world, impacting the counselor on all levels of functioning, both professionally and personally. This can influence the level of empathy and ability to respond to the client (Trippany, Kress, & Wilcoxon, 2004). A counselor experiencing vicarious trauma may have a change in frame of reference from positive to negative after being exposed to several client trauma narratives, which can include the counselor’s beliefs about safety, power, independence, esteem, and intimacy (Elwood, Mott, Lohr, & Galovski, 2011). Counselors who have been vicariously traumatized may no longer feel safe, with increases in fear and a sense of

vulnerability, may no longer trust the world, and may experience a decrease in self esteem, causing a feeling of inadequacy with their ability to help clients (Elwood, et al., 2011).

Vicarious trauma manifests in symptoms similar to PTSD and often mirrors the client's symptoms (Howlett & Collins, 2014). Vicarious trauma symptoms include, but are not limited to: suspiciousness, anxiety, depression, sadness, somatic symptoms, intrusive thoughts and feelings, avoidance of responsibilities related to work, emotional numbing and flooding, increased feelings of personal vulnerability, impacting personal life (relationships as well as physical and mental health), triggering previous traumatic experiences, and decreased job satisfaction and motivation (Adams & Riggs, 2008; Neumann & Gamble, 1995; Pearlman & Mac Ian, 1995; Steed & Downing, 1998).

Vicarious trauma can impact a counselor's effectiveness and be detrimental to a counselor's professional identity and treatment success, which could impact clients by limiting their ability to provide effective treatment. Counselors experiencing unaddressed vicarious trauma could be suffering from symptoms that impede their ability to provide effective treatment to clients (Vrklevski & Franklin, 2008). The literature states that vicarious trauma can significantly impact a counselor's core traits and cognitive schemas negatively, which can deteriorate their level of empathy and ability to respond to the client (Pearlman & Saakvitne, 1995; Trippany, et al., 2004).

It is a counselors' ethical responsibility to monitor effectiveness under the American Counseling Association (ACA) Ethical Code C.2.d. and monitor for impairment under ACA's Ethical Code C.2.g. (ACA, 2014). Therefore, counselors have the responsibility to monitor their own symptoms and changes within themselves to maintain overall well-being to ensure their

effectiveness as a clinician. However, when counselors are in training that responsibility is shared.

In regards to counselors-in-training, the ethical responsibility falls on the counselor educators and supervisors of the students, as denoted by the ACA (2014) and the Council for Accreditation of Counseling and Related Education (CACREP) (2014) to observe student development (Sommer, 2008). CACREP (2014) goes a step further by requiring counselor educators inform counselors-in-training in trauma specific counseling skills as well as on self-care practices to avoid vicarious trauma. The counselor educators' and supervisors' ethical responsibilities are reflected in the 2014 ACA Ethical Code F.1.a., which states that a supervisor's principal obligation is to monitor supervisees provided services, F.5.b. which addresses monitoring for impairment, and F.4.c. which states that supervisors have an obligation to bring awareness to "professional and ethical standards and legal responsibilities" to their supervisees (ACA, 2014). In regards to vicarious trauma specifically, code F.8.d. mandates that adequate supervision be provided to counselors-in-training if they are experiencing vicarious traumatization symptomology (ACA, 2014).

Vicarious trauma is an occupational hazard that impacts counselors' ability to provide the best care possible for their clients making assessing for and addressing vicarious trauma symptomology an ethical obligation of counselors, counselors-in-training, supervisors, and counselor educators. Being mindful of vicarious trauma symptomology is not enough to meet that ethical responsibility. It is essential to be informed of the risk factors that can attribute to the vulnerability of experiencing vicarious trauma as well as the protective factors that can prevent vicarious trauma.

Risk and Protective Factors of Vicarious Trauma

Research provides evidence that there are both risk factors and protective factors for vicarious trauma. A risk factor is defined as variables that hinder a process or development and a protective factor is defined as variables that promote a process or development (http://youth.gov/youth-topics/youth-mental-health/risk-and-protective-factors-youth, n.d.). For the purposes of this study, a risk factor is defined as any variable the counselor possesses or engages in that has been evidenced to increase the likelihood of counselor vulnerability to develop vicarious traumatization, resulting from exposure to client trauma narratives. In contrast, a protective factor is defined as any variable that the counselor possesses or engages in that has been evidenced to decrease current vicarious trauma symptomology or variables that are preventative.

Risk factors for vicarious trauma include counselors that work directly with traumatized persons, counselors that identify as women, new counselors (two years or less experience) or counselors-in-training, counselors who are highly empathetic by nature, counselors who have a history of unresolved personal trauma, heavy/unmanageable caseloads, decreased work satisfaction, insufficient self-care and/or stress management strategies, and counselors who lack supervision, peer support, resources, and trauma specific training (Adams & Riggs, 2008; Jordan, K. 2010; NCTSN, 2011; Sommer, 2008; Vrklevski & Franklin, 2008).

Some of the risk factors are counselor specific while others are organizational. Counselor specific risk factors are variables that they do not have control over (being a woman, highly empathetic by nature, being new counselors) and variables they do have control over (seeking supervision and peer support, seeking counseling for unresolved trauma, maintaining healthy self-care and/or stress management strategies, researching resources, and attending trauma

specific training). Organizational risk factors are variables counselors do not have control over including heavy/unmanageable caseloads, lack of supervision, lack of resources, and lack of trauma specific training provided by the organization.

Protective factors include healthy self-care strategies, supportive work environment, reduced caseload of trauma clients, increased vacation and sick time, trauma-sensitive supervision, peer support, and trauma and vicarious trauma specific education and training (Merriman, 2015; Sommer, 2008; Vrklevski & Franklin, 2008). As with risk factors, protective factors can be counselor driven or organizationally driven.

Further protective factors that are counselor specific strategies, meaning the counselor can control them, include: seeking personal counseling if needed, developing and participating in regular healthy self-care strategies, seeking social and peer support, maintaining a work/life balance, and seeking supervision. Counselors can also participate in counselor professional development opportunities, such as trauma specific and evidence based practices trainings and workshops as a protective factor. Additionally, maintaining an optimistic and hopeful attitude toward working with trauma survivors has been noted as a protective factor for counselors (McCann and Pearlman, 1990). Lastly, a counselor can educate themselves on early signs of impairment caused by vicarious trauma, to increase self-awareness and practice self-monitoring, so they can reach out for help when needed (Harrison & Westwood, 2009).

Protective factors that are organizational and may not be within counselor control include: assigning balanced caseloads with a variety of client presenting concerns to each counselor, providing trauma sensitive supervision, fostering a supportive work environment that is collaborative in nature, providing resources and clear treatment protocols, and providing opportunities for counselors to participate in professional development workshops and trainings

on trauma, vicarious trauma, and self care (Voss Horrell, et. al., 2011). This supportive environment should include an attitude of acceptance and support when counselors are experiencing vicarious trauma and in no way should incorporate shame. Providing a supportive environment that incorporates these protective factors is the critical responsibility of the directors of the organization as well as the supervisors and counselor educators.

The aforementioned factors have all been heavily researched and documented to have a positive or negative impact on the vulnerability of counselors to experience vicarious traumatization. Supervision as a protective factor will be the focus of this study.

Supervision as a Protective Factor

Beginning counselors and counselors-in-training have been identified as having a higher risk of experiencing vicarious traumatization, which puts even more emphasis on the importance of effective clinical supervision with a trauma sensitive lens. Supervision has been used as an intervention tool in the counseling profession to channel knowledge, skills, and support of the supervisor to new and training counselors and is reinforced through ACA ethical guidelines and CACREP (Berger & Quiros, 2014; Sommer, 2008). Consider the 2014 ACA Ethical Code F.1.a., which states that the "primary obligation of counseling supervisors is to monitor the services provided by supervisees". As explored earlier, it is proven that unaddressed vicarious trauma can impede the effectiveness of counselors services provided and treatment for clients (Vrklevski & Franklin, 2008).

Supervision is the process of an experienced clinician, with appropriate credentials, fostering professional growth and development, including counseling skills and self-efficacy in another novice counselor (Bernard & Goodyear, 2009; Lambie & Sias, 2009; Merriman, 2013). As a protective factor to vicarious trauma, Harrison and Westwood (2009) suggest that

supervision acts as both an early monitoring and rapid response to vicarious trauma symptomology displayed in counselors, which can help prevent damage to the client and the counselors.

In continuation of that theme, other researchers suggest that supervision can be a restorative process, by allowing for physical and emotional space and time for supervisees to express their personal and professional goals and needs, which will enhance competence and counselor health (Bernard & Goodyear, 2009; Berger & Quiros, 2004). Productive supervision must include providing that space and trusting environment, creating a healthy supervisory relationship, also referred to as the supervisory working alliance (Bernard & Goodyear, 2009; Harrison & Westwood, 2009). According to Rosenbloom, Pratt, and Pearlman (1999), "supervision should foster an atmosphere of respect, safety, and control for the therapist who will be exploring the difficult issues evoked by trauma therapy" (Rosenbloom, et. al., 1999, pg. 77). The working alliance should include open and honest communication and a safe space for the counselor to express their concerns. Without a strong working alliance, supervision as a protective factor cannot be reached; therefore, building a strong relationship between the counselor and supervisor is the first and an essential step of this protective factor.

Effective clinical supervision has been identified as a protective factor and a tactic to ameliorate vicarious trauma throughout the literature (Adams & Riggs, 2008; Berger & Quiros, 2014; Merriam, 2015, ; Pearlman & Saakvitne, 1995; Slattery & Goodman, 2009; Sommer, 2008; Toren, 2008; Vrklevski & Franklin, 2008). Since 1995, researchers have recommended that supervisors address vicarious trauma as part of trauma sensitive supervision, with guidelines being outlined (Sommer, 2008). Guidelines include a trauma focused theoretical framework, attentiveness to the counselor's frame of reference and outlook on treatment, facilitating a safe

and respectful, as well as collaborative, environment to encourage honest communication, observation of counselor behavior, being watchful of vicarious trauma symptomology, and providing education on vicarious trauma exposure, prevention, symptoms, and treatment (Etherington, 2000; Pearlman, 1999; Pearlman and Saakvitne, 1995; Rosenbloom, Pratt, & Pearlman, 1999; Sommer & Cox, 2005, 2006). Additionally, Sommer and Cox (2005 & 2006), recommend supervisors make time in supervision specifically for conversation on the counselors personal feelings and effects of trauma work, using a collaborative strength-based approach, allowing for further vicarious trauma symptom and risk factor checks.

Supervision is documented as a protective factor of vicarious trauma and as a way to address and heal vicarious trauma symptomology. However, there is a paucity of research regarding whether the average supervisor's experiences with vicarious trauma includes the ability to identify, attend to, and prevent vicarious traumatization in supervision with their supervisees (Merriman, 2015; Slattery & Goodman, 2009; Sommer, 2008). This paucity leads into the purpose and significance of this study in an effort to fill that gap.

Purpose of the Study

The purpose of this qualitative phenomenological study is to explore counselor supervisors' perceptions of the vicarious trauma phenomenon. The study will include a focus on supervisors' lived experiences of the phenomenon of vicarious trauma within their supervisees. The intention is to provide thick, rich descriptions of supervisors' perceptions of their supervisees that are experiencing vicarious trauma and how they respond to the symptoms.

Significance of the Study

This study is impactful for the counseling profession as a whole. Implications for counselor supervision best practices, counselor education and training, supervisor training, and

clinician health in regards to vicarious trauma will be provided. By giving a voice to supervisors and their perceptions of the vicarious trauma phenomenon, the results yield insight into the treatment and prevention methods of vicarious trauma through a supervisor's lens. This study aims to focus on caring for the caregivers to maintain clinician health, thus maintaining ethical obligations as well as continuity of best practices for clients.

Research Questions

The researcher aims to answer a central question, what are supervisors' perceptions of the vicarious trauma phenomenon? This leads into a set of subset questions to inquire about supervisors' perceptions of vicarious trauma:

How do supervisors describe vicarious trauma?

How do supervisors identify vicarious trauma symptoms displayed by their supervisees?

How do supervisors attend to vicarious trauma in supervision?

How do supervisors describe the prevention of vicarious trauma?

Chapter Summary

The abovementioned literature has provided evidence that trauma is prevalent which increases the number of individuals with trauma histories seeking mental health treatment, putting counselors at a higher risk for experiencing vicarious trauma. Additionally indicated, counselors are experiencing and suffering from vicarious trauma symptomology, which can be detrimental to treatment effectiveness and the counseling experience for clients. Researchers recommend protective factors and strategies to ameliorate vicarious trauma in counselors, with a heavy emphasis on agency organizational change, including clinical supervision. Trauma-

sensitive supervision guidelines are available; however, there is a paucity of research on supervisor's ability to identify, attend to, and prevent as well as perceptions of vicarious trauma.

Chapter 2

Methodology

Organization of Chapter

The purpose of this chapter is to present the methodology the researcher utilized to explore the perceptions of supervisors on vicarious trauma. Chapter 2 outlines the research design and details the methodology, utilizing Creswell's qualitative constructivist interpretive format for qualitative proposals (Creswell, 2009; Creswell 2013). The chapter includes an introduction discussing the statement of the problem, purpose of the study, research questions, as well as delimitations and limitations. Discussion of the procedures, such as the characteristics of a hermeneutical phenomenology, is included. Furthermore, the role of the researcher, including any possible research biases, participant recruitment methods, data collection, and data analysis strategies are discussed. Lastly, exploration of trustworthiness, including credibility, confirmability, intracoder reliability, and additional ethical procedures for validating findings.

Introduction

The primary researcher for this study began her journey with an interest and curiosity on how the criminal justice world and mental health treatment intersect. She has served the at-risk youth population and high risk clients across all age groups as a mental health counselor in a juvenile detention center, a crisis residential treatment center, a family and child outpatient center, and a college counseling center. She quickly discovered that several of her clients reported having a trauma history and would share their narrative as part of the therapeutic process. She has experience collaborating as part of a research team that conducted studies at a juvenile detention facility and a residential treatment home, which focused on providing best practices through program evaluation and needs assessment with a concentration on trauma-

informed care. While conducting these other studies it became evident that burnout and vicarious trauma are a predominant occurrence for counselors providing services to populations that have high trauma exposure. In addition to bringing with her experiences of conducting research studies and working with clients who have experienced trauma to a Counselor Education and Supervision doctoral program, the primary researcher also brought a sense of wonder and self-reflection. These feelings and thoughts drove her to research how to best provide supervision to counselors that work with traumatized clients and to maintain clinician health. The researcher's contemplations about her perceptions of her experiences as a supervisor for counselors-in-training who work with traumatized clients compelled her to explore the perceptions of other supervisors. She believes that this exploration will contribute to the literature through an in-depth examination of the perceptions of counseling supervisors on vicarious trauma. The researcher desires to give a voice to supervisors that have been unheard and give meaning to their experiences. This desire lead to the development of the research questions. The methodological approach selected for this study is phenomenology, which aligns with the purpose of the study.

Research Questions

To examine the main question, "what are supervisors' perceptions of the vicarious trauma phenomenon?, the researcher utilized the following subset questions to inquire about supervisors' perceptions of vicarious trauma:

How do supervisors describe vicarious trauma?

How do supervisors identify vicarious trauma symptoms displayed by their supervisees?

How do supervisors attend to vicarious trauma in supervision?

How do supervisors describe the prevention of vicarious trauma?

Rationale for Qualitative Inquiry

The purpose of this qualitative study is to explore counselor supervisors' perceptions of vicarious trauma to develop a deeper understanding of their experiences. The goal is understanding the phenomenon of vicarious trauma through supervisors' lens. Research has provided evidence that all counselors have the potential to be vicariously traumatized with variables that can be risk factors for or protective factors against their vulnerability to experience vicarious trauma (Adams & Riggs, 2012; Knight, 2010). Vicarious trauma symptomology occurs over a period of time for counselors who provide services to clients who have experienced trauma. The symptomology can effect several areas of the counselors' personal and professional lives, potentially impacting quality of life for the counselor and quality of service provided to clients (Trippany, et al., 2004; Vrklevski & Franklin, 2008). The literature has also determined that supervision is a protective factor of vicarious trauma for counselors (Rasmussen, 2005; Trippany, et al., 2004). However, there is a paucity of research regarding supervisors' ability to identify, attend to, and prevent vicarious traumatization. An exploration of supervisors' perceptions of the vicarious trauma phenomenon aims to aid in filling that research gap, by exploring supervisors' perceptions of vicarious trauma and ways they address the phenomenon within the supervision process.

This study's goal is to strengthen the understanding of supervisors' perception of vicarious trauma, treatment of vicarious trauma, and prevention of vicarious trauma phenomenon within a supervisory relationship through the supervisors' voice. To build the perception of supervisors lived experiences will allow for the opportunity for future research, such as determining if specific supervisory models aid in vicarious trauma prevention in supervisees more than others, and/or if specific interventions are more successful. Additionally, further

research in tertiary trauma may be benefited by the potential outcomes of this study, allowing for further understanding of a supervisor that may be experiencing tertiary trauma, while providing supervision to a supervisee that is vicariously traumatized.

The overarching objective of this qualitative study is to strengthen the understanding of supervisors' viewpoint of vicarious trauma when working with their supervisees and to provide evidence for vicarious trauma prevention strategies from the supervisor perspective. Understanding supervisors' views on vicarious trauma treatment and prevention strategies may potentially impact academic education and training of counselors and supervisors. Maintaining the health of counselors is a benefit reaching clients, ensuring best practices from healthy counselors; therefore, benefiting the counseling profession as a whole. A qualitative methodology is the best fit for the goal of this study.

The qualitative approach allows for an in-depth exploration of supervisors' perspectives rather than focusing on breadth. Qualitative research is the best approach for building an inquiry about perception, such as understanding supervisors' lived experiences of vicarious trauma within supervision (Langdridge, 2007).

Rationale for Phenomenological Approach

Phenomenology lends itself well to the task of staying as true as possible to the lived experiences of the supervisors, who have lived the phenomenon through reflective descriptions (Moustakas, 1994). According to Creswell (2014), "phenomenological research is a design of inquiry coming from philosophy and psychology in which the researcher describes the lived experiences of the individuals about a phenomenon as described by participants. This description culminates in the essence of the experiences for several individuals who have all experienced the phenomenon" (Creswell, 2014, p. 14).

According to Van Manen (1990), a hermeneutic phenomenological approach includes six research activities including: 1. identifying a phenomenon that is of great importance to the researcher, 2. investigating the lived experience of the phenomenon, 3. reflection of the essential themes, 4. describe the phenomenon through writing, 5. maintaining an academic outlook to the phenomenon, and 6. maintaining a balance of the findings by looking at the big picture as well as the details (Van Manen, 1990, p. 30-31).

A hermeneutical phenomenological approach permits for a true emergent design allowing the study to grow and move with the findings, such as developing new questions for participants for second round interviews to enrich the descriptions and obtain an essence of the lived experiences (McLeod, 2011). The hermeneutical approach to phenomenology research is a great match for the research questions, as it aims to study an experience or phenomenon through supervisors perspectives (Creswell, 2014; Landridge, 2007).

Additionally, a hermeneutical phenomenological approach is best suited for finding common meaning and shared experiences for several supervisors lived experiences of the phenomenon of vicarious trauma to be able to develop practices or to develop a deeper understanding (Creswell, 2013). This methodology meets the goals of this study by seeking to reduce individual experiences of the supervisors to a description of the universal essence (Van Manen, 1990).

With that in mind, a hermeneutical phenomenological approach was selected over other qualitative approaches (grounded theory, case study, ethnography); specifically, due to the point that the research questions aim to provide thick, rich descriptions of the participants' lived experiences and perceptions of vicarious trauma in supervision and the commonality of the lived experiences (Creswell, 2013). A hermeneutical phenomenological qualitative methodology was

utilized to give a voice to supervisors and make meaning of their experiences with vicarious trauma in the supervisory setting.

Theoretical Framework

Due to the paucity of research regarding the protective factor of supervision for vicarious trauma (specifically supervisors' perceptions of vicarious trauma), this study gives a voice to the participants because they have been unheard in the literature. In an effort to uncover a comprehensive look into the perceptions of supervisors' experience of vicarious trauma phenomenon, a qualitative phenomenological approach was utilized. This approach allowed for exploration of supervisors' perceptions of vicarious trauma, giving a voice to the participants.

Due to several differing theoretical frameworks that qualitative researchers can subscribe to in phenomenology, it is essential to designate which framework was utilized for this study. The theoretical framework for this qualitative phenomenological study was social constructivism, due to the researcher seeking to interpret meaning from the perceptions of the supervisors on vicarious trauma. According to Creswell (2013 & 2014), when a researcher's intent is to decipher the meaning others have of the world, they are utilizing a social constructivist framework. A social constructivist framework includes the ideology that understanding the world of others and developing meanings that align with their experiences is formed through social interactions with individuals in society (Creswell, 2013).

Social constructivism is the philosophy that reality is built through social interactions. Thus, people learn from each other and make meaning of the world through their perceptions of the world. The researcher aimed to understand the phenomenon of vicarious trauma through supervisors' perspectives, aligning with the social constructivist theoretical framework and the hermeneutical approach. According to McLeod (2011), hermeneutics inquires about the lived

experiences of individuals through a cultural lens, seeking to understand those experiences by engaging in dialogue. That dialogue relates back to the social constructivist theory that individuals learn from each other.

By utilizing open ended questions, the researcher allows for participants to fully and freely describe their experiences through their lens and perception. The phenomenological approach explores what the participants have in common as they experience the phenomenon, allowing for textual and structural descriptions of the phenomenon (Creswell, 2013). The textual and structural descriptions of the phenomenon allow for the researcher and others that read this study to learn from other people, thus fulfilling the social constructivist theoretical framework.

Role of Researcher

The role of the primary researcher in a hermeneutical phenomenological qualitative study traditionally involves a "sustained and intensive experience with participants" (Creswell, 2014). This experience occurred through the phone interviews and member checking. The researcher reduced the data into common themes, then she reviewed the lived experiences of the supervisors to develop rich, thick descriptions. She used these descriptions to provide the commonality of the phenomenon of vicarious trauma within a supervisory relationship, through the perspective of the supervisors. She was also in the role of data collector, reductionist, interviewer, and observer. However, she was not in the role of a supervisor or counselor and did not provide services to participants.

The primary researcher entered this study with prior experience with the topic of vicarious trauma, as she has assisted with presentations on the topic and aided in the data collection of a dissertation on trauma-informed care. She brought with her biases about the phenomenon of vicarious trauma, including how to identify vicarious trauma symptomology as a

counselor and a supervisor. These assumptions exist based on her own experiences as a doctoral student in counselor education and supervision, which has allowed her to participate in multiple practicum and internship experiences as a clinician and supervisee. Additionally, she has been a doctoral student supervisor to counselors-in-training, providing assumptions of how vicarious trauma may be identified, addressed, and potentially prevented within the supervision relationship from her perspective. The primary researcher kept a record, as part of her reflective audit trail, of any assumptions, reflections, biases, moods, and/or responses that she had in reaction to any part of this study. This journal, as well as peer debriefing and intercoder agreement, provided monitoring of her biases and assumptions to allow for a true emergent design.

Procedures

Participants

Participants were eligible to participate in this study if they were a supervisor that had provided supervision to counselors/counselors-in-training within the last six months. All participants must have provided supervision to counselors/counselors-in-training that currently worked with clients who have experienced trauma. To determine if supervisees were working with this population, the site was the determining factor. Exclusionary criteria included supervisors that had not provided supervision within the last six months and supervisors that are not supervising counselors that work with traumatized clients. Criterion sampling was utilized ensuring that participants have experienced the phenomenon being explored (Creswell, 2013).

Recruitment

Once the research proposal was approved by the researcher's dissertation committee, the research proposal was submitted to the Auburn University Institutional Review Board (AUIRB)

for the use of human subjects in research (Please see IRB Proposal Approval Letter in Appendix A). When granted approval by the AUIRB, the researcher set in motion the recruitment process.

The researcher utilized criterion sampling to recruit 5 to 11 participants for this study. Participants for this study were recruited via word of mouth, counseling list-servs, and through emails. Recruitment of participants included a call for participants through the Alabama Counseling Association list-serv and the Counselor Education and Supervision Network (CESNET) list-serv. Additionally, the researcher asked for professors and cohort members to share her IRB approved Call for Participants Email to individuals they thought would fit the inclusionary criteria of this study.

The IRB approved Call for Participants Email (Please see Appendix B) included an outline of the purpose and details of study, eligibility criteria for participation, what was involved in participating (interview and time commitment), an incentive statement, and information on how to contact the investigator of the study for more information or to participate. Once the potential participants emailed the researcher inquiring about participation in the study, the researcher responded to schedule the initial phone interview and with the IRB Approved Informed Consent (Please see Appendix C). Participants were asked to review the attached Informed Consent form and if they were comfortable with the document, to please sign and scan back to the researcher prior to the interview. It was stated that the informed consent form must be signed and scanned back before the interview was conducted; however, if they had any questions to please ask and the researcher would provide any clarification they may need.

The informed consent document included the invitation to participate, eligibility requirements to participate, what was involved in participating, risks and discomforts, benefits, compensation for participating ($15.00 Amazon or Starbucks gift card awarded after member

checking), the ability to withdraw at anytime, and reviewed that the interviews would be audio recorded. The participant's privacy protection was reviewed in the informed consent as well. Any identifiable information obtained in connection with the study remained confidential. The identities of the participants is kept confidential and pseudonyms selected by the participants were used during the audio recordings and for the dissemination of findings. The primary researcher is the only individual aware of the identities of the participants, which was necessary to maintain contact with the participants for member checking. The researcher's dissertation committee had access to unidentifiable transcripts, recordings, and other raw data to maintain the confidentiality of the participants. Data was securely stored on an encrypted external hard drive and the primary researcher is the only individual with the password. Participants were recruited until saturation was reached meaning there were no new themes emerging.

Data Collection Methods

Once the participants signed and returned the informed consent to the researcher, the initial phone interview was scheduled. Participants were asked to provide dates and times to schedule the phone interview. The phone interview began by reviewing the informed consent prior to turning on the audio recorder. Participants were asked to select a pseudonym for identification purposes and to ensure confidentiality. During the interview, the researcher established rapport with the participants by explaining the purpose for conducting the research study, by explaining confidentiality, and answering any questions they had.

The data collection procedure included one (30-45 minutes) phone interview for each participant with an option for a second member checking interview (10-15 minutes). Questions in the first interview included supervisors understanding of vicarious trauma, symptomology of

vicarious trauma, and treatment and prevention to begin to build the "essence of experience" from the participants (Creswell, 2014).

A semi-structured interview approach was utilized as a primary means of data collection in this study. Phone interviews were selected as means of data collection for this study to provide the opportunity to reach potential participants across the United States, rather than be restricted to local supervisors. Additionally, Creswell (2014) suggests that phone interviews should be selected when the interviewer does not have the ability to meet in person with the participants.

The interviews were held over the phone at the convenience of the participants in the researcher's office to maintain confidentiality of the participants and clarity of the audio recordings. Utilizing phone interviews also allowed for the participants to choose where they were located during the interview. Thus, allowing them to feel safe and secure as well as encouraging them to be more open and honest about their experiences. Several of the participants asked for the researcher to call them at their work office (both in clinical and academic settings), several requested to be called on their cell phone (so they could be in the privacy of their own home), and one participant asked to be called on their cell phone while she was driving home from work (so she would not be disturbed at home or at work). Accommodating participant's schedules was a component of the researcher's efforts to foster the beginning of rapport and encourage participants to be more open and honest with their answers.

The researcher used the same introduction that incorporates the informed consent as a means to ensure standard procedure and that each participant in the research study experienced the same questions and topics. While the initial questions were developed for the initial interview protocol, the semi-structured interview method allowed for the interviewer to probe and ask follow-up questions related to the specific participant responses during the interview. The nature

of qualitative research allows for the opportunity to ask additional questions that are meant to enrich the textual meaning of emerging themes towards saturation; therefore, additional unforeseeable questions were asked by researcher. During the interview process, the researcher utilized reflection, paraphrasing, and summarizing skills to seek clarification from participants as they provided answers. Utilizing these skills ensured for a deeper understanding of the supervisors' experiences of vicarious trauma with their supervisees.

The initial interview was estimated to last approximately 30-45 minutes; however, the interviews ranged from 25-60 minutes, with the most common time frame being 30 minutes. During the initial interview, the researcher had an Interview Protocol (Please see Appendix D for Interview Questions/Interview Protocol) that included a list of inclusionary criteria questions and demographic questions which allowed for confirming that the participant matched the criteria for the study. The protocol also included the interview questions and space for the researcher to record thoughts, questions, discrepancies, issues, and potential themes regarding the participant responses which were added to the audit trail (Creswell, 2007). The interview questions were open-ended probing supervisors on their knowledge of vicarious trauma and asking them to reflect on their experiences with vicarious trauma within supervision providing the opportunity for thick, rich descriptions of their experiences. The researcher's chair reviewed the protocol prior to administration. A thank you statement of appreciation was the conclusion of the initial interview (Creswell, 2007).

The initial interview was transcribed via a secure encrypted transcription service. All audio tapes submitted only used pseudonyms. The transcription service was bound by a confidentiality clause and ensured confidentiality and privacy by splitting the files into smaller parts and giving those parts to different transcribers, guaranteeing that no individual transcriber

has access to the full file. They utilized 256-bit SSL encryption on their website, so all communication between servers and browsers are encrypted. The service signed a confidentiality agreement (Please see agreement attached in Appendix E). The researcher had full control over the files and once the researcher deleted the files from her account with the service, they deleted the files permanently from their servers.

Participant's transcriptions from the interviews were coded with a pseudonym to ensure confidentiality and were kept separate from the informed consent forms and contact summary sheet. The audio recordings of the participants were destroyed after they were transcribed. All identifying data was stored at researcher's office. The data was stored on an encrypted flash drive as well as locked in a file cabinet. The identifiable data, including IRB approval documents, consent forms, and contact summary sheet, was kept in separate locked file cabinet. IRB approval forms and participant consent forms will be retained for 3 years after the completion of the study and destroyed by July 2020. De-identified transcriptions of the interviews will be retained indefinitely.

The second interview was offered to the participants after data was compiled revealing common themes from the first interview. Through email, participants were provided the transcript of their interview. They were given the opportunity to confirm and/or clarify to ensure credibility of the information and narrative accounts through the process of member checking (Creswell & Miller, 2000). If they wanted to clarify any of the information from the transcript they were asked to respond to the email with a date and time for a second interview which would last approximately 10-15 minutes. If they wanted to confirm the findings and transcript, they were instructed to respond to the email with a confirmation statement and were asked to provide how they would like to be compensated. At the end of the second interview or if they confirmed

findings through email, the participant was asked whether they preferred a $15 Amazon or Starbucks gift card and what address the gift card could be sent to.

Once the researcher received the confirmation email or the second interview was concluded with all participants, the interviewer made any adjustments to the findings that the participants clarified as a part of the member checking process. This concluded the data collection process for this research study.

Data Analysis Procedures

The data analysis conducted reflects the qualitative data analysis steps outlined by Creswell including: 1. organize and prepare the data, 2. read and review all data, 3. start coding, 4. utilize coding to produce descriptions, 5. determine how to convey descriptions and themes in the narrative, and 6. interpretation of the findings (Creswell, 2014, p. 199-200).

The data was organized by individual transcripts and read and reread by the researcher several times prior to being coded. While reading the transcripts, the researcher made notes in the margin regarding overarching thoughts and ideas (Creswell, 2014; Tesch, 1990). Due to the audio recordings being transcribed by a transcription service, the researcher chose to hand code rather than utilize a qualitative computer data analysis program. Hand coding the transcripts allowed the researcher to immerse herself in the details and live with the narratives (Van Manen, 1990).

Individual transcripts were coded for emerging themes first, then all of the transcripts were compared and analyzed for common themes across participants. The coding process began by reviewing the transcriptions, isolating significant sentences, organizing the significant statements into categories, and labeling categories with a term (an in vivo term) developing the themes (Creswell, 2014). A traditional qualitative phenomenological approach of allowing codes

to emerge during data analysis was followed. While reading the individual transcripts, the researcher identified significant statements describing how the participant experienced the vicarious trauma phenomenon (Moustakas, 1994). Next, the significant statements were organized into categories that were labeled with an in vivo term (participants language) (Creswell, 2014). The researcher identified quotes from the transcripts to provide clear evidence of the relationship between the significant statements and the developed themes, which is typically labeled as a textural description (Creswell, 2013).

The hermeneutic circle was utilized to allow the coding to develop meaningful descriptions. According to McLeod (2011), "the hermeneutic circle refers to the idea that valid hermeneutic inquiry proceeds by building up an interpretation, through moving back and forth between the part and the whole. This involves: (a) gaining a sense of the meaning of the whole text; and (b) carrying out micro-analysis of the possible meanings of small sections of text, and using these to challenge or reinterpret the overall sense of the total text." (McLeod, 2011, p. 33). The hermeneutic circle is a way of interpreting text, such as transcriptions, that includes a process of understanding the parts to then bring an individual to understand the meaning of the whole text (Creswell, 2007). You cannot understand the whole without understanding the parts. The researcher moved back and forth between the part (significant statements) and the whole (themes) for individual transcripts. Then, the researcher moved back and forth between the parts (themes of individual transcripts) and the whole (commonality across all of the transcripts) to understand the universal experience of the participants.

Individual transcripts were coded for themes first and then all of the transcripts were compared and analyzed for commonality across all participants to develop universal common themes. This allowed for the identification of the commonality of supervisors lived experiences

of the vicarious trauma phenomenon. Once the researcher completed this process of the data analysis, the data was examined by an external auditor to ensure credibility of results.

Trustworthiness of the Data

Several methods to strengthen the credibility and trustworthiness of the study were used to enhance the confidence in the conclusions of the study (Creswell, 2014). The methods include saturation, member checking, audit trail, and utilizing a peer reviewer and external auditor.

Saturation. Langdridge (2007), states that the movement towards saturation level is key to the strength of a qualitative study. In order to move towards saturation, continuous recruitment of participants was conducted until no new themes and codes were found. Participants were recruited until saturation was reached and an enriched textual meaning of participant's perceptions was documented. For this study, saturation was reached with the tenth participant.

Member Checking. Participants were provided with the transcription of their interview and had an opportunity to confirm and/or clarify to ensure credibility of the information and narrative accounts (Creswell, 2014; Creswell & Miller, 2000; McLeod, 2011). Only one of the ten participants requested a second interview to provide clarification on their transcription. Two of the ten participants provided clarification of minor transcription errors through email. For example, Mary wanted to change the original text of "Meaning, not immediate exposure, or secondary exposure through our client, supervisee and students" to "Meaning, not immediate exposure, *but* secondary exposure through our client, supervisee and students". None of the clarifications impacted coding. The rest of the participants confirmed the transcriptions through email. Additionally, participant feedback was encouraged during the initial interview through the use of reflections and summaries to make sure that their lived experiences were reflected in their own words. Member checking is an additional source of data, which contributes to triangulation,

adding validity to the study. Triangulation adds validity to the study because it examines several sources of the data to determine if they converge, thus justifying the themes developed (Creswell, 2014). Triangulation also increases confirmability by reducing the potential researcher bias (Shenton, 2004).

Audit Trail. Maintaining a researcher's journal to record observations as part of a reflective audit trail strengthen triangulation measures as well (Shenton, 2004). A reflective audit trail provided transparency through the description of each step taken and the decision making process from the start of this research project through to the findings. Lincoln and Guba (1985, p. 319-310) cite Halpern's (1983) categories for audit trails including all raw data (de-identified for confidentiality), data reduction and analysis, data reconstruction, process notes, and instrument development. The researcher's journal also included documentation of experiences throughout the study including assumptions and biases that may arise (Giorgi, 2008).

External Audit. Furthermore, to strengthen the credibility of this study, an external auditor was utilized to enhance the accuracy by asking a peer to objectively review the study to guarantee that the study resonates with other people besides the primary researcher. An Auburn University Counselor Education and Supervision doctoral student was invited to fill the role of the external auditor. He was not familiar with the study ahead of time to ensure his objectivity. He was asked to review the relationship between the research questions and the data as well as the entire data analysis process, from the de-identified raw data to textual descriptions (Creswell, 2014). The interactions with the external auditor and any recommendations given were documented in the reflective audit trail.

Peer Review. An Auburn University Counselor Education and Supervision doctoral student was invited to be the individual that cross-checks codes (intercoder agreement) to

provide evidence for consistent results of the study for reliability (Creswell, 2014). She is familiar with the literature of vicarious trauma as her primary area of research focus includes counselor burnout. Also, she is familiar with the literature on supervision as she has completed her courses and internships as part of the doctoral program. Additionally, she is an adjunct faculty member at a nearby university and part of her duties is the provision of supervision to Master's level counseling students.

The peer reviewer was given two out of the ten transcripts and was asked to code them. The two transcripts were selected at random by asking a colleague to choose two numbers between one and ten. The two numbers selected were the participant transcripts that were given to the peer reviewer. The researcher then analyzed if the peer reviewer coded with the similar codes and determined if there was consistency within the coding at least 80% of the time to establish reproducibility (Creswell, 2014; Miles & Huberman, 1994). Thus, adding to the triangulation of the data because it checked the reliability of the codes developed by the primary researcher (Creswell, 2007). These interactions were documented through the reflective audit trail of the primary researcher. The peer reviewer enhanced the triangulation of the data and cross-checked the codes providing evidence of consistency and reproducibility within the coding, adding reliability to the study.

Chapter Summary

In conclusion, the literature provides ample evidence that vicarious trauma exists and even dares to state that any counselor who works with clients with trauma narratives are at risk for vicarious traumatization. However, the literature also provides protective factors that can help reduce the possibility of being vicariously traumatized and working through the symptoms; one of these protective factors is supervision. Trauma-sensitive supervision guidelines are available;

however, there is a paucity of research on supervisors' ability to identify, attend to, and prevent vicarious trauma. This study aimed to fill that void by gathering qualitative phenomenological data from supervisors on their knowledge of vicarious trauma and the treatment and prevention of vicarious trauma through the perceptions of the supervisors' lived experiences.

A phenomenological approach allowed for the researcher to explore and understand the phenomenon of vicarious trauma through the lived experiences of the supervisors. A hermeneutical phenomenological qualitative approach allowed for data analysis methods of understanding the parts to then ultimately understand the whole of the lived experiences of supervisors with the phenomenon of vicarious trauma within the supervisory setting. A commonality of the experiences provides a understanding of supervisors' experiences of the phenomenon of vicarious trauma and the recommendations they have for working with vicarious trauma in supervision. This approached gave the unheard supervisors' a voice.

Using the hermeneutical phenomenological approach, interviews were conducted with ten supervisors who provided supervision to at least one counselor/counselor-in-training who provide services to individuals who have experienced trauma. To identify the commonality of their experiences, the researcher analyzed the transcripts from the interviews individually developing emergent themes and then determined any common themes across all of the participants. This approach allowed the research questions to be answered. Several methods were implemented to confirm the credibility of the study's findings.

Chapter 3

Results

Introduction

Supervision is a documented protective factor for vicarious trauma. However, the voices of the supervisors themselves have been unheard. The purpose of this study was to examine supervisors' perceptions of the vicarious trauma phenomenon and how they navigate that phenomenon in supervision. The research questions guided the phenomenological qualitative exploration of supervisor's perceptions of the vicarious trauma phenomenon. The interview questions allowed for the supervisors to expand on how they identify and approach vicarious trauma in supervision. Additionally, the interview questions provided an opportunity for the supervisors to offer recommendations to other supervisors on how to work with and prevent vicarious trauma in supervision. A thick rich description of the supervisors' experiences of working with vicariously traumatized supervisees was reached through the interview questions and member checking.

This chapter describes the findings obtained from 10 semi-structured interviews. The chapter begins with a brief description of the supervisors (who were participants in this study) and demographic information, with Table 1 providing an overview. Table 1 includes the pseudonym selected by the participant, participant age, the gender and race/ethnicity they identify with, years employed as a supervisor, number of supervisees they have worked with, and if they were licensed supervisors. The researcher input the information using the participant's words.

Following the demographics, the findings are organized by theme. The findings are reviewed to highlight the common themes. The quotes from the participants are utilized to

provide evidence of the themes and give the participants a voice in an additional way. The chapter concludes with a chapter summary of the findings.

Demographics

This study included ten supervisors who have provided supervision to at least one counselor/counselor-in-training within the past six months. The counselors/counselors-in-training they supervised all worked at sites where they provided counseling to individuals who have experienced trauma. Out of the ten participants, two identified as men and eight identified as women. Additionally, seven supervisors identified as Caucasian/White, two supervisors identified as Black, one supervisor identified as Caucasian Hispanic, and one identified as an American of Arab decent. The supervisors' age ranged from 29 to 65 years old. The participants' years of experience employed as a supervisor ranged from two years to ten years. There was a wide range of the number of supervisees each supervisor has worked with from four to approximately one hundred and fifty. Four of the supervisors provided estimations of how many supervisees they had worked with utilizing words such as "about", "around", and "more than".

All of the supervisors were licensed professional counselors (LPC) in there designated states; however, only eight of the ten stated they held the supervisor credential such as a Licensed Professional Counselor Supervisor (LPC-S). Several of the supervisors were from Alabama due to the call for participants through the ALCA list-serv. The remainder of the supervisors were from Florida, Illinois, New Jersey, Washington, D.C., and a three were unknown.

Nine out of the ten supervisors identified that they had worked with a supervisee that was vicariously traumatized prompting the researcher to use the interview question protocol A. One supervisor stated that they had not worked with a supervisee that had experienced vicarious

trauma which prompted the researcher to use the interview question protocol B. The counselors/counselors-in-training that the supervisors worked with all were placed at sites that allowed them to work with individuals with trauma. The supervisors described the sites: group clinical practice, private and community outpatient, medical setting for sexual assault survivors, children services, sexual assault services, non-profit social services, behavioral health outpatient services for teens in contact with the juvenile justice department, non-profit child abuse services, outpatient counseling services for the severely mentally ill, a clinic associated with a university, and a hospital clinic.

Table 1

Participant Demographic Information

Pseudonym	Age	Gender	Race/Ethnicity	Years Employed as a Supervisor	Number of Supervisees	Licensed
Paul	65	Male	Caucasian	10	4	Yes
John	57	Male	Caucasian	4	≈150	Yes
Renee	35	Female	Caucasian	2	5	No
Dulce	51	Female	Caucasian Hispanic	9	>60	Yes
Ann	32	Female	American of Arab Decent	3	≈10	Yes
Michelle	36	Female	Black	4	25	Yes
Katherine	35	Female	Caucasian	3	6	Yes
Cindy	29	Female	Black	2	4	No
Mary	40	Female	White	7	>100	Yes
Kay	53	Female	White	6	≈20	Yes

Discussion of Themes

The primary research question "What are supervisors' perceptions of the vicarious trauma phenomenon?" is best answered by reviewing the responses to the interview questions and allowing for themes to emerge. Aligning with the phenomenological process, data analysis incorporated isolating statements from the narratives of the supervisors to represent the enriched themes embedded within the supervisors lived experiences (Moustakas, 1994).

The interviews provided individual and shared views, successes, and challenges of supervisors lived experiences of the vicarious trauma phenomenon in the supervision setting. The findings allow for the conceptualization of the supervisors experience by understanding the

parts to then understand the whole. The analysis of the research questions include common themes that emerged per question. The commonality of those themes are discussed below. The themes are enhanced with quotes from the supervisors. The identified themes are: 1) Knowledge of Vicarious Trauma, 2) Attending to Vicarious Trauma in Supervision, 3) Challenges and Successes of Attending to Vicarious Trauma in Supervision, 4) Recommendations made by Supervisors for Supervisors, and 5) Vicarious Trauma Prevention.

Knowledge of Vicarious Trauma

The majority of the supervisors described vicarious trauma as an indirect trauma with some labeling it as a secondhand traumatic experience, secondary traumatic stress, or contributing to burnout. All of the supervisors described vicarious trauma as a counselor listening to a client's trauma story and that story impacting the counselor in some way.

Many of the supervisors stated that vicarious trauma is an emotional response to a client's trauma narrative that affects the counselors. Katherine explained "Vicarious trauma is the emotional response that people in the helping profession can experience after listening to the trauma of others." Other emotions that were identified were sadness, anxiety, depression, empathy, and feeling overwhelmed. Many of the supervisors mentioned that their supervisee would cry in supervision when recounting the client's trauma story.

Supervisors also observed that some of their supervisees would be triggered by their client's trauma narratives leading to symptoms similar to Post Traumatic Stress Disorder (PTSD) including nightmares, hypervigilance, isolation, change in worldview and level of trust, avoidant behaviors, increased anxiety symptoms, and the inability to sleep. Katherine explained how PTSD symptoms were displayed in a supervisee that she worked with that was vicariously traumatized:

She exhibited symptoms that are similar to that of PTSD, which usually corresponds with vicarious trauma. She had increased arousal in the sense that she was becoming very sad and very depressed. She started isolating herself from others, her worldview started to change. She saw basically the world as a bad place. Her level of trust began to change because of all of the stories she had heard. She became very hypervigilant about the protection of her niece and nephew. Her dad, who was working at a church with children, and she was trying to protect him from having false allegations pressed against him, so things like that. Nightmares as well.

The supervisors continued to elaborate on the symptoms of vicarious trauma that they identify within supervision. A few of the supervisors made a point to state that a few of the symptoms were not directly observed by the supervisor themselves, but reported by the supervisee to the supervisor. The symptoms included the aforementioned emotions. Other symptoms discussed were the adoption of the client's symptoms. Michelle gave a description "Vicarious trauma is when a clinician is working with someone that has experienced trauma and then they start to develop some of the trauma symptoms or behaviors that the client or clients were reporting from the trauma".

Several of the supervisors explained that they would observe their supervisee be avoidant. The counselor would begin to avoid the client by rescheduling or cancelling appointments, avoid the work site by calling in sick, avoid by coming in late, or avoid the client narrative by not probing further or changing the topic in session with the client. Additional avoidant behaviors described included rearranging their schedule to make sure the heavier clients were not one right after the other. Dulce described that behavior as "dancing around the calendar". When the researcher asked her to elaborate she responded with "Yeah, changing

clients from here to there to here to there. Because it's like, I can't listen to this client before the next, or I can't listen to family A before family B comes in".

The participants described how their supervisees would display physiological symptoms as well in session and out of session. They described increased heart rate, eyes widening, sweating, and heavy breathing while talking about the client's story. Supervisors also observed that their supervisees would become physically ill and need time away.

A decrease in clinical effectiveness was commonly noted by the supervisors. They noticed through listening to supervisee's tapes that they would regress to old mistakes. Michelle stated "But I'll see them make slips that they haven't made since they were doing their Individual Counseling Skills Class". Additionally, a decline in clinician performance was illustrated by Cindy "Kind of impaired their judgment, or impaired their ability to work or function as a counselor. And not just with that client, but other clients."

Frustration and annoyance with clients was another symptom observed by the supervisors. Blurred boundaries continued to arise as well. Supervisors stated their supervisees would report thinking about their clients outside of the work place or allow specific clients more leeway than others. Another common find was that supervisors found that several of their supervisees reported needing a break from their site.

Additionally, several of the participants talked about how the counselors would feel shame and embarrassment from being affected by the client's narrative and had an intense fear about appearing weak. Cindy shared what her supervisee was concerned about "Does this mean I'm a bad counselor? Does that mean I'm not going to be good at this? Does that mean I can't do it? Does that mean I can't work for this client? Does that mean I have to switch sites? Does that mean I am not going to be considered strong?" Cindy continued to reflect on how her supervisee

described feeling fearful of admitting they were experiencing vicarious trauma because that would mean they were weak and unable to handle being a counselor. The participants continued with similar stories stating that their supervisees believed that experiencing vicarious trauma equaled failure as a counselor. This idea of failure included questioning their abilities as a counselor and if they were in the right profession. John recounted "I mean there was serious doubt about whether or not she was in the right profession and whether or not she could handle listening to these things, helping people like this".

Overall, the supervisors' descriptions of vicarious trauma align with the definitions in the literature including the negative impact of an indirect exposure to a trauma specific to the counselor due to the empathetic engagement with the client's trauma narrative (Pearlman & Saakvitne, 1995; McCann & Pearlman, 1990). However, a few of the participants mislabeled vicarious trauma as secondary traumatic stress; though, that aligns with the literature that some individuals in the field of counseling use the terms interchangeably (Howlett & Collins, 2014; Jordan, 2010; Trippany, White, Kress, & Wilcoxon, 2004). Supervisors were able to identify several of the well documented symptoms of vicarious trauma including suspiciousness, anxiety, depression, sadness, somatic symptoms, intrusive thoughts and feelings, avoidance of responsibilities related to work, emotional numbing and flooding, increased feelings of personal vulnerability, impacting personal life (relationships as well as physical and mental health), triggering previous traumatic experiences, and decreased job satisfaction and motivation (Adams & Riggs, 2008; Neumann & Gamble, 1995; Pearlman & Mac Ian, 1995; Steed & Downing, 1998). Additionally, the supervisors described the effectiveness of treatment being impacted as well. This parallels Vrklevski & Franklin (2008) who state that counselors experiencing

unaddressed vicarious trauma could be suffering from symptoms that impede their ability to provide effective treatment to clients.

Attending to Vicarious Trauma in Supervision

The supervisors described attending to vicarious trauma in supervision with their supervisees. These descriptions allows for a snapshot of how they live with the phenomenon of vicarious trauma in supervision. The participants had several reoccurring sub-themes for attending to vicarious trauma which included the need to for a supportive and safe environment, psycho-education on vicarious trauma, self-disclosure of supervisor's own experiences of vicarious trauma, the importance of self-care, and the concept of check-ins.

The supervisors stressed the importance of having a strong supervisory alliance which must be based on a supportive environment to allow the supervisee to feel safe to be vulnerable and bring up the vicarious trauma symptoms openly in supervision. Kay explained how she starts supervision off with a talk to foster a safe environment that includes:

> I expect that you're not going to do this perfectly and I want you to feel safe to come to me if something doesn't seem right. If you are struggling in an area or if you think you did something that wasn't exactly the best therapeutic thing to do, I want to know so we can fix it together. I want you to be proactive. I'm here to help you be successful, I'm not here to try to weed you out.

The participants believe that a supportive environment includes empathetically validating and normalizing supervisee’s symptoms and concerns. Mary described how she attends to vicarious trauma in supervision "Well I am first of all very empathetic and validating, so I would kind of normalize the situation, validate what my supervisee's going through." The supervisors shared that to normalize this experience, it is important to tell their supervisees that vicarious

trauma can happen to anyone despite level of experience and that it is an occupational hazard for counselors who work empathetically with clients who have experienced trauma. Paul shared that he explains this to his supervisees by "talking about the fact that it's an occupational hazard for us, it's part of what goes with the work that we do, it's just part of the package". The supervisors speak on how important it is to stress that vicarious trauma is not a weakness and that it is a natural response because counselors are human. Michelle explained how she would approach a supervisee:

> You're a counselor or a counselor-in-training, but you're also human and some of these things that you will experience with your clients or your clients will tell you can be very, very, very traumatic. So don't look at it as a sign of weakness that you're struggling or even if you are dreading working with this person because it is so heavy.

Providing reinforcement to the supervisee for being open and honest about the symptoms they were experiencing which furthers encouragement of vulnerability, self-awareness, and insight was a common discussion as well. Focusing on that vicarious traumatization does not equal failure was a passionate subject for Dulce "I tell them not be ashamed, that this is part of doing your job!" and "If you're not experiencing this, I would be surprised right now.".

Psychoeducation on vicarious trauma was common discussion by the supervisors during the interviews. They discussed how psycho-education needs to occur early and that it needs to be individualized to the supervisee to fill in the gaps of knowledge. Katherine reflected on how because she provided early psycho-education on vicarious trauma had an impact on her supervisee "She didn't just start experiencing these things and wondered what the heck was going on. She recognized that these were the symptoms and then felt comfortable enough to bring them up in supervision". Psychoeducation for Mary included resources and referrals such as "Phone

numbers for private practices, clinics, and then also self worksheets designed to your wellness and self-care". For the participants who were also counselor educators, they talked about providing psycho-education in classes as well including Dulce "Also the students that I've had in the Introduction to Family Counseling, I specifically teach about this topic because of the potential is so much greater with family counseling for parents and vicarious trauma".

Continuing with normalizing and validating supervisees' responses to vicarious trauma, the majority of the supervisors discuss the use of self-disclosure. Participants explained that they use transparency of their own experiences to normalize their supervisee's experiences to hopefully alleviate the shame and embarrassment the supervisee is feeling. John illustrated this point "I think people who are in the process of becoming a counselor don't realize that everybody else has the same fears and doubts and concerns that they do. Some self disclosure helps normalize what they're going through".

Paul valued self-disclosure as well, but he also had a cautionary statement "I intentionally was careful not to give the supervisee another traumatic experience to deal with" and "recommendations of being careful of how much details you provide to a supervisee so that your sharing your own experience doesn't in turn become vicarious trauma for your supervisee". Paul explained that he values self-disclosure to share that he has experienced vicarious trauma to normalize and validate his supervisee's feelings and includes how he moved past it to provide hope. But, he cautioned not share the traumatic story from the client that vicariously traumatized him. Ann had a similar outlook by sharing with her supervisees "How I deal with it doesn't necessarily help the way you deal with it and something you do might help differently. And then I talk about what would work for them."

Self-care was a commonality among all of the participants. The supervisors talked about how important it is to encourage individual self-care daily and start that conversation early in supervision. Ann described how she approaches vicarious trauma with supervisees "I guess I would approach it from a self-care perspective and ask them what they are doing to handle the stress of the job outside of work."

Renee also spoke on how effective group self-care and organizational self-care can be "So doing that as a group together I think has really helped team-build, number one, and that make it so that we're all modeling for each other what's healthy". Renee continued to talk about how group self-care can include "intentionally spending time away from our desks, away from the site during the day. Whether it's going outside for a walk or eating lunch somewhere else". Another part of self-care reported was encouragement of the supervisees receiving their own counseling. Self-care concepts also included mental health days, breaks, and time away from work. The supervisors talk about sometimes taking a step back includes not assigning that counselor any more clients.

Another topic discussed by the supervisors for addressing vicarious trauma was the notion of "check-ins". The supervisors talked about how it is important to check-in on self-care every supervision session to help build those healthy habits early in a counselor’s career. Additionally, they spoke about how they use check-ins to assess vicarious trauma symptoms including emotional responses and the use of boundaries.

Overall, the participants aligned with the guidelines recommended for addressing vicarious trauma as part of trauma sensitive supervision including facilitating a safe and respectful, as well as collaborative, environment to encourage honest communication, observation of counselor behavior, being watchful of vicarious trauma symptomology, and

providing education on vicarious trauma exposure, prevention, symptoms, and treatment (Etherington, 2000; Pearlman, 1999; Pearlman and Saakvitne, 1995; Rosenbloom, Pratt, & Pearlman, 1999; Sommer & Cox, 2005, 2006). Additionally, Sommer and Cox (2005 & 2006), recommend supervisors make time in supervision specifically for conversation on the counselors personal feelings and effects of trauma work, using a collaborative strength-based approach, allowing for further vicarious trauma symptom and risk factor checks. The supervisors talked about that conversation as weekly "check-ins" with their supervisees to assess for emotional responses to trauma narratives and to also check-in on the use of self care.

Challenges and Successes of Attending to Vicarious Trauma in Supervision

A look into what the supervisors perceive as the challenges and successes of attending to vicarious trauma in supervision allows for a deeper look into how they perceive the vicarious trauma phenomenon. During the interviews, reoccurring aspects of challenges when attending to vicarious trauma in supervision included that the supervisee had a lack of self-awareness, lack of education, and/or were in denial about their vicarious trauma symptoms.

Cindy mentioned that being fearful of the perceived consequences of being vicariously traumatized can keep supervisees from coming forward with how they are feeling. Renee agreed "I think that that comes from being worried that if they do experience vicarious trauma, that somebody's going to tell them, 'Well then, I guess you're not cut out for this work,' which is not the case at all. I think that you can do this work and still be affected by the people you serve and their stories.".

Though, several of the supervisors believed that an overall lack of insight and self-awareness lead the supervisees to be in denial or try to rationalize the symptoms. Mary reflected on this challenge as being dangerous:

> The first one that comes to my mind is the supervisee's denial or a way of justifying what's going on and rationalizing things and kind of not being able to hear feedback and thinking that nothing's going to happen to them, that they're strong and it's not going to affect them and they have abilities to cope with it. So I think that's a very dangerous area, if I have a supervisee coming in with the mindset of, "Oh, it's not going to be me, cannot happen to me. I have the skills and abilities and I'm not going to be the one.".

The challenges take a shift of focus from the supervisee to challenges the supervisors themselves face. Reoccurring challenges included the idea of having to balance being a supervisor and being a human being in the room with their supervisee. John explained the challenge is maintaining appropriate boundaries but also being real and human while having supervisory boundaries in place. Ann and Cindy also voiced that they were concerned about being unprepared as a supervisor to work with supervisees experiencing vicarious trauma. Ann expressed "I don't know if I felt prepared to work on it with supervisees. I don't know if I felt trained to do that. Also I think I wasn't prepared to deal with how difficult it is from, to deal with vicarious trauma as a supervisor". Kay explained the challenge of having to listen to the trauma narratives through her supervisee as well. She stressed the importance of being about to manage her own emotions while also being there for her supervisee.

Dulce talked about an additional challenge for working with counselors-in-training. She mentioned that it can be a challenge to evaluate your supervisee to determine if their symptoms are normal for counselor-in-training development or if it is vicarious trauma. She gave an example of her supervisee stating they were not sleeping and then finding out that it is not due to a client trauma narratives, but due to the student preparing for the National Counselors Exam.

Katherine illustrated the other common theme "The challenge is, I think, is the fact that it exists. Period.". She went on to explain that "I haven't met someone yet that has been unaffected by it".

Successful experiences of attending to vicarious trauma in supervision were described as working with supervisees who were self-aware, insightful, and open to feedback. However, they mention that in order for a successful interaction to take place a safe validating and normalizing environment needs to be present. The participants spoke about how early detection of the signs and symptoms of vicarious trauma lead to faster healing. They also spoke on how a sense of relief washed over the supervisee once vicarious trauma was talked about as an occupational hazard. Successful experiences also included when vicarious trauma is overcome by the supervisee.

Ann reflected on a success that included her providing psycho-education that lead to early detection of symptoms which lead to lessening the severity of symptoms overall "So it seems like if we can catch it early and they're aware of it, then they can put up a little more guard and kind of start to process it to where it doesn't build up to the point that it's too much to handle". Katherine had a similar experience "I had another one who recognized the symptoms a lot sooner and was able to process them and move on, and so that was definitely a success because the education was provided early on, she felt comfortable processing in supervision, and that was it".

A sense of relief was considered a success to Dulce "I think the relief on their faces. And I think their embracing of themselves as humans, flawed humans, who are still able to help clients". Majority of the participants talked about a sense of relief their supervisees felt as a positive response to attending to vicarious trauma in supervision. Several of the participants

believe the relief was connected to the shame and embarrassment the supervisee may have been feeling about being vicariously traumatized. It was discussed how there was a sense of gratitude towards the supervisor for the support provided. Paul reflected on a positive experience with a supervisee "I think she felt relieved that I was understanding and concerned about her wellbeing and that I could relate to the experience".

Another common theme among the successful experiences of attending to vicarious trauma in supervision included what occurs once the vicarious trauma symptoms are alleviated. The supervisors shared that when a supervisee is healed they become a better clinician overall leading them to have increased intentionality on self care, increased positive interactions with clients, and increased successful counseling relationships. John reflected "Successes are from watching them. It's people who become counselors. They go out and they help hundreds, thousands more people than I can reach".

Overall, the supervisors perceive several challenges and successes to attending to vicarious trauma in supervision. They identify the challenges as being threefold: 1) when a supervisee is not self-aware, 2) when the supervisor does not feel prepared to work on vicarious trauma with supervisees, and 3) that vicarious trauma exists at all. The participants describe several successful experiences including when signs and symptoms of vicarious trauma can be detected early leading to faster healing, when the supervisor witnesses a sense of relief on the supervisee's face, and that once the supervisee's symptoms of vicarious trauma are alleviated that they become a stronger counselor with a healthy self care plan.

Recommendations made by Supervisors for Supervisors

Supervisors provided several recommendations for other supervisors for approaching vicarious trauma with supervisees in supervision. This leads into further perceptions that

supervisors have about the vicarious trauma phenomenon. The recommendations fell into two categories: 1) recommendations for the supervisors themselves, and 2) recommendations for how to approach vicarious trauma in supervision with a supervisee.

Recommendations supervisors had for themselves includes self-care and attending trainings on vicarious trauma. The majority of the participants recommend the supervisor practices what they preach to their supervisees. They encourage attending to your own self-care to maintain overall wellness. This may include attending a support group for supervisors. Practicing healthy work boundaries and self-care strategies allows for the supervisor to be a good model for their supervisees. Paul offered his recommendation for supervisors "Well my advice is that you be healthy." He continued "Yeah, that you be spiritually and psychologically and emotionally healthy. Without that you can't help people. So a supervisor needs to be on a path of growth all the time.".

Additionally, the participants explain that the supervisor needs to be knowledgeable about vicarious trauma early signs and symptoms. This may include attending trainings on vicarious trauma or consulting. Mary explained "My recommendation would be know all the signs and presentation of vicarious trauma, so that would be the first one" and "Then of course my second recommendation, know how to approach it. So read about it or get supervision on it, so you are effective as a supervisor". Mary continued to explain how important it is to be knowledgeable about vicarious trauma "I would say let's not get scared of vicarious trauma. Let's normalize and let's get ourselves competent so once we are facing a supervisee who are affected, then we know how to proceed".

Recommendations on how to approach vicarious trauma in supervision includes fostering a safe environment, appropriate self-disclosure, modeling, psycho-education on vicarious

trauma, having an individualized approach, encouraging self-care and providing resources, and check-ins.

The safe environment has been explored in previous themes and continues here. A safe environment includes empathy, genuineness, normalizing, and patience. The safe environment encourages vulnerability and honesty and does not shame supervisees for experiencing the occupational hazard of vicarious trauma. Dulce talked about fostering that safe environment by not making it a competence issue "I feel passionate about this, and not approaching it as a 'you're not competent' issue". Cindy emphasized being patient with your supervisees "Be patient with them as they work through that, and allow them to do that, so they can be healthy and a functional and a effective counselor".

Utilizing appropriate self-disclosure was a common subject to help normalize the experience of the occupational hazard of vicarious trauma. Michelle explained how it is essential for modeling as well "And I think modeling is important and I think that appropriate self-disclosure is important because then you can help them see exactly what it looked like when you were experiencing it or just to help them make it more practical and normal for them". Dulce cautioned that self-disclosure also needs to be genuine "So, if I'm putting on a big false front for my supervisees, what am I training them to do? I'm training them to put on a big false front".

Early psycho-education on vicarious trauma despite the population the supervisee works with was a common recommendation for supervisors. It was recommended that psycho-education be provided within the first few sessions along with the development of self-care plans. Katherine explained her recommendation "I think an educational component is imperative. I think that educational component needs to be there regardless of whether or not the person is working in a high trauma environment". Ann also agreed that a conversation needs to be

conducted with every supervisee "I think my recommendation would be to address it and open that conversation with every supervisee because it should come up at least at certain points". She elaborated "And I think just like you should always discuss culture and bring up, it should be the supervisor who brings up that conversation to make sure the supervisee knows that it's okay to talk about".

An additional common recommendation included having an individualized approach with your supervisee. This includes conceptualizing your supervisee to evaluate if there are gaps in knowledge, how self-aware they are, how receptive they are to feedback, how they use self-care, and the severity of their vicarious trauma symptoms. This conceptualization helps you develop a treatment plan on how to move forward with your supervisee that is experiencing vicarious trauma. Cindy explained "You want to approach it, you want to touch that subject with them about something that you are seeing because it can be detrimental to the counselor, the client and counselor relationship; but kind of gauging them where they are, getting that knowledge of it, educating them if they're not".

Encouraging self-care and providing resources was a commonality among the participant recommendations. They explained a part of approaching vicarious trauma in supervision includes collaborating on a self-care plan that the supervisee can do daily. Part of the encouragement of self-care is check-ins on if the supervisee is following through with their plans. Several supervisors recommend weekly check-ins with your supervisee on vicarious trauma symptoms and progress on self-care plans. Katherine described what her check-ins look like with her supervisees each week "Just basically asking them how they're handling the emotional aspect of their cases. Were there any cases that bothered them that week? Were there cases that they took home and they haven't been able to let go of for the week". Incorporated into self-care is that

encouragement of the supervisee receiving their own counseling. Some of the participants expressed that they would provide resources for their supervisees, if needed.

Vicarious Trauma Prevention

When the supervisors were asked about any recommendations they had for the prevention of vicarious trauma, the majority of them started their response with "that's a tough one", "that's an unusual question", "I am not sure if it can be prevented", and "oh, that's really hard". Several of the supervisors believe that prevention of vicarious trauma may not be possible. John shared his thoughts on prevention "You're not going to prevent it from occurring. It's just, it's going to happen if you're a compassionate human being".

However, several of the supervisors believe that while complete prevention may not be possible, being proactive is possible. The supervisors discussed that being proactive can lead to decreasing the severity and duration of the vicarious trauma symptoms. They believed that being proactive or seeking to prevent vicarious trauma is a responsibility that falls on both the supervisor and the supervisee.

The supervisors believe that some preventative measures can be put into place such as screening clients and sites, but are unsure how realistic doing that would be. They talked about screening as not allowing high risk clients to be seen by beginning counselors or counselors-in-training. Also, consideration of site placement for counselors-in-training can help to avoid too heavy of caseloads and high risk clients for beginning counselors as well.

To be proactive, the supervisors recommend early psycho-education on vicarious trauma with every supervisee in supervision and in coursework. They discussed how important it is to encourage supervisee self-awareness and insight into their own triggers. As well as, early and

often psycho-education and encouragement of self-care plans. Renee spoke to the importance of self-care and awareness:

> So if we've got really good self-care and good self-awareness, then I think that's going to decrease the vicarious trauma we experience. The clients' stories aren't going to change, they're going to be scary and traumatic, so we have to make sure that we are taking care of ourselves and doing things on our part to stop that.

The participants revisited this notion of having weekly check-ins on self-care plans to ensure that healthy habits are being formed including daily self-care tasks. Michelle reflected on self-care, education, and self-awareness as being essential "Once again, just self-care and educating yourself about what vicarious trauma is, and then using that information with the information you know about yourself as an individual because all of us are individuals and have different response to things or have a different tolerance level". She continued "So knowing yourself and knowing what vicarious trauma is and incorporating regular self-care things every single day, even if it's something small, just to keep yourself grounded and balanced is a really great way, at least in my experience, to prevent it or to mitigate it when it does happen, minimizing it".

Participants discussed the need for the safe environment in supervision to allow for the supervisee to feel safe to be open and vulnerable about the symptoms they are experiencing. The supervisors believed by fostering this environment early detection can take place.

Supervisors recommended encouraging their supervisees to seek support both individually and in groups. Ann reflected on this as part of gatekeeping for the counseling profession "Probably what would be helpful is I think part of the gatekeeping process is making sure that counselors who are graduating have a level of insight and a level of support to be able

to be successful in this field". She went on to recommend that individual support can include the supervisee going to a counselor of their own. John reflected on group support as part of self-care:

> Well that all goes back to the gentle self care. You need to have a group around you. I meet monthly with a group of therapists and we process things. And that's the thing about supervision, you're there for them. But there's a point where the person's out there and licensed and there's no more supervision. And now you've got to figure out how to find the support.

Ann also believed that advocating for agency wellness is essential "So maybe there are ways that we could prepare our counselors to be able to advocate for themselves within the organization that they work in".

Another common topic was supervisors needing to be knowledgeable about vicarious trauma. They recommend that supervisors have training on how to detect and address vicarious trauma in supervision. They suggest using the supervisor's own theoretical model to identify ways to approach vicarious trauma. Lastly, they believe that vicarious trauma needs to be incorporated into supervision training. Kay illustrated the commonality that vicarious trauma needs to be incorporated into the training of supervisors:

> I took a course for supervision probably six or seven years ago, and I don't recall anything about vicarious trauma. We talked about ethics and we talked about things to do procedurally, but I think maybe just a little more attention to the importance of helping supervisors look for that and understand it because I think often, if I wasn't in a doctoral program, would I have even been aware?"

It is noteworthy that the recommendations made by the supervisors for being proactive with vicarious trauma align with protective factors noted in the literature. Protective factors

include healthy self-care strategies, supportive work environment, reduced caseload of trauma clients, increased vacation and sick time, peer support, and trauma and vicarious trauma specific education and training (Merriman, 2015; Sommer, 2008; Vrklevski & Franklin, 2008). Harrison and Westwood (2009) suggest that supervision acts as both an early monitoring and rapid response to vicarious trauma symptomology displayed by counselors. Supervisors' perceptions of vicarious trauma phenomenon was the focus of this study. It is clear that supervisors may not believe that vicarious trauma is preventable, but they do have hope that by being proactive supervisors can help alleviate and decrease the duration of the symptoms their supervisees report.

Chapter Summary

A description of the ten supervisors, participants in this study, lived experiences with the phenomenon of vicarious trauma within supervision was presented in this chapter. This aligns with the primary research question, what are supervisors' perceptions of the vicarious trauma phenomenon? Data collection methods included a semi-structured interview with ten participants. The interviews were transcribed which allowed for the researcher to code for significant statements to understand the parts to ultimately understand the collective whole. The significant statements led to themes. The common themes across the participants were discussed in this chapter. The first theme was vicarious trauma knowledge which incorporated how the supervisors describe vicarious trauma and how they identify vicarious trauma symptoms within their supervisees. The second theme was attending to vicarious trauma in supervision providing a description of how supervisors attend to vicarious trauma in supervision with their supervisees. The third theme was challenges and successes of attending to vicarious trauma in supervision which allowed for descriptions of the supervisors perceptions of successful ways to approach vicarious trauma and challenges of approaching vicarious trauma in supervision. The fourth

theme was recommendations made by supervisors for supervisors. This theme incorporated what the supervisors recommend for other supervisors to do for themselves and how to approach vicarious trauma in supervision successfully. The fifth and final theme was vicarious trauma prevention which allowed for supervisors to express their perceptions of vicarious trauma prevention and their lived experiences of being proactive against vicarious trauma. All of the themes were enhanced by quotes of the participants. The quotes and detailed descriptions of the participants' perceptions of the vicarious trauma phenomenon within supervision gave the supervisors a voice among the vast literature available on vicarious trauma in the counseling profession. In the next chapter, the results will be summarized, implications for supervisors and counselor education will be discussed, limitations of this study will be reviewed, and recommendations for future research will be provided.

Chapter 4

Discussion

Overview

The findings of this study provide a deeper understanding of the supervisors' experience of the phenomenon of vicarious trauma. The purpose of this study was to answer the primary research question: what are supervisors' perceptions of the vicarious trauma phenomenon? To answer this question, a hermeneutical phenomenological qualitative study with a social constructivist theoretical lens was designed to elicit findings that would provide a voice to supervisors among the literature available on vicarious trauma.

Data collection methods included a semi-structured interview with participants until saturation was reached. A hermeneutical phenomenological data analysis approach was utilized to understand the parts of the data (individual interviews) to inform understanding the collective whole (commonality among the interviews). This maintains a balance of the findings by looking at the big picture as well as the details (Van Manen, 1990). To make meaning of the data, the findings were presented in the supervisor's own voice through quotes. The quotes supported five themes: 1) Knowledge of Vicarious Trauma, 2) Attending to Vicarious Trauma in Supervision, 3) Challenges and Successes of Attending to Vicarious Trauma in Supervision, 4) Recommendations made by Supervisors for Supervisors, and 5) Vicarious Trauma Prevention. Several methods to strengthen the credibility and trustworthiness of the study were utilized to enhance the confidence of the findings of the study (Creswell, 2014). The methods included saturation, member checking, audit trail, and utilizing a peer reviewer and external auditor.

In this chapter, the results will be summarized and display how they answer the research questions, implications for supervisors and counselor education will be discussed, limitations of the study will be reviewed, and recommendations for future research will be provided.

Discussion of Results

The findings of this study were analyzed utilizing a social constructivist theoretical framework. A social constructivist framework includes the ideology that understanding the world of others and developing meanings that align with their experiences is formed through social interactions (Creswell, 2013). The researcher's intent was to understand the experiences supervisors have of the phenomenon of vicarious trauma through the social interaction of engaging in dialogue. The researcher learned from the supervisors about their perceptions of vicarious trauma as well as the supervisors offered recommendations to allow for other supervisors and counselor educators to learn from them. Allowing individuals to learn from each other fulfills the social constructivist theoretical framework.

The phenomenological approach explored what the supervisors had in common as they experienced the phenomenon of vicarious trauma (Creswell, 2013). The commonalities were enhanced with the use of quotes from the individual transcripts. This allows for the reader to understand the individual supervisors experience to add meaning and understanding of the common whole through a hermeneutical outlook. During the exploration from the individual supervisors and the common findings among them, five themes emerged.

The five themes will be discussed in relationship to the research questions. The aim was to answer a central question, what are supervisors' perceptions of the vicarious trauma phenomenon? This led into a set of subset questions to inquire about supervisors' perceptions of vicarious trauma including: 1) How do supervisors describe vicarious trauma?, 2) How do

supervisors identify vicarious trauma symptoms displayed by their supervisees?, 3) How do supervisors attend to vicarious trauma in supervision?, and 4) How do supervisors describe the prevention of vicarious trauma. The themes discussed will answer the central and subset questions.

There is evidence in the literature that trauma is prevalent which increases the number of individuals with trauma narratives seeking mental health treatment, putting counselors at a higher risk for experiencing vicarious trauma. Counselors are experiencing and suffering from vicarious trauma symptoms, which can be detrimental to the treatment effectiveness and the counseling experience for clients. Researchers provide protective factors to ameliorate vicarious trauma symptomology with a heavy emphasis on agency organizational change, including clinical supervision. Trauma-sensitive supervision guidelines are provided in the literature; however, there is a paucity of research on the supervisor's ability to identify, attend to, and prevent vicarious trauma from the supervisors themselves. These themes that emerged from the transcripts of supervisors provide a voice to the supervisors on these topics.

Knowledge of Vicarious Trauma

This theme answered the subset research questions of how supervisors describe vicarious trauma and how do supervisors identify vicarious trauma symptoms displayed by their supervisees. All of the supervisors described vicarious trauma as a counselor listening to a client's trauma story and that story impacting the counselor in some way. Some of the supervisors mislabeled vicarious trauma as secondary traumatic stress. Supervisors identified vicarious trauma symptoms displayed by their supervisees by observing them in supervision and on the client tapes as well as through the supervisees self-report. The majority of the supervisors stated that vicarious trauma is an emotional response to a client's trauma narrative that affects the

counselor. Supervisors identified observing emotions of sadness, anxiety, depression, empathy, frustration, annoyance, and feeling overwhelmed.

Supervisors also observed PTSD symptomology along with the emotional response. The PTSD symptoms included nightmares, hypervigilance, isolation, change in world view and level of trust, avoidant behaviors, increased anxiety symptoms, and the inability to sleep. Additionally, the supervisors noted that sometimes the symptoms displayed by their supervisee were adoption of their client's symptoms. Supervisors also observed their supervisees with their own trauma histories being triggered by their client's narratives. Additional vicarious trauma symptoms identified by the supervisors included decrease in clinician effectiveness and blurred boundaries.

Majority of the participants discussed the shame and embarrassment they observed within their supervisees when they were experiencing vicarious trauma. The participants shared instances of their supervisees believing that experiencing vicarious trauma means that they are failing as a counselor and caused them to question if they were in the right profession.

Overall, the supervisors' description of vicarious trauma aligns with the definitions in the literature which includes the negative impact of a counselors indirect exposure to a trauma due to the empathetic engagement with a client's trauma narrative (Pearlman & Saakvitne, 1995; McCann & Pearlman, 1990). Most of the supervisors identified vicarious trauma as occurring when their supervisee attached to one client story which does not match the definition in the literature. Secondary traumatic stress is in response to a specific case and client, while vicarious trauma can be a reaction to a specific case, but generally is a response to chronic exposure to numerous client's trauma narratives (Adam & Riggs, 2008; Aparicio, Michalopoulos, & Unick, 2013; Pearlman & Saakvitne, 1995; Tosone, Nuttman-Shwartz, & Stephens, 2012). The phenomenon of vicarious trauma is a result of cumulative exposure and not specific to any one

client (Adams & Riggs, 2008). However, it is important to note that the supervisors mislabeling vicarious trauma also supports the literature that includes that some individuals in the field of counseling use the terms interchangeably (Howlett & Collins, 2014; Jordan, 2010; Trippany, White, Kress, & Wilcoxon, 2004).

The supervisors were able to identify several of the well documented symptoms of vicarious trauma including an emotional reaction that impacts the supervisees ability to function personally and professionally. The supervisors ability to describe vicarious trauma and identify the symptoms displayed by their supervisees demonstrates their knowledge of vicarious trauma. This indicated supervisors are aware of the vicarious trauma phenomenon and how it presents within supervision with their supervisees. The knowledge that supervisors have about vicarious trauma and its symptoms directly relates to how the supervisor attends to vicarious trauma. A supervisor that knows about vicarious trauma and can recognize the symptoms allows for early monitoring and rapid response, which can help prevent damage to the supervisees and their clients (Harrison & Westwood, 2009).

The supervisors that were a part of this study demonstrated that they were knowledgeable about vicarious trauma and that they can identify vicarious trauma symptoms displayed by their supervisees. The next theme of how the supervisors attended to vicarious trauma will allow for further understanding the lived experiences of supervisors with the phenomenon of vicarious trauma.

Attending to Vicarious Trauma in Supervision

The supervisors displayed that they can define vicarious trauma and that they can identify vicarious trauma symptomology displayed by their supervisees. The next step in understanding the lived experiences of the supervisors is to review the descriptions of how they attend to

vicarious trauma symptoms in supervision sessions. This theme directly answers the subset research question of: How do supervisors attend to vicarious trauma in supervision?

Several of the participants described that attending to vicarious trauma in supervision with their supervisees as needing to include a supportive and safe environment, psycho-education on vicarious trauma, appropriate self-disclosure of supervisors own experiences of vicarious trauma, the importance of self-care, and check-ins that monitor symptoms and self-care plans. The supervisors stressed the importance of having a strong supervisory alliance which includes a supportive environment allowing for supervisees to feel safe to be vulnerable and open about symptoms in supervision. The environment must be accepting and validating of the supervisees experience to diminish the shame and embarrassment. The supervisors align with the literature regarding a supportive environment. Rosenbloom (1999) stated that "supervision should foster an atmosphere of respect, safety, and control for the therapist who will be exploring the difficult issues evoked by trauma therapy" (p. 77).

Once the supportive environment and rapport is established, the supervisors stated that they provide psycho-education on vicarious trauma and self-care early on in the supervision process. The supervisors describe that the psycho-education should be individualized to fill the gaps in knowledge per supervisee. Participants believed that early education on vicarious trauma can help the supervisee become more self-aware and catch if they are experiencing symptoms early on allowing for earlier intervention.

Supervisors explained that to normalize and validate a supervisee’s experience that they will utilize appropriate self-disclosure. They described sharing their experiences of overcoming vicarious trauma and what they do for self-care with their supervisees. However, a few of the

supervisors caution not to share the client narrative that vicariously traumatized them as to avoid re-traumatizing their supervisee.

Self-care was part of every supervisors protocol for attending to vicarious trauma. The participants describe providing psycho-education on self-care and encouraging the development of a daily self-care plan. Sometimes, the self-care plan includes the supervisee attending counseling. Along with self-care, the supervisors stressed the importance of regular check-ins during supervision to assess vicarious trauma symptoms and the follow through of the self-care plans. The notion of check-ins is recommended by Sommer and Cox (2005 & 2006), they describe setting time aside in supervision specifically for a conversation on the counselor's personal feelings and effects of trauma work, using a collaborative strength-based approach, allowing for further vicarious trauma symptom and risk factor checks.

Overall, the participants aligned with the guidelines recommended for trauma sensitive supervision. Guidelines include a trauma focused theoretical framework, attentiveness to the counselor's frame of reference and outlook on treatment, facilitating a safe and respectful, as well as collaborative, environment to encourage honest communication, observation of counselor behavior, being watchful of vicarious trauma symptomology, and providing education on vicarious trauma exposure, prevention, symptoms, and treatment (Etherington, 2000; Pearlman, 1999; Pearlman and Saakvitne, 1995; Rosenbloom, Pratt, & Pearlman, 1999; Sommer & Cox, 2005, 2006). However, the supervisors provided practical examples of facilitating a safe and respectful collaborative environment and providing education on vicarious trauma. To facilitate the safe environment supervisors explain the use of appropriate self-disclosure to normalize and validate the experiences of the supervisee. Additionally, the supervisors provide individualized

education on vicarious trauma, symptoms, and treatment. The participants made it know that a focus for treatment is encouraging a self-care plan that includes daily tasks.

This theme revealed the participants utilization of the guidelines provided in the literature for trauma-sensitive supervision as a tactic to ameliorate vicarious trauma symptoms within their supervisees, although the supervisors did not describe their approach as trauma-sensitive. The descriptions of the supervisors protocols for attending to vicarious trauma in supervision allows for an understanding of their lived experiences. To further that understanding, it is essential to understand what parts of their protocol they described to be successful and what parts they described to be challenging.

Challenges and Successes of Attending to Vicarious Trauma in Supervision

During the interviews, the supervisors expressed a supervisee's lack of awareness, lack of education, and/or their being in denial about their vicarious trauma symptoms caused attending to vicarious trauma to be challenging. Several of the supervisors believed that an overall lack of insight and self-awareness led the supervisees to be in denial or try to rationalize the vicarious trauma symptoms. The supervisors explain that it is difficult to approach vicarious trauma with a supervisee who is not open to feedback.

Additional challenges the supervisors discuss include the balance of being a supervisor and being a human in the room with their supervisee. They talk about how gatekeeping can impact their ability to be genuine with their supervisees.

A few of the supervisors voiced that they were concerned that they were inadequately trained on how to approach vicarious trauma as a supervisor. They expressed that they understood how to cope with vicarious trauma as a counselor, but felt unprepared for the

responsibility as a supervisor. The concerns of the supervisors presents implications for counselor education and supervisor training which will be discussed later.

Successful experiences of attending to vicarious trauma were described as working with supervisees who were self-aware, insightful, and open to feedback. They stated that successful experiences were due to having the supportive environment and a healthy supervisory alliance. The supervisors believe working with a supervisee that is self-aware and having that safe environment allows for early detection of the signs and symptoms of vicarious trauma leading to faster healing and decreasing the severity of symptoms overall. Supervisors reflected on successful experiences included supervisees becoming more intentional with their self-care and increased overall clinician effectiveness. Another common theme amongst the supervisors regarding successes included the relief that the supervisees would feel after vicarious trauma was approached with them.

These findings support that supervision can be a restorative process when a supervisee is open to feedback and has self-awareness and insight. The supervisors challenges provide insight into areas of vicarious trauma treatment that may not have been discussed previously. Similar to counseling, a supervisee cannot make progress if they are not open to the supervision process despite the abilities of the supervisor. The findings regarding successful experiences support the guidelines of trauma-sensitive supervision. However, another area not discussed in the literature is the relief experienced by the supervisee and how that can be an indicator of a successful supervisory experience while addressing vicarious trauma symptomology.

Recommendations for Supervisors by Supervisors

To further the understanding of supervisors perceptions of the vicarious trauma phenomenon it is essential to consider the recommendations that supervisors have for other

supervisors. The recommendations provide insight to how the supervisor perceives their lived experiences of vicarious trauma and how they recommend other supervisors to cope allowing for the social constructivist framework to be fulfilled. The supervisors are allowing other supervisors to learn from their experiences.

The recommendations fell into two groups: recommendations for the supervisors and recommendations for how to approach vicarious trauma with a supervisee. Recommendations that supervisors had for themselves included maintaining healthy self-care and attending trainings on vicarious trauma. Practicing healthy work boundaries and self-care methods allows for the supervisor to maintain personal health and to be a good model for their supervisees. The recommendation to enhance the supervisors knowledge of vicarious trauma was to ensure that supervisors know how to approach vicarious trauma as a supervisor.

Recommendations on how to approach vicarious trauma in supervision align with the trauma-sensitive supervision guidelines again, including: fostering a supportive environment, utilizing appropriate self-disclosure, modeling, psycho-education on vicarious trauma, having an individualized approach, encouraging self-care and providing resources, and the use of weekly check-ins.

These findings allowed for the supervisors to provide guidance with their own voices regarding the phenomenon of vicarious trauma in supervision. They valued the health and wellness of the supervisor to model appropriate self-care and work boundaries. Additionally, they encouraged increased training on vicarious trauma to feel prepared for the responsibility of attending to symptoms in supervision.

Vicarious Trauma Prevention

The theme of vicarious trauma prevention directly answers the subset research question: how do supervisors describe the prevention of vicarious trauma. A noteworthy finding includes that nearly all of the supervisors began answering this question by stating they believe vicarious trauma is not preventable. This describes how supervisor perceive the phenomenon of vicarious trauma as being an occupational hazard that cannot be prevented. However, the supervisors did believe in being proactive to decrease the severity and duration of vicarious trauma symptoms.

Proactive methods described parallel protective factors listed in the literature including screening clients and sites to ensure high risk clients do not receive treatment from beginning counselors or counselors-in-training, avoiding heavy caseloads, providing psycho-education early with every supervisee, training on vicarious trauma in coursework, encouragement of self-care plans, encouragement of self-awareness, seeking support (both individual and group), seeking personal counseling, and advocating for agency wellness. Methods to be proactive described by the supervisors that did not parallel the literature included supervisors receiving training on vicarious trauma. Additionally, while the supervisors all clearly believe that supervision can make a difference in alleviating vicarious trauma symptomology, none of them specifically discussed supervision as a method to be proactive.

The findings suggest that supervisors do not believe that vicarious trauma can be prevented, but they do have hope of proactive methods decreasing the severity and duration of vicarious trauma symptoms.

Implications for Supervisors and Counselor Education

The findings of this study provide a voice to supervisors' experience of vicarious trauma among the vicarious trauma literature. The findings indicate that supervisors have an accurate understanding of vicarious trauma; however, at times mislabel vicarious trauma as secondary traumatic stress and compassion fatigue. The participants demonstrated that they have the ability to identify vicarious trauma symptomology displayed by their supervisees. Adding to the literature, the supervisors indicated that an element of vicarious trauma is shame and embarrassment felt by the supervisee suffering from symptoms.

Additionally, the results provide evidence of supervisors utilizing methods to attend to vicarious trauma that align with the guidelines available in the literature and even provide practical examples to demonstrate how they facilitate the guidelines in session. One of the practical examples provided has not been noted in the vicarious trauma literature. The supervisors stress the importance of utilizing self-disclosure of their own experiences of vicarious trauma as a way to normalize and validate the vicariously traumatized supervisees experience to soothe the elements of shame and embarrassment. The participants also discussed that self-disclosing how they coped with vicarious trauma allows for modeling of appropriate self-care and wellness methods and to open dialogue to develop individualized self-care plans for their supervisees.

Perhaps, the supervisor's individual experience of vicarious trauma informs their response to vicarious trauma symptoms displayed by a supervisee. It is possible that supervisors who have experienced vicarious trauma themselves may have awareness of vicarious trauma and the ability to identify symptoms due to the fact they have observed the symptoms within themselves as a

counselor. Their own experiences may inform the way they address vicarious trauma in supervision with supervisees allowing them to be more empathetic and knowledgeable.

While the protocol described by the supervisors parallels the trauma sensitive supervision guidelines, the supervisors did not describe their approach to vicarious trauma as trauma sensitive. The supervisors stated that providing psycho-education on vicarious trauma, developing individualized self-care plans, and incorporating regular check-ins should be conducted with every supervisee regardless of the population the supervisee provides counseling services to. Furthermore, the supervisors noted that they did not always feel prepared for the responsibility to address vicarious trauma in supervision. Thus, signifying that supervisors may not feel confident in their abilities to address vicarious trauma in supervision and/or they have not been specifically trained on how to approach vicarious trauma.

Further findings reveal the lived successful and challenging experiences of the supervisors when attending to vicarious trauma within supervision. These experiences shed light on successful methods of attending to vicarious trauma from the perspectives of supervisors and support the guidelines in the literature. The challenges provide insight to vicarious trauma treatment methods that may not have been discussed previously. The supervisors stated when supervisees are not open to the supervision process and feedback on vicarious trauma symptomology, then progress cannot be made despite the knowledge and abilities of the supervisor.

The results regarding vicarious trauma prevention are revealing and new. Several of the supervisors believe vicarious trauma is not preventable because it is an occupational hazard of an empathetic and skillful counselor. In fact, nine out of the ten supervisors interviewed had supervised several counselors who had been vicariously traumatized. While prevention was not

perceived as possible, the supervisors believe that proactive methods can be employed in supervision before and after vicarious traumatization occurs which can decrease the severity and duration of vicarious trauma symptomology.

The findings of this study provide implications for clinical supervisors and for counselor education programs. The implications allow for the participants to provide recommendations to other supervisors and those who train future counselors and supervisors. The participants of this study were able to share their experiences of vicarious trauma and allow for other professionals to learn from them, fulfilling the social constructivist framework of this study. These implications are offered to better assist supervisors with attending to vicariously traumatized supervisees and to assist counselor educators in training future counselors and supervisors to be prepared for vicarious trauma in their respective roles.

Implications for Supervisors

The participants in this study noted that vicarious trauma is a common occurrence they experience with their supervisees. The supervisors in this study provided recommendations they have for supervisors regarding the phenomenon of vicarious trauma. The participants recommend that supervisors maintain healthy self-care and work boundaries. Practicing healthy work boundaries and self-care methods allows for the supervisor to maintain personal health and to be a model for their supervisees.

The supervisors also recommended attending trainings on vicarious trauma and consulting when unsure of how to proceed. Supervisors suggest having a group of professionals to meet regularly with for support and consultation. Enhancing knowledge on vicarious trauma is to ensure supervisors know how to and are confident in approaching vicarious trauma in the supervisory role.

Recommendations on how to approach vicarious trauma in supervision include: 1) Fostering a supportive environment to allow for supervisees to feel comfortable being vulnerable, 2) Utilizing appropriate self-disclosure to normalize and validate the supervisees experience and mitigate their shame and embarrassment, 3) Modeling offers the supervisee to observe healthy self-care and work boundaries, 4) Providing psycho-education on vicarious trauma early in supervision encourages self-awareness in supervisees that could lead to early detection and treatment, 5) Developing an individualized approach with each supervisee allows for gaps in knowledge to be filled and rapport to be built, 6) Encouraging self-care plans early in supervision enables the development of healthy wellness habits early in a counselors career, and 7) Regularly checking-in on your supervisees emotional reactions to trauma narratives and maintenance of self-care plans allows for early detection of symptoms to decrease severity and duration of vicarious traumatization. These recommendations parallel what has been suggested in the literature as protective factors of vicarious trauma and trauma sensitive guidelines for supervision (Etherington, 2000; Pearlman, 1999; Pearlman and Saakvitne, 1995; Rosenbloom, Pratt, & Pearlman, 1999; Sommer & Cox, 2005, 2006).

These recommendations suggest several methods to better prepare supervisors to address these issues. This can be of great value in the process of promoting the health and wellness of supervisors. They can also be the foundation to helping them be more effective as supervisors, while modeling healthy behavior for counselors. Additionally, the encouragement of increased training on vicarious trauma to feel confident and prepared for the responsibility of attending to vicarious trauma symptoms in supervision was highlighted.

Implications for Counselor Educators

The findings of this study indicate that while supervisors are utilizing trauma sensitive supervision guidelines to approach vicarious trauma, they are unaware that they are doing so. None of the supervisors specifically stated that they were utilizing a trauma sensitive approach. The results also indicate the supervisors are aware of vicarious trauma and symptoms due to their own personal experiences of being vicariously traumatized. While prevention was not considered possible by the supervisors, being proactive was highly regarded. Providing further education about vicarious trauma during training can be a way of being proactive. If supervisors are trained on vicarious trauma, vicarious trauma symptoms, and how to attend to vicarious trauma in supervision utilizing trauma-sensitive supervision guidelines, supervisors can feel more confident and knowledgeable in their roles.

Additionally, the findings of this study also indicated supervisors thought it was critical to provide psycho-education on vicarious trauma to their supervisees. This highlights the need for this to be incorporated in supervision, and may suggest the need for increased attention in counselor training. Specifically, it may be necessary for counselor education programs to infuse this training into the preparation of students prior to practicum and internship. This parallels the recommendations of other researchers who have emphasized the need for education and training (Merriman, 2015; Sommer, 2008; Vrklevski & Franklin, 2008). Counselor educators have an ethical obligation to include vicarious trauma in counselor education programs for counselors-in-training and future supervisors. Vicarious trauma is an occupational hazard that impacts counselors' effectiveness and can be detrimental to clients, making assessing and addressing vicarious trauma symptomology, training on trauma specific counseling skills, and self-care practices an ethical obligation of counselors, counselors-in-training, supervisors, and counselor

educators (ACA, 2014; CACREP, 2014; Vrklevski & Franklin, 2008). By maintaining the health of counselors, potential benefits could reach clients ensuring best practices from healthy counselors; therefore, benefiting the counseling profession as a whole.

Limitations of the Study

A limitation of this study are the participants themselves. It is reasonable to consider that individuals interested in participating in this study would have an interest in the phenomenon of vicarious trauma within supervision. The call for participants included the title of the study and the eligibility requirements that clearly explain the topic as discussing vicarious trauma within supervision. Supervisors that volunteered to be a part of this research study may already have a base knowledge of vicarious trauma and may not be an accurate representation of an typical supervisor.

While the ages of the supervisors and years of experiences as a supervisor varied eight of the ten participants were women and seven of the ten participants identified as Caucasian/White. Additionally, several of the participants were from Alabama and the rest were from the east coast. Perhaps participants from other areas of the country would have yielded differing results.

Qualitative research limits the ability to make generalizations to other populations of supervisors due to the focus on depth not breadth of data collected from participants.

Recommendations for Future Research

This study deepened the understanding of the perception of supervisors lived experiences of the vicarious trauma phenomenon in supervision and provided recommendations for supervisors and counselor educators. Now that supervisors' voices have been heard, it would be beneficial to continue that exploration in other ways. The use of focus groups could yield further results deepening the understanding of the experiences of supervisors with the vicarious trauma

phenomenon. Additionally, a case study or phenomenological qualitative study examining pairs of supervisors and supervisees would deepen the understanding of the phenomenon of vicarious trauma from both perspectives of the individuals in the supervision room.

Future research exploring if specific supervision models and/or specific methods of approaching vicarious trauma are more proactive/protective than others would be beneficial to the literature a well. Exploration of the use of self-disclosure as a method to approach vicarious trauma in supervision could inform on the effectiveness of this approach. Furthermore, a study that explores the effectiveness of vicarious trauma treatment by supervisors trained in trauma-sensitive supervision compared to traditionally trained supervisors could provide results that support the vicarious trauma protective factor literature. Lastly, a research study that examines supervisors that are also counselor educators could reveal an additional set of challenges and successes experienced. Further exploration into the challenge of differentiating between developmentally appropriate stress symptoms of students attending a master's program and vicarious trauma symptoms could reveal implications for counselor educators.

Chapter Summary

This chapter reviewed a summary of the results, implications for supervisors and counselor educators, limitations of the study, and recommendations for future research. The purpose of this study was to gain a deeper understanding of the lived experiences of supervisors' perceptions of the vicarious trauma phenomenon. The findings of the study indicated that supervisors, while not always confident in their abilities and knowledge of vicarious trauma, follow trauma-sensitive guidelines while approaching vicarious trauma symptoms with a supervisee. Their knowledge provided insight to another element of vicarious trauma including shame and embarrassment of the supervisee that is affected. The supervisors gave practical

examples of methods they use to intervene when a supervisee is experiencing vicarious trauma including a new method not mentioned in the literature, self-disclosing their own personal experiences of vicarious traumatization. Through their own voice, supervisors provided examples of challenging and successful experiences of addressing vicarious trauma with a supervisee. Recommendations by the supervisors for other supervisors included the importance of the supervisors taking steps to be healthy themselves by practicing self-care and healthy work boundaries. Lastly, the supervisors suggest prevention of vicarious trauma is impossible because it is an occupational hazard that will occur if the counselor is empathetic, but being proactive can decrease the severity and duration of symptoms. Recommendations for counselor educators included implementing training specifically on vicarious trauma for future counselors and supervisors as it is an ethical mandate. If the counseling profession can care for the caregivers, health and wellness can be maintained to be able to provide the best care possible for our clients.

Chapter 5

Manuscript

Abstract

Trauma is prevalent in the world and traumatized persons may seek counseling services. Vicarious trauma is a term used to describe negative effects of professional helping; therefore, is considered an occupational hazard of providing counseling to traumatized persons (Merriman, 2015; Rank, Zaparanick, & Gentry, 2009; Pearlman, 1999). The National Child Stress Network (2011) estimates that 50% of counselors are at risk of developing vicarious trauma. Supervisors and counselor educators have an ethical responsibility to address vicarious trauma with counselors they are supervising to prevent harm to clients (Sommer, 2008). Supervision has been documented as a protective factor against vicarious trauma; however, there is a paucity of research regarding supervisors' ability to identify, attend to, and prevent vicarious trauma (Merriman, 2015; Slattery & Goodman, 2009; Sommer, 2008). This manuscript will present literature on vicarious trauma and the protective factor of supervision as well as the findings of a phenomenological qualitative study allowing for supervisors' voices to be heard. An examination into the perceptions of supervisors' experiences with the phenomenon of vicarious trauma are explored including how supervisors describe vicarious trauma, how they identify vicarious trauma in a supervisee, how they approach vicarious trauma in supervision, and recommendations they have for supervisors on approaching and prevention vicarious trauma within the supervision process. Recommendations for clinical supervisors, counselor education, and future research will be addressed.

Introduction

Traumatic events that impact people are prevalent. These events may include natural disasters, manmade disasters, sexual assault, personal assault, community based violence, war, domestic violence, grief, neglect, other violent crimes, and childhood trauma, just to name a few (Substance Abuse and Mental Health Services Administration, 2016; The National Child Traumatic Stress Network, n.d.). When traumatized persons seek counseling, counselors listen to and are exposed to explicit trauma narratives. Vicarious trauma occurs when counselors empathetically listen to client trauma narratives. Vicarious trauma is an occupational hazard of working with individuals that have experienced traumatic events (Pearlman, 1999). The symptoms can impede counselor effectiveness. It is an ethical responsibility of both the counselor and the supervisor to prevent and address vicarious trauma symptomology. Supervision has been documented to be a protective factor against vicarious trauma; however, there is a paucity of research identifying supervisors' ability to address, identify, and attend to vicarious trauma. A review of the literature on trauma, vicarious trauma, and supervision is provided. A recommendation for further research and counselor preparation strategies are explored.

Trauma is widespread in the world and traumatized persons may seek counseling services. According to the U.S. Department of Veteran Affairs National Center of PTSD (2015), trauma is not a rare occurrence, with about six out of ten men and five out of ten women experiencing at least one trauma in their lives. Trauma prevalence in the United States is additionally confirmed by the National Child Traumatic Stress Network (NCTSN) (2011), which states that 10 million children experience a traumatic event per year. Counselors are the

individuals that empathetically listen to trauma narratives, thus experiencing indirect trauma exposure.

Vicarious trauma is a term used to describe negative effects of professional helping; therefore, it is considered an occupational hazard of providing counseling to traumatized persons (Merriman, 2015; Pearlman, 1999; Rank, Zaparanick, & Gentry, 2009). Studies indicate that up to 50% of counselors working with traumatized persons are at high risk of vicarious trauma (NCTSN, 2011). Vicarious trauma refers to the empathetic engagement with a traumatized client, which impacts the inner experience of the therapist. This may cause changes in the counselors self and professional cognitive frame of reference, affecting the personal, professional, and social aspects of the counselor (Adams & Riggs, 2008; Aparicio, Michalopoulos, & Unick, 2013; NCTSN, 2011; Saakvitne & Pearlman, 1996). Vicarious trauma manifests in symptoms similar to PTSD and often mirrors the client symptoms (Howlett & Collins, 2014).

Vicarious trauma can impact a counselor's effectiveness and be detrimental to their professional identity and success. Counselors experiencing unaddressed vicarious trauma can suffer from symptoms that impede their ability to provide effective treatment to clients (Vrklevski & Franklin, 2008). It is a counselor's ethical responsibility to monitor effectiveness under the American Counseling Association (ACA) Ethical Code C.2.d. and monitor for impairment under ACA's Ethical Code C.2.g. (ACA, 2014). However, for counselors-in-training, the ethical responsibility for monitoring this behavior also falls on the counselor educators and supervisors, who have a responsibility to monitor behaviors that might impede a counselor in training or indicate deficits. This is specified in the ACA Ethical code (2014), as well as the

accreditation standards of Council for Accreditation of Counseling and Related Education (CACREP) (Council for Accreditation of Counseling and Related Education, 2016).

Understanding the factors that impede counselors-in-training is critical to client well-being. This includes helping educators and supervisors understand the risk factors and signs of vicarious trauma. Some of the risk factors of vicarious trauma include: counselors who work directly with traumatized persons, counselors who identify as a women, new counselors (two years or less experience) or counselors-in-training, individuals who are highly empathetic by nature, counselors who have history of unresolved personal trauma, counselors with heavy caseloads, counselors with insufficient self-care strategies, and counselors who have lack supervision, peer support, resources, and trauma specific training (Adams & Riggs, 2008; Jordan, K. 2010; NCTSN, 2011; Sommer, 2008; Vrklevski & Franklin, 2008). Protective factors include: counselors who practice healthy self-care strategies, counselors who have a supportive work environment, counselors with a reduced caseload of trauma clients, counselors with increased vacation and sick time, trauma-sensitive supervision, peer support, and trauma specific education and training (Merriman, 2015; Sommer, 2008; Vrklevski & Franklin, 2008).

Supervision is documented as a protective factor against vicarious trauma and as a way to address vicarious trauma symptomology; however, there is a rarity of research regarding whether supervisors are trained in trauma sensitive supervision and the ability to identify, attend to, and prevent vicarious traumatization (Merriman, 2015; Slattery & Goodman, 2009; Sommer, 2008). This study will aim to fill that paucity by researching supervisors' knowledge of vicarious trauma and recommendations for prevention of vicarious trauma.

Literature has provided evidence that trauma is rampant, which increases the number of individuals with trauma histories seeking mental health treatment; therefore, putting counselors

at a higher risk for experiencing vicarious trauma. Research indicates that counselors are experiencing and suffering from vicarious trauma symptomology, which can affect treatment effectiveness and the counseling experience for clients. Studies recommend protective factors and strategies to ameliorate vicarious trauma in counselors, with a heavy emphasis on organizational change within agencies, including clinical supervision. Trauma-sensitive supervision guidelines are available; however, there is a lack of research on the ability of supervisors to identify, attend to, and prevent vicarious trauma, as well as their perceptions of vicarious trauma. Supervision is an excellent screening and intervention tool for vicarious trauma; however, it cannot be effective if supervisors are unaware of the vicarious trauma phenomenon. This study aims to explore counseling supervisors' perceptions of vicarious trauma and understanding the phenomenon of vicarious trauma through the supervisory lens. By building the perception of supervisors' lived experiences of vicarious trauma the study will aim to fill the research gap.

Significance

This study is impactful for the counseling profession as a whole. Implications for counselor supervision best practices, counselor education and training, supervisor training, and clinician health in regards to vicarious trauma will be provided. By giving a voice to supervisors and their perceptions of the vicarious trauma phenomenon, the results yield insight into the treatment and prevention methods of vicarious trauma through a supervisor lens. This study aims to focus on caring for the caregivers to maintain clinician health, thus maintaining ethical obligations as well as continuity of best practices for clients.

Purpose

An exploration of supervisors' perceptions of the vicarious trauma phenomenon aims to explore perceptions of vicarious trauma and ways they address the phenomenon within the supervision process. This study's goal was to strengthen the understanding of supervisors' perception of vicarious trauma, treatment of vicarious trauma, and prevention of vicarious trauma phenomenon within a supervisory relationship through the supervisors' voice.

The overarching objective of this qualitative study is to strengthen the understanding of supervisors' viewpoint of vicarious trauma when working with their supervisees and to provide evidence for vicarious trauma prevention strategies from supervisors perspectives. The researcher aimed to answer a central question, what are supervisors' perceptions of the vicarious trauma phenomenon? This leads into a set of subset questions to inquire about supervisors' perceptions of vicarious trauma: 1) How do supervisors describe vicarious trauma?, 2) How do supervisors identify vicarious trauma symptoms displayed by their supervisees?, 3) How do supervisors attend to vicarious trauma in supervision?, and 4) How do supervisors describe the prevention of vicarious trauma?

Participants

Participants were eligible to participate in this study if they were a supervisor that had provided supervision to counselors/counselors-in-training within the last six months. All participants must have provided supervision to counselors/counselors-in-training that currently worked with clients who have experienced trauma. To determine if supervisees were working with this population, the site was the determining factor. Criterion sampling was utilized ensuring that participants have experienced the phenomenon being explored (Creswell, 2013).

Procedures

The participants were recruited via word of mouth, counseling list-servs, and through emails. A call for participants was sent through the Alabama Counseling Association list-serv and the Counselor Education and Supervision Network (CESNET) list-serv. Participants were recruited until saturation was reached.

Participants were provided with the informed consent and scheduling of the interview took place. They were asked to select a pseudonym for identification purposes and to ensure confidentiality. Each participant participated in a semi-structured phone interview that was audio recorded. The data collection procedure included one (30-45 minutes) phone interview for each participant with an option for a second member checking interview (10-15 minutes). Questions in the first interview included supervisors understanding of vicarious trauma, symptomology of vicarious trauma, and treatment and prevention to begin to build the essence of experience from the participants (Creswell, 2014).

A semi-structured interview approach was utilized as a primary means of data collection in this study. Phone interviews were selected as means of data collection for this study to provide the opportunity to reach potential participants across the United States, rather than be restricted to local supervisors. Additionally, Creswell (2014) suggests that phone interviews should be selected when the interviewer does not have the ability to meet in person with the participants. A interview protocol was utilized to maintain consistency throughout each interview. The protocol also included the interview questions and space for the researcher to record thoughts, questions, discrepancies, issues, and potential themes regarding the participant responses which were added to the audit trail (Creswell, 2007). The interview questions were open-ended probing supervisors on their knowledge of vicarious trauma and asking them to reflect on their experiences with

vicarious trauma within supervision providing the opportunity for thick, rich descriptions of their experiences. The interviews were transcribed via a secure transcription service.

The second interview was offered to the participants after data was compiled revealing common themes from the first interview. Through email, participants were provided the transcript of their interview. They were given the opportunity to confirm and/or clarify to ensure credibility of the information and narrative accounts through the process of member checking (Creswell & Miller, 2000).

Data Analysis

A hermeneutical phenomenological qualitative approach was utilized to design the study and for the data analysis procedures. The data was organized by individual transcripts and read and reread by the researcher several times prior to coded. While reading the transcripts, the researcher made notes in the margins regarding overarching thoughts and ideas (Creswell, 2014; Tesch, 1990). Due to the audio recordings being transcribed by a transcription service, the researcher chose to hand code rather than utilize a qualitative computer data analysis program. Hand coding the transcripts allowed the researcher to immerse herself in the details and live with the narratives (Van Manen, 1990).

Individual transcripts were coded for emerging themes first, then all of the transcripts were compared and analyzed for common themes across participants. The coding process began by reviewing the transcriptions, isolating significant sentences, organizing the significant statements into categories, and labeling categories with a term (an in vivo term) developing the themes (Creswell, 2014). A traditional qualitative phenomenological approach of allowing codes to emerge during data analysis was followed. While reading the individual transcripts, the researcher identified significant statements describing how the participant experienced the

vicarious trauma phenomenon (Moustakas, 1994). Next, the significant statements were organized into categories that were labeled with an in vivo term (participants language) (Creswell, 2014). The researcher identified quotes from the transcripts to provide clear evidence of the relationship between the significant statements and the developed themes, which is typically labeled as a textural description (Creswell, 2013).

The hermeneutic circle was utilized to allow the coding to develop meaningful descriptions. The hermeneutic circle is a way of interpreting text, such as transcriptions, that includes a process of understanding the parts to then bring an individual to understand the meaning of the whole text (Creswell, 2007). You cannot understand the whole without understanding the parts (McLeod, 2011). The researcher moved back and forth between the part (significant statements) and the whole (themes) for individual transcripts. Then, the researcher moved back and forth between the parts (themes of individual transcripts) and the whole (commonality across all of the transcripts) to understand the universal experience of the participants with the phenomenon of vicarious trauma.

Individual transcripts were coded for themes first and then all of the transcripts were compared and analyzed for commonality across all participants to develop universal common themes. This allowed for the identification of the commonality of the lived experiences of the vicarious trauma phenomenon by the participants.

Several methods to strengthen the credibility and trustworthiness of the study were used to enhance the confidence in the conclusions of the study (Creswell, 2014). The methods include saturation, member checking, audit trail, and utilizing a peer reviewer and external auditor.

Demographics

This study included ten supervisors who have provided supervision to at least one counselor/counselor-in-training within the past six months. The counselors/counselors-in-training they supervised all worked at sites where they provided counseling to individuals who have experienced trauma. The supervisors described the sites: group clinical practice, private and community outpatient, medical setting for sexual assault survivors, children services, sexual assault services, non-profit social services, behavioral health outpatient services for teens in contact with the juvenile justice department, non-profit child abuse services, outpatient for the severely mentally ill, clinic associated with a university, and a hospital clinic.

Out of the ten participants, two identified as men and eight identified as women. Additionally, seven supervisors identified as Caucasian/White, two supervisors identified as Black, one supervisor identified as Caucasian Hispanic, and one identified as an American of Arab decent. The supervisors age ranged from 29 to 65 years old. The participants years of experience employed as a supervisor ranged from two years to ten years. There was a wide range of the number of supervisees each supervisor has worked with from four to approximately one hundred and fifty.

All of the supervisors were licensed professional counselors (LPC) in there designated states; however, only eight of the ten stated they held the supervisor credential, such as an Licensed Professional Counselor Supervisor (LPC-S). Several of the supervisors were from Alabama due to the call for participants through the ALCA list-serv. The remainder of the supervisors were from Florida, Illinois, New Jersey, and Washington, D.C..

Results

The interviews provided individual and shared views, successes, and challenges of supervisors lived experiences of the vicarious trauma phenomenon in the supervision setting. The findings allow for the conceptualization of the supervisors experience. Analysis of the transcriptions include common themes that emerged. The commonality of those themes are discussed below. The themes are enhanced with quotes from the supervisors.

Knowledge of Vicarious Trauma. The majority of the supervisors described vicarious trauma as an indirect trauma with some labeling it as a secondhand traumatic experience or secondary traumatic stress. All of the supervisors described vicarious trauma as a counselor listening to a clients trauma story and that story impacting the counselor in some way. Katherine elaborated on the emotional response "vicarious trauma is the emotional response that people in the helping profession can experience after listening to the trauma of others". Other emotions identified were sadness, anxiety, depression, empathy, and feeling overwhelmed. Supervisors discussed observing supervisees being triggered by client narratives and leading to similar symptoms of Post Traumatic Stress Disorder (PTSD) including nightmares, hypervigilance, isolation, change in worldview and level of trust, avoidant behaviors, increased anxiety symptoms, and the inability to sleep. Other symptoms discussed were the adoption of the clients symptoms. Michelle gave a description "Vicarious trauma is when a clinician is working with someone that has experienced trauma and then they start to develop some of the trauma symptoms or behaviors that the client or clients were reporting from the trauma". A decrease in clinical effectiveness was commonly noted by the supervisors. They noticed through listening to supervisees tapes that they would regress to old mistakes. Michelle stated "But I'll see them make slips that they haven't made since they were doing their Individual Counseling Skills

Class". Additionally, a decline in clinician performance was illustrated by Cindy "Kind of impaired their judgment, or impaired their ability to work or function as a counselor. And not just with that client, but other clients." Additionally, several of the participants talked about how the counselors would feel shame and embarrassment from being affected by the clients narrative and had an intense fear about appearing weak. Cindy shared what her supervisee was concerned about "Does this mean I'm a bad counselor? Does that mean I'm not going to be good at this? Does that mean I can't do it? Does that mean I can't work for this client? Does that mean I have to switch sites? Does that mean I am not going to be considered strong?". Cindy continued to reflect on how her supervisee described feeling fearful of admitting they were experiencing vicarious trauma because that would mean they were weak and unable to handle being a counselor. The participants continued with similar stories stating that their supervisees believed that experiencing vicarious trauma equaled failure as a counselor. This idea of failure included questioning their abilities as a counselor and if they were in the right profession. John recounted "I mean there was serious doubt about whether or not she was in the right profession and whether or not she could handle listening to these things, helping people like this".

Attending to Vicarious Trauma in Supervision. The supervisors stressed the importance of having a strong supervisory alliance which must be based on a supportive environment to allow the supervisee to feel safe to be vulnerable and bring up the vicarious trauma symptoms openly in supervision. Kay explained how she starts supervision off with a talk to foster a safe environment that includes:

> I expect that you're not going to do this perfectly and I want you to feel safe to come to me if something doesn't seem right. If you are struggling in an area or if you think you did something that wasn't exactly the best therapeutic thing to do, I want to know so we

can fix it together. I want you to be proactive. I'm here to help you be successful, I'm not here to try to weed you out.

The participants believe that a supportive environment includes empathetically validating and normalizing supervisees symptoms and concerns. Mary described how she attends to vicarious trauma in supervision "Well I am first of all very empathetic and validating, so I would kind of normalize the situation, validate what my supervisee's going through." The supervisors shared that to normalize this experience, it is important to tell their supervisees that vicarious trauma can happen to anyone despite level of experience and it is an occupational hazard for counselors who work empathetically with clients who have experienced trauma. Paul shared that he explains this to his supervisees by "talking about the fact that it's an occupational hazard for us, it's part of what goes with the work that we do, it's just part of the package". The supervisors spoke on how important it is to stress that vicarious trauma is not a weakness and that it is a natural response because counselors are human. Michelle explained how she would approach a supervisee:

> You're a counselor or a counselor-in-training, but you're also human and some of these things that you will experience with your clients or your clients will tell you can be very, very, very traumatic. So don't look at it as a sign of weakness that you're struggling or even if you are dreading working with this person because it is so heavy.

Focusing on that vicarious traumatization does not equal failure was a passionate subject for Dulce "I tell them not be ashamed, that this is part of doing your job!" and "If you're not experiencing this, I would be surprised right now.".

Psychoeducation on vicarious trauma was a common discussion by the supervisors during the interviews. They discussed how psycho-education needs to occur early and that it

needs to be individualized to the supervisee to fill in the gaps of knowledge. Psycho-education also included self-care. Self-care was a commonality among all of the participants. The supervisors talked about how important it was to encourage individual self-care daily and start that conversation early in supervision. Another part of self-care reported was encouragement of the supervisees receiving their own counseling. Self-care concepts also included mental health days, breaks, and time away from work. The supervisors talked about sometimes taking a step back includes not assigning that counselor any more clients.

The supervisors explained that they use transparency of their own experiences of vicarious trauma to normalize their supervisees experiences to hopefully alleviate the shame and embarrassment the supervisee is feeling. John illustrated this point "I think people who are in the process of becoming a counselor don't realize that everybody else has the same fears and doubts and concerns that they do. Some self disclosure helps normalize what they're going through".

Paul valued self-disclosure as well, but he also had a cautionary statement "I intentionally was careful not to give the supervisee another traumatic experience to deal with" and "recommendations of being careful of how much details you provide to a supervisee so that your sharing your own experience doesn't in turn become vicarious trauma for your supervisee". Paul explained that he values self-disclosure to share that he has experienced vicarious trauma to normalize and validate his supervisees feelings and includes how he moved past it to provide hope. But, he cautioned to not share the traumatic story from the client that vicariously traumatized him.

Another method commonly discussed by the supervisors for addressing vicarious trauma was the notion of "check-ins". The supervisors talked about how it is important to check-in on self-care every supervision session to help build those healthy habits early in a counselors career.

Additionally, they spoke about how they use check-ins to assess vicarious trauma symptoms including emotional responses and the use of boundaries.

Challenges and Successes of Attending to Vicarious Trauma in Supervision. During the interviews, reoccurring aspects of challenges when attending to vicarious trauma in supervision included that the supervisee had a lack of self-awareness, lack of education, and/or were in denial about their vicarious trauma symptoms.

Cindy mentioned that being fearful of the perceived consequences of being vicariously traumatized can keep supervisees from coming forward with how they are feeling. Renee agreed "I think that that comes from being worried that if they do experience vicarious trauma, that somebody's going to tell them, 'Well then, I guess you're not cut out for this work,' which is not the case at all. I think that you can do this work and still be affected by the people you serve and their stories."

Though, several of the supervisors believed that an overall lack on insight and self-awareness lead the supervisees to be in denial or try to rationalize the symptoms. Mary reflected on this challenge as being dangerous:

> The first one that comes to my mind is the supervisee's denial or a way of justifying what's going on and rationalizing things and kind of not being able to hear feedback and thinking that nothing's going to happen to them, that they're strong and it's not going to affect them and they have abilities to cope with it. So I think that's a very dangerous area, if I have a supervisee coming in with the mindset of, "Oh, it's not going to be me, cannot happen to me. I have the skills and abilities and I'm not going to be the one."

The challenges took a shift of focus from the supervisee to challenges the supervisors themselves face. Reoccurring challenges included the idea of having to balance being a

supervisor and being a human being in the room with your supervisee. John explained that the challenge is maintaining appropriate boundaries but also being real and human and having supervisory boundaries in place. Ann and Cindy also voiced that they were concerned about being unprepared as a supervisor to work with supervisees experiencing vicarious trauma. Ann expressed "I don't know if I felt prepared to work on it with supervisees. I don't know if I felt trained to do that. Also I think I wasn't prepared to deal with how difficult it is from, to deal with vicarious trauma as a supervisor". Kay explained the challenge of having to listen to the trauma narratives through her supervisee as well. She stressed the importance of being about to manage her own emotions while also being there for her supervisee.

Dulce talked about an additional challenge for working with counselors-in-training. She mentioned that it can be a challenge to evaluate your supervisee to determine if their symptoms are normal for counselor-in-training development or if it is vicarious trauma. She gave an example of her supervisee stating they were not sleeping and then finding out that it is not due to client trauma narratives, but due to the student preparing for the National Counselors Exam.

Successful experiences of attending to vicarious trauma in supervision were described as working with supervisees who were self-aware, insightful, and open to feedback. However, they mentioned that in order for a successful interaction, that a safe validating and normalizing environment needs to be present. The participants spoke about how early detection of the signs and symptoms of vicarious trauma lead to faster healing. They also spoke on how a sense of relief washed over the supervisee once vicarious trauma was talked about as an occupational hazard. Successful experiences also included when vicarious trauma is overcome by the supervisee. Ann reflected on a success that included her providing psycho-education that lead to early detection of symptoms which lead to lessening the severity of symptoms overall "So it

seems like if we can catch it early and they're aware of it, then they can put up a little more guard and kind of start to process it to where it doesn't build up to the point that it's too much to handle". Katherine had a similar experience "I had another one who recognized the symptoms a lot sooner and was able to process them and move on, and so that was definitely a success because the education was provided early on, she felt comfortable processing in supervision, and that was it". Several of the participants believed the relief was connected to the shame and embarrassment the supervisee may have been feeling about being vicariously traumatized. It was discussed how there was a sense of gratitude towards the supervisor for the support provided. Paul reflected on a positive experience with a supervisee "I think she felt relieved that I was understanding and concerned about her wellbeing and that I could relate to the experience".

Another common theme among the successful experiences of attending to vicarious trauma in supervision included what occurs once the vicarious trauma symptoms are alleviated. The supervisors shared that when a supervisee is healed they become a better clinician overall leading them to have increased intentionality on self care, increased positive interactions with clients, and increased successful counseling relationships. John reflected "Successes are from watching them. It's people who become counselors. They go out and they help hundreds, thousands more people than I can reach".

Recommendations made by Supervisors for Supervisors. The recommendations fell into two categories: 1) recommendations for the supervisors themselves, and 2) recommendations for how to approach vicarious trauma in supervision with a supervisee. Recommendations that supervisors had for themselves includes self-care and attending trainings on vicarious trauma. The majority of the participants recommend that the supervisor practices what they preach to their supervisees. They encourage attending to your own self-care to maintain overall wellness.

This may include a support group for supervisors. Practicing healthy work boundaries and self-care strategies allows for the supervisor to be a good model for their supervisees. Paul offered his recommendation for supervisors "Well my advice is that you be healthy." He continued "Yeah, that you be spiritually and psychologically and emotionally healthy. Without that you can't help people. So a supervisor needs to be on a path of growth all the time." Additionally, the participants explained that the supervisor needs to be knowledgeable about vicarious trauma early signs and symptoms. This may include attending trainings on vicarious trauma or consulting. Mary explained "My recommendation would be know all the signs and presentation of vicarious trauma, so that would be the first one" and "Then of course my second recommendation, know how to approach it. So read about it or get supervision on it, so you are effective as a supervisor". Mary continued to explain how important it is to be knowledgeable about vicarious trauma "I would say let's not get scared of vicarious trauma. Let's normalize and let's get ourselves competent so once we are facing a supervisee who are affected, then we know how to proceed".

Recommendations on how to approach vicarious trauma in supervision included fostering a safe environment, appropriate self-disclosure, modeling, psycho-education on vicarious trauma, having an individualized approach, encouraging self-care and providing resources, and check-ins.

Vicarious Trauma Prevention. When the supervisors were asked about any recommendations they had for the prevention of vicarious trauma, the majority of them started their response with "that's a tough one", "that's an unusual question", "I am not sure if it can be prevented", and "oh, that's really hard". Several of the supervisors believe that prevention of vicarious trauma may not

be possible. John shared his thoughts on prevention "You're not going to prevent it from occurring. It's just, it's going to happen if you're a compassionate human being".

However, several of the supervisors believe that while complete prevention may not be possible, being proactive is possible. The supervisors discussed that being proactive can lead to decreasing the severity and duration of the vicarious trauma symptoms. They believe that being proactive or seeking to prevent vicarious trauma is a responsibility that falls on both the supervisor and the supervisee. To be proactive, the supervisors recommended early psycho-education on vicarious trauma with every supervisee in supervision and in coursework. They discuss how important it is to encourage supervisee self-awareness and insight into their own triggers. As well as, early and often psycho-education and encouragement of self-care plans. Renee reflected on the importance of self-care and awareness:

> So if we've got really good self-care and good self-awareness, then I think that's going to decrease the vicarious trauma we experience. The clients' stories aren't going to change, they're going to be scary and traumatic, so we have to make sure that we are taking care of ourselves and doing things on our part to stop that.

The participants revisited the notion of having weekly check-ins on self-care plans to ensure that healthy habits are being formed including daily self-care tasks. Michelle reflected on self-care, education, and self-awareness as being essential "Once again, just self-care and educating yourself about what vicarious trauma is, and then using that information with the information you know about yourself as an individual because all of us are individuals and have different response to things or have a different tolerance level". She continued "So knowing yourself and knowing what vicarious trauma is and incorporating regular self-care things every single day, even if it's something small, just to keep yourself grounded and balanced is a really

great way, at least in my experience, to prevent it or to mitigate it when it does happen, minimizing it". Supervisors recommended encouraging their supervisees to seek support both individually and in groups. Ann reflected on this as part of gatekeeping for the counseling profession "Probably what would be helpful is I think part of the gatekeeping process is making sure that counselors who are graduating have a level of insight and a level of support to be able to be successful in this field". She went on to recommend that individual support can include the supervisee going to a counselor of their own. John reflected on group support as part of self-care:

> Well that all goes back to the gentle self care. You need to have a group around you. I meet monthly with a group of therapists and we process things. And that's the thing about supervision, you're there for them. But there's a point where the person's out there and licensed and there's no more supervision. And now you've got to figure out how to find the support.

Ann also believed that advocating for agency wellness is essential "So maybe there are ways that we could prepare our counselors to be able to advocate for themselves within the organization that they work in".

Another common topic was supervisors needing to be knowledgeable about vicarious trauma. They recommended that supervisors have training on how to detect and address vicarious trauma in supervision. They suggested using your own theoretical model to identify ways to approach vicarious trauma. Lastly, they believe that vicarious trauma needs to be incorporated into supervision training. Kay illustrated the commonality that vicarious trauma needs to be incorporated into the training of supervisors:

> I took a course for supervision probably six or seven years ago, and I don't recall anything about vicarious trauma. We talked about ethics and we talked about things to do

procedurally, but I think maybe just a little more attention to the importance of helping supervisors look for that and understand it because I think often, if I wasn't in a doctoral program, would I have even been aware?"

Discussion

The findings of this study provide a voice to supervisors' experience of vicarious trauma among the vicarious trauma literature. The findings indicate that supervisors have an accurate understanding of vicarious trauma; however, at times mislabel vicarious trauma as secondary traumatic stress and compassion fatigue. The participants demonstrated that they have the ability to identify vicarious trauma symptomology displayed by their supervisees. Adding to the literature, the supervisors indicated that an element of vicarious trauma is shame and embarrassment felt by the supervisee suffering from symptoms.

Additionally, the results provide evidence of supervisors utilizing methods to attend to vicarious trauma that align with the guidelines available in the literature and even provide practical examples to demonstrate how they facilitate the guidelines in session. One of the practical examples provided has not been noted in the vicarious trauma literature. The supervisors stress the importance of utilizing self-disclosure of their own experiences of vicarious trauma as a way to normalize and validate the vicariously traumatized supervisees experience to soothe the elements of shame and embarrassment. The participants also discussed that self-disclosing how they coped with vicarious trauma allows for modeling of appropriate self-care and wellness methods and to open dialogue about developing individualized self-care plans for their supervisees. Perhaps, the supervisor's individual experience of vicarious trauma informs their response to vicarious trauma symptoms displayed by a supervisee. It is possible that supervisors who have experienced vicarious trauma themselves may have awareness of

vicarious trauma and the ability to identify symptoms due to the fact they have observed the symptoms within themselves as a counselor. Their own experiences may inform the way they address vicarious trauma in supervision with supervisees allowing them to be more empathetic and knowledgeable.

Despite the described approach paralleling the trauma sensitive supervision guidelines noted as a protective factor of supervision, the supervisors did not describe their approach to vicarious trauma as trauma-sensitive and stated that providing psycho-education, developing individualized self-care plans, and conducting regular check-ins should be conducted with every supervisee, despite the population they provide counseling services to. Furthermore, the supervisors noted that they did not always feel prepared for the responsibility to address vicarious trauma in supervision. Thus, suggesting that supervisors may not feel confident in their abilities to address vicarious trauma in supervision and/or they have not been specifically trained on how to approach vicarious trauma.

Further findings reveal the lived successful and challenging experiences of the supervisors when attending to vicarious trauma within supervision. These experiences shed light on successful methods of attending to vicarious trauma from the perspectives of supervisors and support the guidelines in the literature. The challenges provide insight to vicarious trauma treatment methods that may not have been discussed previously. The supervisors stated when supervisees are not open to the supervision process and feedback on vicarious trauma symptomology progress cannot be made despite the knowledge and abilities of the supervisor.

The results regarding vicarious trauma prevention are revealing and new. Several of the supervisors believe that vicarious trauma is not preventable because it is an occupational hazard of an empathetic and skillful counselor. In fact, nine out of the ten supervisors interviewed had

supervised several counselors who had been vicariously traumatized. While prevention was not perceived as possible, the supervisors believe that proactive methods can be employed in supervision before and after vicarious traumatization occurs which can decrease the severity and duration of vicarious trauma symptomology.

The findings of this study provide implications for clinical supervisors and for counselor education programs. The implications allow for the participants to provide recommendations to other supervisors and those who train future counselors and supervisors. The participants of this study were able to share their experiences of vicarious trauma and allow for other professionals to learn from them, fulfilling the social constructivist framework of this study. These implications are offered to better assist supervisors with attending to vicariously traumatized supervisees and to assist counselor educators in training future counselors and supervisors to be prepared for vicarious trauma in their respective roles.

Implications for Supervisors

The participants of this study noted that vicarious trauma is a common occurrence they experience with their supervisees. The supervisors of this study provided recommendations that they have for supervisors regarding the phenomenon of vicarious trauma. The participants recommend that supervisors maintain healthy self-care and work boundaries. Practicing healthy work boundaries and self-care methods allows for the supervisor to maintain personal health and to be a model for their supervisees.

The supervisors also recommended attending trainings on vicarious trauma and consulting when unsure of how to proceed. Supervisors suggest having a group of professionals to meet regularly with for support and consultation. Enhancing knowledge on vicarious trauma is

to ensure supervisors know and are confident in approaching vicarious trauma in the supervisory role.

Recommendations on how to approach vicarious trauma in supervision include: 1) Fostering a supportive environment to allow for supervisees to feel comfortable being vulnerable, 2) Utilizing appropriate self-disclosure to normalize and validate the supervisees experience and mitigate there shame and embarrassment, 3) Modeling offers the supervisee to observe healthy self-care and work boundaries, 4) Providing psycho-education on vicarious trauma early in supervision encourages self-awareness in supervisees that could lead to early detection and treatment, 5) Developing an individualized approach with each supervisee allows for gaps in knowledge to be filled and rapport to be built, 6) Encouraging self-care plans early in supervision enables the development of healthy wellness habits early in a counselors career, and 7) Regularly checking-in on your supervisees emotional reactions to trauma narratives and maintenance of self-care plans allows for early detection of symptoms to decrease severity and duration of vicarious traumatization. These recommendations parallel what has been suggested in the literature as protective factors of vicarious trauma and trauma sensitive guidelines for supervision (Etherington, 2000; Pearlman, 1999; Pearlman and Saakvitne, 1995; Rosenbloom, Pratt, & Pearlman, 1999; Sommer & Cox, 2005, 2006).

These recommendations suggest a great value in the health and wellness of supervisors to be effective supervisors and models of healthy counselors. Additionally, the encouragement of increased training on vicarious trauma to feel confident and prepared for the responsibility of attending to vicarious trauma symptoms in supervision was highlighted.

Implications for Counselor Educators

The findings of this study indicate that while supervisors are utilizing trauma sensitive supervision guidelines to approach vicarious trauma, they are unaware that they are doing so. The results also indicate the supervisors are aware of vicarious trauma and symptoms due to their own personal experiences of being vicariously traumatized. While prevention was not considered possible by the supervisors, being proactive was highly regarded. Providing further education about vicarious trauma during training can be a way of being proactive. If supervisors are trained on vicarious trauma, vicarious trauma symptoms, and how to attend to vicarious trauma in supervision utilizing trauma-sensitive supervision guidelines, supervisors can feel more confident and knowledgeable in their roles.

Additionally, the findings of this study also indicated supervisors thought it was critical to provide psycho-education on vicarious trauma to their supervisees. This highlights the need for this to be incorporated in supervision, and may suggest the need for increased attention in counselor training. Specifically, it may be necessary for counselor education programs how to infuse this training into the preparation of students prior to practicum and internships. This parallels the recommendations of other researchers who have emphasized the need for education and training (Merriman, 2015; Sommer, 2008; Vrklevski & Franklin, 2008). Counselor educators have a ethical obligation to include vicarious trauma in counselor education programs for counselors-in-training and future supervisors. Vicarious trauma is an occupational hazard that impacts counselors' effectiveness and can be detrimental to clients, making assessing and addressing vicarious trauma symptomology, training on trauma specific counseling skills, and self-care practices an ethical obligation of counselors, counselors-in-training, supervisors, and counselor educators (ACA, 2014; CACREP, 2014; Vrklevski & Franklin, 2008). By maintaining

the health of counselors, potential benefits could reach clients ensuring best practices from healthy counselors; therefore, benefiting the counseling profession as a whole.

Limitations of the Study

A limitation of this study are the participants themselves. It is reasonable to consider that individuals interested in participating in this study would have an interest in the phenomenon of vicarious trauma within supervision. The call for participants included the title of the study and the eligibility requirements that clearly suggest the topic of discussing vicarious trauma within supervision. Supervisors that volunteered to be a part of this research study may already have a base knowledge of vicarious trauma and may not be an accurate representation of an typical supervisor.

While the ages of the supervisors and years of experiences as a supervisor varied eight of the ten participants were women and seven of the ten participants identified as Caucasian/White. Additionally, several of the participants were from Alabama and the rest were from the east coast. Perhaps a participants from other areas of the country would have yielded differing results.

Qualitative research limits the ability to make generalizations to other populations of supervisors due to the focus on depth not breadth of data collected from participants.

Recommendations for Future Research

This study deepened the understanding of the perception of supervisors' lived experiences of the vicarious trauma phenomenon in supervision and provided recommendations for supervisors and counselor educators. Now that supervisors' voices have been heard, it would be beneficial to continue that exploration in other ways. The use of focus groups could yield further results deepening the understanding of the experiences of supervisors with the vicarious trauma phenomenon. Additionally, a case study or phenomenological qualitative study examining pairs

of supervisors and supervisees would deepen the understanding of the phenomenon of vicarious trauma from both perspectives of the individuals in the supervision room.

Future research exploring if specific supervision models and/or specific methods of approaching vicarious trauma are more proactive/protective than others would be beneficial to the literature a well. Further exploration of the use of self-disclosure as a method to approach vicarious trauma in supervision could inform on the effectiveness of this approach. Additionally, a study that explores the effectiveness of vicarious trauma treatment by supervisors trained in trauma-sensitive supervision compared to traditionally trained supervisors could provide results that support the vicarious trauma protective factor literature. Lastly, a research study that examines supervisors that are also counselor educators could reveal an additional set of challenges and successes experienced. Further exploration into the challenge of differentiating between developmentally appropriate stress symptoms of students attending a master's program and vicarious trauma symptoms could reveal implications for counselor educators.

Summary

The purpose of this study was to gain a deeper understanding of the lived experiences of supervisors perceptions of the vicarious trauma phenomenon. The findings of the study indicated that supervisors, while not always confident in their abilities and knowledge of vicarious trauma, follow trauma-sensitive guidelines while approaching vicarious trauma symptoms with a supervisee. Their knowledge provided insight to another element of vicarious trauma including shame and embarrassment of the supervisee that is affected. The supervisors gave practical examples of methods they use to intervene when a supervisee is experiencing vicarious trauma including a new method not mentioned in the literature, self-disclosing their own personal experiences of vicarious traumatization. Through their own voice, supervisors provided

examples of challenging and successful experiences of addressing vicarious trauma with a supervisee. Recommendations by the supervisors for other supervisors included the importance of the supervisors taking steps to be healthy themselves by practicing self-care and healthy work boundaries. Lastly, the supervisors suggest prevention of vicarious trauma is impossible because it is an occupational hazard that will occur if the counselor is empathetic, but being proactive can decrease the severity and duration of symptoms. Recommendations for counselor educators included implementing training specifically on vicarious trauma for future counselors and vicarious trauma as it is an ethical mandate. If the counseling profession can care for the caregivers, health and wellness can be maintained to be able to provide the best care possible for our clients.

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Appendix A: IRB Official Approval Letter

AUBURN UNIVERSITY

Office of Research Compliance
115 Ramsay Hall, basement
Auburn University, AL 36849

Telephone: 334-844-5966
Fax: 334-844-4391
IRBadmin@auburn.edu
IRBsubmit@auburn.edu

July 12, 2017

MEMORANDUM TO: Ms. Sarah Fucillo
College of Education

PROTOCOL TITLE: "Caring for the Caregivers: A Phenomenological Study of Supervisors and Vicarious Trauma"

IRB AUTHORIZATION NO: 17-244 EP 1707
APPROVAL DATE: July 07, 2017
EXPIRATION DATE: July 06, 2018

The referenced protocol was approved as "Expedited" by the IRB under Sections 45 CFR 46.110 (6 and 7) of the Code of Federal Regulations (http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html)

When you accepted this approval, you agreed to the following:

1. **Changes to your protocol** *must* be approved in advance by submitting a modification request to the IRB. The use of any unauthorized procedures may result in penalties.
2. **Unanticipated problems** involving risk to participants *must* be reported *immediately* to the IRB.
3. A **renewal request** *must* be submitted three weeks before your protocol expires.
4. A **final report** *must* be submitted when you complete your study, along with copies of any consents used.
5. **Expiration** – If you allow your protocol to expire without contacting the IRB, it will be administratively closed. The project will be suspended. You will then need to submit a new protocol to resume your research.
6. You must **use only the approved, stamped version** of your **information letter.** A copy must be given to participants.

Per memo dated 5/9/2017 from Howard Gobstein, Executive Vice President, Association of Public & Land-Grant Universities, APLU activities will follow the approved AU IRB protocol.

All forms can be found at http://www.auburn.edu/research/vpr/ohs/index.htm. Questions concerning this Board action may be directed to the Office of Research Compliance

If you have any questions concerning this Board action, please contact the Office of Research Compliance.

Sincerely,

Bernie R. Olin, Phar. D.
Chair of Institutional Review Board #2
for the Use of Human Subjects in Research

Appendix B: IRB Approved Call for Participants Email

Dear Potential Participant,

My name is Sarah Fucillo and I am a doctoral candidate in the Counselor Education and Supervision Program and Auburn University. Please consider participating in my research study. This study seeks to explore supervisors lived experiences of the phenomenon of vicarious trauma.

You are eligible to participate in this study if you are a supervisor that has provided supervision to counselors and/or counselors-in-training within the last six months. All participants must provide supervision to counselors and/or counselors-in-training that currently work with clients that have experienced trauma.

Participation in this study involves completing two phone interviews. The first phone interview will last for approximately 30-45 minutes. The second interview allows for you to confirm and/or clarify the summary of findings and will last approximately 10-15 minutes. You will be asked to provide a phone number as well as schedule dates and times you are available for the phone interviews.

Your participation in this study is completely voluntary and is confidential. To thank you for your time, you will be offered a $15.00 Amazon or Starbucks gift card.

If you would like to participate in this research study or would like more information, please contact Sarah Fucillo at sjf0015@auburn.edu. My dissertation chair is Dr. Jamie Carney and she may be reached at carnejs@auburn.edu.

Thank you for your consideration,

Sarah Fucillo, M.S., NCC
Doctoral Candidate, Counselor Education and Supervision
Auburn University

Appendix C: IRB Approved Informed Consent

The Auburn University Institutional Review Board has approved this Document for use from 07/07/2017 to 07/06/2018 Protocol # 17-244 EP 1707

AUBURN UNIVERSITY

DEPARTMENT OF SPECIAL EDUCATION, REHABILITATION, AND COUNSELING

INFORMED CONSENT

You are invited to participate in a research study to provide insight into how clinical supervisors perceive the phenomenon of vicarious trauma. This study entitled, "Caring for the Caregivers: A Phenomenological Study of Supervisors and Vicarious Trauma" is being conducted by Sarah Fucillo, a doctoral candidate, under the direction of Dr. Jamie Carney in the Auburn University Department of Counselor Education and Supervision.

You are eligible to participate in this study if you are a supervisor that has provided supervision to counselors and/or counselors-in-training within the last six months. All participants must provide supervision to counselors and/or counselors-in-training that currently work with clients that have experienced trauma.

What will be involved if you participate? Your participation is completely voluntary. If you decide to participate in this research study, you will be asked to participate in two phone interviews. During these interviews, the researcher will audio tape the conversations about your experiences of providing supervision to counselors and/or counselors-in-training. The audio tape will be transcribed for qualitative analysis. Once the audio tape is transcribed it will be destroyed. Your total time commitment for the first phone interview will be approximately 30-45 minutes. In the second phone interview, you will be given the opportunity to confirm and/or clarify the summary of findings. The second phone interview will be approximately 10-15 minutes. If you meet the requirements of the study, you will be asked to provide a phone number as well as schedule dates and times that you are available for a phone interview.

Are there any risks or discomforts? This risks associated with participating in this study are the same risks associated with working with clients that have experienced trauma. To minimize these risks, we will advise you to utilize your self-soothing and mindfulness techniques if you feel yourself being triggered.

Are there any benefits to yourself or others? There are no direct benefits from participating in this study. However, it is hopeful that the results of this study will provide more insight into how to provide supervision that helps prevent and treat vicarious trauma when working with supervisees. This could benefit the wellness of the clinicians that treat clients with trauma; therefore, providing better care and treatment to the clients.

Will you receive compensation for participating? To thank you for your time you will be offered a $15.00 Amazon or Starbucks gift card.

Are there any costs? If you decide to participate, you will not incur any costs.

If you change your mind about participating, you can withdraw at any time during the study. Your participation is completely voluntary. If you choose to withdraw, your data can be withdrawn as long as it is identifiable. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University, the Department of Special Education, Rehabilitation, and Counseling.

2084 Haley Center, Auburn, AL 36849-5222 Telephone 334-844-7676; Fax: 334-844-7677
www.auburn.edu/sere

Your privacy will be protected. Any information obtained in connection with this study will remain confidential. The identities of the participants with be kept confidential and pseudonyms with be used during the audio recordings and for dissemination of findings.

If you have any questions about this study, please contact Sarah Fucillo at sjf0015@auburn.edu or Dr. Jamie Carney at carnej@auburn.edu.

If you have any questions about your rights as a research participant, you may contact the Auburn University Office of Research Compliance or the Institutional Review Board by phone (334)-844-5966 or e-mail at IRBadmin@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE WHETHER OR NOT YOU WISH TO PARTICIPATE IN THIS RESEARCH STUDY. YOUR SIGNATURE INDICATES YOUR WILLINGNESS TO PARTICIPATE.

Participant's Signature	Date	Investigator Obtaining Consent	Date
Printed Name		Printed Name	

The Auburn University Institutional Review Board has approved this Document for use from 07/07/2017 to 07/06/2018 Protocol # 17-244 EP 1707

Appendix D: Interview Questions/Interview Protocol

INTERVIEW QUESTIONS/INTERVIEW PROTOCOL

Inclusionary Criteria:

1. Are you currently a licensed supervisor?

2. Are you currently providing supervision to at least one counselor or counselor-in-training?

    a. If not, have you supervised at least one counselor or counselor-in-training within the last 6 months?

3. Does your supervisee work at a clinical site where they provide counseling services to individuals who have experienced trauma?

    a. Have you worked with a supervisee who has provided counseling services to individuals who have experienced trauma within the last 6 months?

Demographics:

4. What gender do you identify with?

5. How old are you?

6. How do you describe yourself in regards to race/ethnicity?

7. How long have you been employed as a supervisor?

8. How many supervisees have you provided supervision to?

Interview Questions:

1. How do you describe vicarious trauma?

2. As a supervisor, have you observed vicarious trauma in a supervisee?

(If yes, go with "A" options for rest of interview. If no, go with "B" options for rest of interview).

3. a) What did you observe in your supervisee(s) that led you to believe that they were experiencing vicarious trauma? (Follow-up if needed- signs, symptoms)

3. b) What might you observe in a supervisee that would lead you to believe they were experiencing vicarious trauma?

4. a) How aware do you believe your supervisee was of their experiencing vicarious trauma? How would you describe this awareness as a component of your supervision process?

5. a) Please describe how you approached the vicarious trauma symptomology with your supervisee(s).

5. b) Please describe how you might approach vicarious trauma with your supervisee?

6. a) How would you describe how the supervisee responded to the way you approached vicarious trauma symptomology in supervision?

6. b) What do you consider to be the potential responses of supervisees to having vicarious trauma symptomology approached in supervision?

7. a) What do you identify as the challenges and successes you have had when approaching vicarious trauma with your supervisee(s)?

7. b) What challenges do you see as a supervisor in approaching vicarious trauma with a supervisee?

8. Please describe any recommendations you have for supervisors on how to approach vicarious trauma within supervision.

9. Please describe any recommendations you have for the prevention of vicarious trauma within the supervision process.

10. What additional information would you like to share about your experiences with vicarious trauma as a supervisor?

Appendix E: Transcription Service Confidentiality Agreement

scribie
Audio Transcription, Perfected

https://scribie.com

Confidentiality Letter

TO WHOM IT MAY CONCERN

I, Rajiv Poddar, on behalf of Scribie.com, agree to treat in absolute confidence all information that we become aware of in the course of transcribing the interviews or other material connected with the files which we receive for transcription. We agree to respect the privacy of the individuals mentioned in the interviews that we are transcribing. We will not pass on in any form information regarding those interviews to any person or institution. On completion of transcription we will not retain or copy any information involving the above project.

We are aware that we can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if we disclose identifiable information contained in the audiotapes and/or files to which we will have access.

Signature: .....Rpoddar..... Date: February 20, 2017