

Invisible Wounds: Preventing Vicarious Trauma in Practicing Counselors

by

Margaret A. Taylor

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Approved by

Jamie Carney, Chair, Humana-Germany-Sherman Distinguished Professor of Special Education,
Rehabilitation, and Counseling

Malti Tuttle, Assistant Professor of Special Education, Rehabilitation, and Counseling

Jessica Melendez Tyler, Assistant Clinical Professor of Special Education, Rehabilitation, and
Counseling

David Shannon, Humana-Germany-Sherman Distinguished Professor of Educational
Foundations, Leadership, and Technology

Abstract

The purpose of this study was to understand the relationship between supervision and levels of vicarious trauma in practicing counselors. Due to the diverse number of traumatic events, the probability of counselors encountering trauma related material is quite great, placing counselors at a higher risk for experiencing vicarious trauma (Sommer, 2008). The lack of knowledge and training on vicarious trauma can potentially result in an impaired counselor who can no longer effectively treat the trauma of the client due to their own distress. Possible harm to the client receiving counseling may result if the counselor is no longer capable of providing effective counseling. Therefore, it is essential counselor educators and supervisors begin to identify measures that will prevent the occurrence of vicarious trauma or lessen its effects in future and practicing counselors. This study found supervision to be strongly correlated with lower levels of vicarious trauma in practicing counselors. Additionally, this study indicated self care was the most effective supervision strategy in mitigating vicarious trauma symptoms in practicing counselors. Implications for supervisors and counselor educators are discussed to assist supervisors and educators in lessening the damaging effects of vicarious trauma on practicing counselors.

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Chapter 1

Introduction and Background

Counselors are increasingly being required to work with populations who are in crisis or who have experienced trauma (Abassary & Goodrich, 2014). National surveys point to over half the population having experienced one event that meets the DSM-V criteria for trauma (Yanos et al., 2013). According to PTSD United (2013), 70% of adults in the United States have experienced at least one traumatic event during their lifetime, and as many as 20% of those people proceed to develop a Post Traumatic Stress Disorder diagnosis. This risk appears even higher for individuals with mental health issues; research has suggested that severely mentally ill individuals are at an increased risk of being exposed to trauma (Goodman et al., 2001). These numbers clearly illustrate the reality that counselors are likely to be working with clients who have experienced trauma and are thus at a risk of being exposed to the secondary impact of this trauma.

Educational institutions and accreditation boards have highlighted this risk. This risk has been highlighted by educational institutions and accreditation boards. This awareness is reflected in the Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards (2016). Specifically, the CACREP standards require counselors to be prepared to work with clients who have experienced crisis or trauma. CACREP standards C.2.f. states counselors should comprehend the “impact of crisis and trauma on individuals with mental health diagnoses” (CACREP, 2016). If CACREP believes it is necessary to require counselors to

understand crisis and trauma, then indeed crisis and trauma have become a more recurrent issue in counseling.

One component of this process is preparing counselors to understand what traumatic events are, signs of posttraumatic stress syndrome, and the impact of experiencing these events through counseling on the both the client and counselor. This includes crisis situations, which are likely to be similar to traumatic conditions (Trippany, White Kress & Wilcoxon, 2004). Traumatic events may consist of abuse, experiencing the death of a loved one, witnessing a death, domestic violence, drug use, involvement in a natural disaster, car accidents or a war. To be traumatic to a client, the event must be extremely upsetting or overwhelming to the client (APA, 2013). It is important to note that indirect exposure to details of crisis and traumatic situations can also be traumatic, causing similar symptoms to PTSD (Brere & Scott, 2015).

For counselors a critical problem arises when the counselor is ill prepared to treat the trauma of the client, nor prepared to prevent the possible traumatic effects they may experience while processing their client's trauma. The lack of knowledge and training on treating trauma and the risk of vicarious trauma can potentially result in an impaired counselor who can no longer efficiently address the trauma of the client due to their own distress and discomfort with the topic (Lonn & Haiyasoso, 2016). The counselor may be ineffective or even harmful to the client due to the intense psychological effects of the vicarious trauma. These effects can be excruciating and disturbing to the counselor, lasting for an extended period (McCann & Pearlman, 1990). Therefore, it is essential that counselors understand that they can experience vicarious trauma working with clients and that this trauma may negatively impact them and their clients.

The American Counseling Association (2014) Code of Ethics has emphasized the ethical and professional responsibility of counselors. Explicitly, the *ACA Code of Ethics* states it is the responsibility of the counselor to recognize and monitor themselves for possible impairment due to physical, mental or emotional problems. To accomplish this goal, it is critical that counselors and developing counselors prepare in understanding trauma and the impact of trauma on the counseling process. It is imperative that supervisors assist counselors in recognizing their professional impairment, such as vicarious trauma, and intervening in order to prevent harm to clients and themselves. Moreover, counselor educators and supervisors must have education on how to recognize indirect trauma and use effective supervision techniques to mitigate the effects of vicarious trauma on counselors. An essential part of this process is understanding the experience of vicarious trauma.

Vicarious Trauma

When a counselor works therapeutically with clients who have experienced trauma, the counselor themselves then becomes exposed to the graphic details of trauma (Trippany, Kress & Wilcoxon, 2004). Symptoms of vicarious trauma can be similar to those of Post Traumatic Stress Disorder. The main difference being counselors experience the traumatic event indirectly rather than directly by listening to the client discuss the traumatic event. Pearlman and Saakvitne (1995) have defined vicarious trauma as “the transformation of the helper’s inner experience as a result of empathic engagement with survivor clients and their trauma material.” This transformation can result in a change in the worldview of the counselor, leading to a more negative outlook on life and those around them (Pearlman & Sakkvitne, 1995).

Symptoms of Vicarious Trauma

Signs of vicarious trauma in counselors include four of the diagnostic criterion for Post Traumatic Stress Disorder (APA, 2013). Criterion A is the actual stressor which could be a person who was exposed to death, threatened death, serious injury or threaten sexual violence. The stressor can be experienced directly, as a witness, indirectly (learning that a close relative had exposure to trauma), or repeated indirect exposure to the details of the traumatic event usually in the course of professional work. In the case of this study, it would be indirect exposure to details of the trauma while in the professional role of a counselor (APA, 2013). Criterion B is intrusion symptoms/re-experiencing symptoms. Symptoms include traumatic nightmares, flashbacks, recurrent intrusive memories, elongated stress after exposure to a traumatic reminder, and physiological reactivity after the exposure to trauma-related stimuli (APA, 2013). For example, counselors may have nightmares or flashbacks after hearing prolonged details of a client's trauma. After repeated exposure to details of traumatic events, counselors may have nightmares or unwanted thoughts about the trauma enter their mind throughout the day (Lonn & Hyyiasos, 2016). The nightmares may be related to the traumatic material of a client or unrelated. Criterion C is avoidance symptoms. This includes avoiding trauma-related stimuli that causes trauma related thoughts or feelings, or avoiding external reminders such as people, places or activities that a remind one of the trauma (APA, 2013). For example, a counselor may avoid driving past an area where the client's trauma occurred. Criterion D is negative alterations in cognitions and mood. This includes negative changes in thinking and mood that started after the traumatic event. Examples include the inability to remember essential parts of the traumatic event, persistent negative beliefs about self or the world, distorted blame of self or others for making the traumatic event happen, negative emotions (fear, anger, shame), loss of interest in activities once enjoyed, feeling detached from others, and inability to experience positive

emotions (APA, 2013). For a counselor, this may mean the counselor stops trusting others they once trusted or may begin isolating themselves from family and friends. What was thought about the world at one time may no longer be true for the counselor.

Exposure to trauma can change a counselor's view of the world and others around them. People may not be as "good" or "innocent" as was once thought to lead the counselor to distrust others and fear the possibilities of harm occurring to themselves or loved ones. A sign of this change is the presence increased arousal. The Diagnostic and Statistical Manual of Mental Disorders (2013) defined increased arousal as hypervigilance or a startled response. This may result in counselors becoming hypervigilant about their safety and that of their family. Knowing the details of negative experiences changes a counselor's feeling of being safe in the world. Counselors may now feel more exposed and vulnerable. Increased arousal may manifest itself in feelings of depression, shame, anxiety or feeling incompetent (Adams & Riggs 2008).

Paralleling this experience, Helm (2016) discusses that vicarious trauma can affect the emotion, cognition, physical and behavioral aspects of a counselor's life. The emotional symptoms may include feeling anxious, depressed and numb to their own emotion and the emotion of others. Cognitively, a counselor may have cognitive distortions about the ability to trust others in the world. Schemas disrupt when the counselor empathizes with the client's trauma (Baird and Jenkins, 2003). Carolyn Knight (2013) worked with child abuse victims for over twenty-five years. Her experience led her to identify three cognitive distortions counselors are susceptible to when listening to trauma. These distortions include thinking that anyone is able to do anything and cannot be trusted, the world is not safe, and one must always be on guard, and if you let your guard down then you will be hurt.

Furthermore, physically, a counselor may feel tired, exhausted or have a lack of motivation (Helm, 2016). Counselors may develop sleeping problems due to difficulty in falling asleep or staying asleep, and as a result feel wearied (ACA, 2017). Behaviorally, a counselor may perhaps start to withdraw from loved ones, cry more often, or have less patience and more anger (Helm, 2016). The work behavior of the counselor may be affected as well, resulting in being tardy, increased absences, and making irresponsible decisions (ACA, 2017).

Etherington (2000) also describes the effects vicarious trauma as being disruptive to a counselor's self-esteem and self-identity. The counselor feels more vulnerable and fearful and as a result trusts others less. Counselors may also change their view about their role in life and the way they practice as a counselor (Canfield, 2008). Attitudes about the future may be more negative and their beliefs about the world are now counter to what they once were.

This element, the significant shift in worldview is imperative for understanding what vicarious trauma is, for example McCann and Pearlman (1990) distinguish vicarious trauma from burnout saying vicarious trauma is more severe, encompassing a broader impact on the counselor. In vicarious trauma the process of the counselor sharing in the traumatic experience is more involved and may result in more significant emotional labor. The emotional labor is so excessive it creates distress in the daily functioning of the person experiencing the vicarious trauma (McCann and Pearlman, 1990). Distress in daily functioning may involve increased irritation with loved ones, over-eating or under eating, no longer experiencing happiness in once-loved activities and feeling hopeless about life in general (ACA, 2017).

Vicarious trauma not only effects the person individually but the organization as well. The work performance of counselors is often negatively changed as a result. Increased conflict with staff, perfectionism, low motivation, poor communication, an increase in errors, being

numb to clients and feeling hopeless about work are among the negative occupational effects of vicarious trauma (Stefura & Shatto, 2015). Furthermore, organizations may suffer from low morale in the attitude of their employees and high turnover due to the effects of vicarious trauma (Bell, Kulkarni & Dalton, 2003). Knight (2013) indicated that vicarious trauma could be spread from one person to another in an organization, almost like a contagious disease, creating an atmosphere that is toxic and difficult for any employee to work successfully.

It is clear; vicarious trauma has a negative impact on the counselor, the clients of the counselor, and the organization where the counselor is employed. Adverse effects may be life altering, including an alteration in the view one has of themselves, others and the world around them. These outcomes may impact the counseling process, the well-being of the counselor, and even lead to the counselor leaving the profession due to the overwhelming and isolating aspects of vicarious trauma (Bell, Kulkarni & Dalton, 2003).

At Risk Populations for Vicarious Trauma

A key element in understanding vicarious trauma is awareness of what factors may contribute to the development of vicarious trauma in counselors. It is important to stress that vicarious trauma may affect each counselor differently and can depend on factors such as training, supervision, personality and organizational support (Adams & Riggs, 2008). Research has found that working in the human service field is the largest risk factor for developing vicarious trauma because of the emotional demands of human service workers (Maslach, Schaufeli & Leiter, 2001; Maslach & Leiter, 1997). Counselors are among the many occupations within the human service field and are therefore in danger of being exposed to vicarious trauma (Maslach, Schaufeli & Leiter, 2001; Maslach & Leiter, 1997).

More specific risk factors for vicarious trauma exist for counselors. One such factor is a high caseload of primarily severe trauma cases (Meichenbaum, 2007). Undoubtedly counselors are at risk for symptoms of vicarious trauma when they hear the detailed experiences of graphic traumatic events day in and day out. This material can cause substantial distress and alter the viewpoint of the counselor. Material heard during counseling can include graphic details of sexual abuse, rape and torture, descriptions of intentional acts of cruelty, and clients reenacting their traumatic events in therapy (Meichenbaum, 2007). This material can lead to disrupted beliefs about self and others (Gerding, 2012). Furthermore, a recent study conducted by Sartor (2016) indicated higher scores of vicarious trauma in counselors who had a higher percentage of trauma clients. Trippany, Wilcoxon and Satcher (2003) found that managing the caseload of counselors by limiting the number of trauma clients per week may lessen the effects of vicarious trauma on counselors working with traumatized clients. If the workload is not reduced the counselor may begin to depersonalize the clients on their caseload, which can result in lower quality of services due to the counselor's inability to empathize with the client (Tehrani, 2011). High trauma caseloads are likely to occur at veteran's hospitals, domestic violence shelters, and child advocacy centers.

A second risk factor for developing vicarious trauma is having an unresolved personal history of trauma. Often people chose to enter into the healing profession or human service profession due to their past experiencing with trauma. These experiences can prove to be a source of strength however, it can also make the person more vulnerable to common trauma symptoms (Baird & Kracen, 2006). Personal history of trauma that is unresolved can cause issues of shame, guilt, anxiety and anger (Meichenbaum, 2007). A study by Cunningham (2003) found counselors who had a personal history of trauma are more likely to experience

vicarious trauma if their trauma is unresolved. If these issues remain unresolved, then the counselor is at risk for causing harm to their client due to their inability to cope with their own trauma.

A third risk factor for developing vicarious trauma is counselors who have a lack of experience in the counseling field. Counselors who are a novice to the field pose a higher risk to developing vicarious trauma (Meichenbaum, 2007). Inexperienced counselors do not develop effective coping strategies and do not have time to process the traumatic stories of their clients (Bell et al., 2003). Due to novice counselors lack of experience, they tend to experience vicarious trauma symptoms at a higher strength. Identification of specific coping strategies is especially necessary for younger counselors who are new to the field of counseling.

Based on these variables it is not surprising that counselors most at risk for vicarious trauma are those who work with sexual assault victims (Cunningham, 2003). Counselors who treat sexual assault survivors are likely to exhibit more trauma symptoms than other counselors who work with different trauma clients. Directly witnessing the effects of violence on children and families can be emotionally tolling, leading to adverse reactions from the counselor. A counselor, as quoted from Bell, Kulkarni and Dalton (1998), reflected on her experience with counseling a sexually abused client saying,

“Sometimes after a session, I will be traumatized...I will feel overwhelmed, and I can remember a particular situation with a sexually abused person where I-I just didn’t want to hear any more of her stories about what actually happened. She seemed to want to continue to tell me those over and over and I remember just feeling almost contaminated, like you know, like I was abused...” (p. 464).

A study conducted by Schauben and Frazier (1998) found that counselors who had a higher caseload of sexual violence survivors reported more symptoms of PTSD and more disruptions in their beliefs about themselves and the world, than did counselors who had fewer sexual assault survivors on their caseloads. More recently Sartor (2016) found a significant statistical negative correlation between the level of vicarious trauma in the counselor and self-efficacy. Higher caseloads of trauma correlated with lower levels of self-efficacy.

Furthermore, research indicates counselors who work with sexual assault survivors experience a change in their relationships with family and friends (Morrison, 2007). Counselors may transfer negative feelings to family members, creating a stressful and unstable home environment. Counselors may begin to feel disconnected with friends and others within the community because they feel unappreciated and misunderstood. Consequently, counselors isolate themselves from relationships they once enjoyed (Morrison, 2007).

Moreover, counselors of sexual assault victims may experience negative stereotypes about the work they do, causing counselors to feel frustrated, hurt and isolated from others due to a lack of understanding (Morrison, 2007). Feelings of frustration intensify when dealing with difficulty in finding funding for non-profit organizations that support victims of abuse. Negative responses about sexual assault from the media can cause further stress to the counselor (Morrison, 2007). Additional stressors such as these intensify the symptoms of vicarious trauma, leaving the counselor with less energy to cope with their trauma.

Counselors are at an increased risk for experiencing vicarious trauma due to the nature of the counseling relationship and process. Those counselors who have high trauma caseloads, elevated caseloads of sexual assault survivors, have a personal history of trauma or are fresh to

the counseling field are the most in peril for the damaging effects of vicarious trauma. It is these groups of counselors for which most attention must be given when preventing vicarious trauma.

Vicarious Trauma and the Supervisory Process

Supervision of counselors is essential for counselors in training and practicing counselors. Supervision is first introduced as an important component when students are training to be a counselor. CACREP (2016) requires students who are participating in practicum or internship to engage in weekly supervision that averages one hour, as well as participate in group supervision on a weekly basis. CACREP (2016) views supervision as a valuable way to monitor the work of the supervisee, protect the clients of the supervisee, and continue to contribute to professional development of the supervisee by providing education and guidance. The American Counseling Association Code of Ethics (2014) speaks to the importance of supervision and how it is an opportunity to establish a “meaningful and respectful professional relationship.” Continued supervision can attend to the needs of a counselor while also protecting the welfare of the counselor’s clients.

More specifically, the American Counseling Association (2014) speaks to the role of supervisors in Standard F.2.a in that supervisors must be appropriately trained to supervise counselors. This being the case, supervisors should be educated about specific issues such as vicarious trauma so to advise better counselors on how to prevent vicarious trauma from occurring their own lives. If supervisors are not well prepared, then their supervisee/counselor is at risk of harming a client, which in turn violates ACA ethical standard F.1.a., client welfare. ACA states that supervisors are responsible for supervising the welfare of counselor’s clients.

In this role, supervisors may recognize signs and symptoms of vicarious trauma in supervisees when they can meet weekly with their supervisee. Changes in the work behavior of

the counselor, unwanted thoughts about client trauma, feeling overwhelmed, withdrawal in personal relationships and withdrawal in the supervisory relationship are all changes a supervisor should be attending to in supervision (Etherington, 2000). Attending to these changes can provide an opportunity in supervision to educate supervisees about vicarious trauma and explore the possible symptoms the supervisee is experiencing (Etherington, 2000). Supervision can thus be utilized as a proactive way to educate supervisees on recognizing the signs of vicarious trauma and how to utilize appropriate coping strategies.

Illustrating this dynamic, Baker (2012) conducted a qualitative study on vicarious trauma and found additional education on vicarious trauma to be a theme response from participants in the study. Specifically, participants identified the need for counselors to have educational training on trauma therapy and vicarious trauma. Participants also stated that counselors need awareness that vicarious trauma is a possibility and a normal reaction to conducting therapy with traumatized clients. Many participants also suggested that education and training on vicarious trauma should be mandatory rather than a choice for counselors. These responses indicate as Baker (2012) asserted, supervision is an appropriate avenue for providing education about vicarious trauma and normalizing the effects for counselors.

Related to these recommendations, Sommer and Cox (2005) suggested that when providing supervision for trauma counselors, supervision should be collaborative, and time should be spent on the particular needs of the supervisee. The supervision process needs to include providing time for discussing the direct effects of the client trauma on the counselor, the counselor's personal feelings about the client trauma, and addressing direct vicarious trauma symptoms in the counselor. Supervision is focused on the counselor's direct needs, rather than the client needs.

Additionally, it has been suggested that supervision should create an environment that is respectful, safe, allowing the counselor to feel in control (Sommer 2008; Rosenbloom et al., 1999). Creating such an environment will encourage the counselor to discuss the sensitive issues that are happening as a result of the vicarious trauma. If a counselor feels they are being evaluated or judged, then they are not likely to be vulnerable about their struggles; therefore, creating a protected environment is crucial (Sommer 2008; Rosenbloom et al., 1999).

This highlights the critical need to provide a supervisory process that is supportive and not judgmental. Research has shown counselors are apprehensive of disclosing critical negative events in supervision due to fear of being judged or evaluated (Knight, 2013). Normalizing the vicarious traumatization for the counselor rather than criticizing is essential in helping the counselor to feel safe and at ease. A qualitative study conducted by Sommer and Cox (2005) indicated counselors appreciate supervisors recognizing vicarious trauma and confirming that what they are feeling is normal. Validating the counselor's stress and offering support is invaluable for counselors.

Supervision most often focuses on the practical skills and knowledge of the counselor; for that reason, counselors are unlikely to disclose negative feelings about their experiences with clients (Knight, 2013). Counselors may believe the focus of supervision should be their clients rather than themselves. Supervisors should make a special effort to ask counselors about their experiences and affect regarding their clients, giving the counselor permission to discuss the topic during supervision. Doing so communicates a safe atmosphere and an attitude of care and concern, making it easier for the counselor to discuss negative feelings if necessary (Knight, 2013).

In summary, supervision is an essential component for counselors who are providing services to trauma populations. Both ACA (2014) and CACREP (2016) have established the necessity and purpose of supervision for counselors. Supervision can serve as a safe and supportive environment for counselors to process their thoughts and experiences with trauma, as well as an appropriate setting to provide education on vicarious trauma. Using supervision in this manner can alleviate the effects of vicarious trauma and protect clients from potential harm.

Supervisory Alliance and Vicarious Trauma

Research has indicated the supervisory alliance between a supervisor and a counselor plays a pivotal role in the effectiveness of the counselor (Efstation, Patton, & Kardash, 1990; Ellis & Ladany, 1997; Goodyear & Bernard, 1998; Ladany, Ellis & Friedlander, 1999). A positive relationship between the supervisor and the counselor can contribute to respect and trust in the supervisory relationship (Ladany & Friedlander, 1995). Strong supervisory alliances encourage counselors to discuss and reflect on important issues like the vicarious trauma that can arise with the counselor while treating clients. Weak supervisory alliances have contributed to ethical concerns due to the counselor not feeling comfortable or safe enough to discuss professional issues (Padaman, Shafranske, & Falender, 2015).

Furthermore, trauma -ensitive supervision addresses the need for a strong supervisory alliance between the supervisor and counselor. One of the four components to trauma sensitive supervision is a mutually respectful supervisory relationship, which forms a safe environment for counselors to explore their feelings and responses to trauma in their clients (Lonn & Haiyasoso, 2016). The effects of vicarious trauma lessen with a supportive environment where counselors are validated and their feelings are normalized by their supervisor (Knight, 2013).

Conversely, when the supervisor does not attend to vicarious trauma with the supervisor, it results in a weak supervisory relationship, leaving the counselor feeling the supervision was not helpful. A qualitative study conducted by Sommer and Cox (2008) shared stories from counselors whose supervisors did not recognize vicarious trauma. The lack of attention during supervision to the issue of vicarious trauma left counselors feeling guarded and less likely to be vulnerable. One participant stated, “supervision isn’t the way to go there, (pg. 127)” referring to the discussion of vicarious trauma. Lack of support from the supervisor can intensify the effects of vicarious trauma (Knight, 2013) resulting in ineffective supervision.

In conclusion, a positive and healthy supervisory alliance can lessen the effects of vicarious trauma, leaving the counselor to feel the supervision was useful and beneficial. An unhealthy supervisory alliance that does not attend to counselor issues such as vicarious trauma, can cause the counselor to be guarded and view the supervision process as ineffective.

Supervision Interventions to Address Vicarious Trauma

Research has established supervision to be an active process to prevent or lessen the effects of vicarious trauma (Abassary & Goodrich, 2014; Bell, Kulkarni & Dalton, 2003; Etherington, 2000; Knight, 2013; Lonn & Haiyasoso, 2016; Sommer 2008). However, research is lacking in addressing specific interventions to use during the supervisory process. Particular supervision interventions including self care, psychoeducation and cognitive restructuring, will be discussed in greater detail in the following paragraphs.

Self Care

Taking time to care for oneself is essential when preventing vicarious trauma. Professional self care is defined as skills and strategies used by a counselor that attend to their personal, emotional and spiritual needs. Participating in self care helps the counselor to balance

between the demands of their own life and that of their client (Newell & MacNeil, 2010).

Engaging in self care has been found to reduce stress, subsequently, reducing vicarious trauma symptoms (Gerding, 2012). Vicarious trauma can be prevented if supervisors teach supervisees to engage in self care early in their education and career as a professional counselor.

The Council for Accreditation of Counseling and Related Educational Programs (2016) recognizes the importance of self care in students training to be counselors. In Section 2, Professional Counseling Identity, Standard F.I.I. states counselor educators should include “self care strategies appropriate to the counselor role” in curriculum planning. Being that CACREP includes self care in its standards, it is evident that engaging in self care is an essential factor in counselor education and development.

Supervisors are encouraged to promote self-care in counselors to mitigate the effects of vicarious trauma. Supervisors should communicate the value in self-care and its ability to help counselors shift their focus from what they cannot control, such as trauma in clients, to what they can control, such as helping the self (Carello & Butler, 2015). Additionally, the National Child Traumatic Stress Network suggests supervisors encourage participation in self care groups and a self care accountability system (2017, October 8) retrieved from <http://www.nctsn.org/resources/topics/secondary-traumatic-stress>. Counselors trust the guidance of their supervisors; therefore, counselors generally respect what supervisors recommend to them. If a supervisor believes self care to be a valuable tool, then the counselor is likely to engage in the practice.

Literature has drawn attention to five areas of self care including spiritual, physical, emotional, professional, and psychological (Osofsky, 2011). Spiritual self care involves finding meaning in life. This may include attending religious services, meditation or praying. Physical

self care are activities that encourage physical health in a person, such as exercise, proper sleep and eating a healthy diet. Emotional self care includes taking care of the emotional self. Actions may include spending time with family and friends, encouraging oneself and engaging in enjoyable activities. Professional self care should help professional health. Activities for professional health involve attending relevant trainings, seeking supervision when necessary and setting appropriate boundaries with clients. Psychological self care protects one's ability to make healthy decisions and to remain self aware. Engaging in journaling, therapy and reading are all examples of mental self care (Bloomquist, Wood, Friedmeyer-Trainor & Kim, 2015).

Additional self care strategies may include making changes to one's lifestyle, such as eating differently, incorporating exercise, taking time for self, and finding a balance between work and home life. Adopting appropriate self care strategies is paramount when working with clients who have experienced trauma (Coles, Dartnall & Astbury, 2013). Responses from counselors who participated in a qualitative study by Sommer and Cox (2005) indicated self care on a regular, weekly basis is helpful in lessening the effects of vicarious trauma.

A qualitative study conducted by Killian (2008) included the responses of therapists who practiced self care while working with traumatized clients. When asked to define self care, one participant described self care as proactive practices she engages in to prevent burnout or physical problems. An additional participant defined self care as leaving her thoughts about clients at work and taking time at the conclusion of the day to process what occurred with clients. Participants consistently identified self care to be time spent on self and necessary to engage in when preventing the adverse effects of working with traumatized clients.

Furthermore, the participants identified specific self care practices for which counselors can employ. Self care practices included process time during supervision, spending quality time

with friends and family, engaging in exercise, and having a spiritual connection. One participant spoke to the importance of process time with a supervisor saying,

“Having a supervisor, having people to talk to on the team. I try to do that with the debriefing here because the only people who know what is going on with me are the people that work with me” (Killian, 2008).

Michenbauum (2007) recommended several self care behaviors for counselors. Behaviors included engaging in relaxation exercises in between clients and after leaving work. Physical activities in self care for counselors such as adequate sleep and exercise. Mental health activities in self care for counselors may involve taking vacations or attending personal counseling when needed. Counselors should have an outlet for their emotional release outside of work such as exercise, writing or hobbies. Finally, counselors are encouraged to incorporate activities that renew meaning in their lives in and outside of counseling.

Research and professional educational standards clearly state self care is essential for counselors to incorporate into their lives and practice as a counselor. Engaging in various self care practices can prevent the adverse personal and professional effects of vicarious trauma. Doing so protects the well-being of the counselor and the welfare of clients.

Cognitive Behavioral Techniques

As stated previously, symptoms of vicarious trauma are similar to that of Post Traumatic Stress Disorder, including increased arousal, re-experiencing symptoms, avoidance and negative thinking. The difference between vicarious trauma and PTSD is merely direct exposure versus indirect exposure. In treating PTSD, research has shown cognitive behavioral techniques to be effective in preventing the symptoms of PTSD from occurring or from being as intense (Kearns, et., al, 2012). CBT techniques include cognitive restructuring and anxiety management

techniques (Kearns, et., al, 2012). Many interventions for vicarious trauma include cognitive behavioral techniques such as cognitive restructuring (Murphy, 1996).

Cognitive restructuring is a core aspect of Cognitive Behavioral Therapy (CBT). Cognitive restructuring is taught during the therapeutic process, educating clients to recognize their negative or irrational thought patterns and then replacing with more positive thought patterns. Practicing this process and making it a part of a client's lifestyle will decrease feelings of anxiety and depression (Beck, 2011). The same method can be applied to the supervision of counselors. In supervision, supervisors can first educate the counselor about cognitive restructuring and provide practice exercises. Once the counselor has acquired the skill, the supervisor should advise the counselor to monitor their self talk, taking note of negative thought patterns (Meichenbaum, 2007). When the negative thought patterns have been identified, the counselor can then begin to re-structure those distorted thoughts into more positive realistic thoughts.

Moreover, cognitive restructuring results in decreasing the anxiety of the person and providing them with self-confidence rather than self-doubt. By identifying the automatic thoughts and irrational beliefs about situations, clients can realize their worst fears are not unescapable; rather they can check their thoughts for truth and then restructure the thoughts to more rational thinking (Shubina, 2014). As stated previously, research indicates counselors who work with trauma victims experience distorted thinking, which contributes to feelings of anxiety. Educating counselors about cognitive restructuring can decrease the negative automatic thoughts while also reducing the level of anxiety.

A study conducted by Musser et. al (2015) found cognitive restructuring to have a significant impact on reducing symptoms of PTSD. Participants in the study were provided 9-13

sessions focused on cognitive restructuring. Clients were educated on how to modify incorrect thoughts and then to develop a way to address the thought that was distressing to them.

Following the full treatment, clients not only experienced a decrease in symptoms of PTSD but also an increase in overall functioning.

A similar pilot study that supported these findings was conducted by Muller-Engelmann & Steil (2017). The study assessed the effectiveness of cognitive restructuring techniques on the treatment of PTSD and found substantial reductions in trauma related negative thoughts about self and depression symptoms. The study suggested an effective treatment approach for PTSD symptoms for counselors to address the negative cognitions of the client and then assist in modifying those thoughts by using cognitive restructuring and imagery (Muller-Engelmann & Steil, 2017).

Meichenbaum (2007) suggested counselors should use their cognitive abilities when coping with vicarious trauma. The skills he refers to are similar to those of cognitive restructuring. He states that counselors should use self talk and tell themselves they are not alone in their struggle with vicarious trauma. Thoughts can be restructured to enhance feelings of accomplishment rather than wishing one could do more. Additionally, counselors should challenge their negative thinking and replace with hopeful thinking that focuses on the resilience of clients who engage in counseling.

These findings can be applied to counselors who are experiencing PTSD symptoms due to vicarious trauma. Supervisors can provide education on cognitive restructuring and practice ways for the counselor to modify their inaccurate thought patterns. For example, the counselor may have the irrational thought “the whole world is evil.” The supervisor can assist the counselor in recognizing this thought and applying cognitive restructuring to change the negative thought

to more positive and rational. Doing so decreases the anxiety of the counselor due to the irrational thinking.

Psychoeducation

Psychoeducation has emerged as one of the most effective evidenced based therapeutic interventions. It is a highly useful intervention because of its applicability to different diagnoses and challenges (Lukens & McFarlane, 2004). Psychoeducation is a form of treatment used by counselors that integrates educational and psychotherapeutic interventions while emphasizing strength and empowerment in the person (Lukens & McFarlane, 2004). The principle behind psychoeducation is the more knowledgeable the person is the more positive outcomes in overall health of the person (Lukens & McFarlane, 2004).

Research has demonstrated that psychoeducation and training on trauma is imperative for counselors working with clients who have experienced trauma. Specifically, psychoeducation can provide counselors with information on coping skills and assist in decreasing the symptoms of post traumatic stress disorder (Trippany, Kress & Wilcoxon, 2004). Education should include effects of vicarious trauma, countertransference and a relational perspective on vicarious trauma (Meyer & Ponton, 2006).

Furthermore, research suggests counselors should engage in educational workshops on vicarious trauma, early warning signs and ways to prevent the trauma in themselves (Coles, Dartnall & Astbury, 2013). Through psychoeducation, counselors can develop an awareness of their own risk factors and be able to recognize when those factors play a role in the development of vicarious trauma (Coles, Dartnall & Astbury, 2013). Research has indicated that inadequate training and education on trauma therapy increases the risk for vicarious trauma (Meyer &

Ponton, 2006). Those counselors who have received formal psychoeducation about vicarious trauma display fewer symptoms associated with vicarious trauma (Meyer & Ponton, 2006).

In addition to psychoeducation on signs and symptoms of vicarious trauma, it has been suggested supervisors incorporate preventative checks for vicarious trauma during individual supervision, so to raise awareness in the counselor of possible signs and symptoms (Sansbury, Graves & Scott, 2015). During these checks supervisors can provide counselors with resources on vicarious trauma, assisting the counselor to be more trauma-informed. Supervisors who endorse trauma-informed supervision embrace the concepts of safety, empowerment, trust, collaboration and choice (Sansbury, Graves & Scott, 2015). Including these concepts increases the chance counselors will listen to the education and apply it to their personal lives (Sansbury, Graves & Scott, 2015).

Statement of the Problem

Counselors are engaged in a profession for which they are expected to absorb the trauma of clients and the emotion associated with traumatic events. In training to be a counselor, counselors are taught to be empathetic, placing themselves in the client's position to better understand the feelings and thoughts of clients. In doing so, counselors are made an integral part of the healing process for clients, subsequently exposing themselves to vivid details of the client's stories (Helm, 2016).

Consequently, hearing extreme details of human distress can cause trauma to counselors, resulting in what is called vicarious trauma. Vicarious trauma typically occurs when counselors are providing therapy to a client who experienced a traumatic event (Lonn & Haiyasoso, 2016). Actively listening to the continuous trauma of clients, alters the worldview of the counselor and their beliefs about themselves and others is negatively changed. Symptoms of vicarious trauma

may include invasive thoughts, distortions in thinking, increased arousal and hypervigilance displayed in various life contexts (Lonn & Haiyasoso, 2016).

Due to the diverse number of traumatic events, the probability of counselors encountering trauma-related material is quite significant, placing counselors at a higher risk for experiencing vicarious trauma (Sommer, 2008). The problem arises when the counselor is more focused on the trauma of the client and not focused on the symptoms of trauma in themselves. The lack of knowledge and training on vicarious trauma can potentially result in an impaired counselor who can no longer efficiently treat the trauma of the client due to their own distress. Possible harm to the client receiving counseling may occur if the counselor is no longer capable of providing effective counseling.

Regrettably, counselors may not be educated or prepared sufficiently to cope themselves with the repercussions of treating trauma in clients (Baker, 2012). There is a wealth of material on vicarious trauma and the effects on counselors. Research has established that providing trauma therapy to clients can result in adverse consequences, including symptoms of PostTraumatic Stress Disorder (Baker, 2012), however little study has been conducted on how to prevent vicarious trauma from occurring by utilizing specific supervision techniques.

It is crucial counselors learn about trauma and trauma related ramifications, such as vicarious trauma. Supervision is an appropriate setting to address vicarious trauma; however, research lacks in specifying which supervision techniques are most effective in preventing vicarious trauma. A qualitative study conducted by Sommer and Cox (2008) indicated a number of participants found supervision to be essential, yet nothing was noted on which supervision techniques were most beneficial. Additionally, Lonn and Haiyasoso (2016) reiterate that counselors have great potential to experience vicarious trauma and clinical supervision is an

essential aspect of counteracting vicarious trauma. Unfortunately, nothing specific was discussed about supervision techniques used to prevent vicarious trauma.

Furthermore, Knight (2013) stressed supervision as an essential part of lessening the impact of vicarious trauma by providing general suggestions for supervisors. These suggestions included encouraging the discussion of vicarious trauma, focusing on the affective reactions of counselors and maintaining appropriate boundaries. Again, specific techniques were not provided for supervisors to utilize in supervision to mitigate vicarious trauma.

Additionally, Sommer (2008) reiterated the lack of research on specific supervision methods stating that supervision is strongly encouraged to address vicarious trauma; however, the supervision is not always described in detail, leaving supervisors at a loss for how to precisely address vicarious trauma. A study conducted by Pearlman and Saakvine (1995) concluded that inadequate supervision contributed to symptoms of vicarious trauma but did not elaborate on the process of supervision. Again, we realize supervision is vital for preventing vicarious trauma but are not given the particulars of providing supervision to practicing counselors.

The National Child Traumatic Stress Network (2017) also recognized the importance of supervision for those who are working directly with trauma victims. The NCTSN stated counselors should receive consistent supervision that provides them with the skills necessary to work with trauma, while also discussing the effects trauma work can have on counselors. Coles, Dartnall and Astbury (2013) stated that adequate supervision should be provided to counselors, which includes a discussion of vicarious trauma and its adverse effects. Once again, the authors did not elaborate on which supervision techniques should be used during supervision to prevent vicarious trauma.

Significance of the Study

Negative consequences occur if counselors are impaired from experiencing vicarious trauma as a result of listening to frequent traumatic stories. A compromised counselor risks harming their client and the profession of counseling. Therefore, it is essential counselor educators and supervisors begin to identify measures that will prevent the occurrence of vicarious trauma or lessen its effects in future and practicing counselors. If counselor educators and supervisors do not act to educate counselors about vicarious trauma, then they are contributing to the problem of vicarious trauma in practicing counselors.

While research has demonstrated that vicarious trauma occurs in counselors and that it can have a significantly negative effect on the counseling process and the counselor, there is a paucity of research on the specific supervisory methods that may mediate or prevent the occurrence of vicarious trauma. There have been several methods suggested (Abassary & Goodrich, 2014; Bell, Kulkarni & Dalton, 2003; Etherington, 2000; Knight, 2013; Lonn & Haiyasoso, 2016; Sommer 2008); however, we have limited research to support the use of and the successful outcomes of this research. This study will provide information on techniques in supervision that are associated with preventing or lessening the effects of vicarious trauma in practicing counselors. Research gained from this study can be used by counselor educators and supervisors to educate students in counseling and practicing counselors, on how to prevent vicarious trauma and maintain longevity in the profession of counseling. Appropriate supervision techniques used to address vicarious trauma will protect counselors and their clients from possible harm.

Purpose of the Study

The purpose of this quantitative survey research study was to examine the relationship between supervision techniques utilized in counseling supervision and the prevention of vicarious trauma in practicing counselors. Specifically, the study was conducted to assess which supervision techniques correlated with low levels of vicarious trauma. The independent variables included supervision techniques, while the dependent variables were symptoms of vicarious trauma (re-experiencing, avoidance, intrusive thoughts and increased arousal).

Supervision strategies evaluated included providing psychoeducation on vicarious trauma, the implementation of self care, and cognitive restructuring which can be used to alter the thought process contributing to vicarious trauma. For the purposes of the study, the operational definition for vicarious trauma developed by Pearlman and Saakvitne (1995) was used. Vicarious trauma is when a counselor is changed due to empathically engaging with clients who have suffered from traumatic experiences. This transformation can result in a change in the worldview of the helper (Pearlman & Saakvitne, 1995). Vicarious trauma can be experienced in a variety of counseling settings including independent practice, community mental health agencies, group homes, domestic violence shelters and prison systems.

Research Questions

Research has established supervision is an appropriate avenue for preventing and attending to vicarious trauma in practicing counselors; however, there is a lack of research explicitly examining these three individual supervision techniques in relation to levels of vicarious trauma. This study aimed to expand the research on vicarious trauma to include specific supervision practices that can prevent or lessen the effects of vicarious trauma in practicing counselors. The specific research questions were:

1. Did supervision have an impact on levels of vicarious trauma?

2. Which supervision technique (self care, psychoeducation, and cognitive restructuring) was most correlated with low levels of vicarious trauma? This research hypothesized low levels of vicarious trauma would be positively correlated with the supervision practices of self care, psychoeducation and cognitive re-structuring.
3. Did supervisory alliance between supervisor and counselor relate to levels of vicarious trauma?

Summary

Regrettably, counselors are not educated or prepared sufficiently to cope themselves with the repercussions of treating trauma in clients. Much material exists on the topic of vicarious trauma; however, little research has been conducted on how to prevent vicarious trauma from occurring by utilizing specific supervision techniques. This chapter reviewed the literature about to vicarious trauma, risk factors for vicarious trauma, and supervision techniques useful in preventing vicarious trauma in practicing counselors. The literature outlined as implications for counselor educators and supervisors to help avert vicarious trauma in practicing counselors.

Chapter 2

Methodology

The purpose of this quantitative survey research study was to examine the relationship between supervision interventions utilized in counseling supervision and the mediation of vicarious trauma in practicing counselors. The study was conducted to assess which supervision interventions are correlated with low levels of vicarious trauma. The independent variables included supervision techniques and supervisory alliance, while the dependent variables were symptoms of vicarious trauma (re-experiencing, avoidance, intrusive thoughts and increased arousal).

Research has established supervision is an appropriate avenue for preventing and attending to vicarious trauma in practicing counselors (Abassary & Goodrich, 2014; Bell, Kulkarni & Dalton, 2003; Etherington, 2000; Knight, 2013; Lonn & Haiyasoso, 2016; Sommer 2008). However, to this researcher's knowledge, no study had examined these three individual supervision techniques with levels of vicarious trauma. This study aimed to expand the research on vicarious trauma to include specific supervision practices that can prevent or lessen the effects of vicarious trauma in practicing counselors.

Research Questions

The study presented investigated the following research questions:

1. Did supervision have an impact on levels of vicarious trauma?
2. Which supervision technique (self care, psychoeducation, and cognitive restructuring) was most correlated with low levels of vicarious trauma? This researcher hypothesized low levels of vicarious trauma would be positively correlated with the supervision practices of self care, psychoeducation and cognitive re-structuring.

3. Did supervisory alliance between supervisor and counselor relate to levels of vicarious trauma?

Participants

Participants recruited were practicing professional counselors who had participated in supervision within the last year. Participants who had not engaged in supervision within the previous year were excluded from the study. Participants were surveyed using the PTSD Check List (PLC-V) and the Vicarious Trauma Scale (VTS) to identify those who had experienced symptoms of vicarious trauma. Participants with no vicarious trauma, as determined by these measures, were excluded from the study. Those who had experienced vicarious trauma were asked if they had discussed vicarious trauma with their supervisor in the past year and then identify the specific interventions that were used in supervision. Participants who had not addressed vicarious trauma with their supervisors within the last year were directed to the end of the study.

Participants were recruited from the Alabama Counseling Association list-serve, Counselor Education and Supervision Network (CESNET) list serve, Children Advocacy Center's in the State of Alabama, and the American Mental Health Counseling Association list-serve. Participants included counselors who worked in environments identified as high risk for vicarious trauma. This included counselors working with sexual assault victims, counselors with high caseloads of intense trauma cases, and those counselors with fewer than five years' experience in the counseling field.

Procedures

A quantitative methods approach was conducted to collect data for this study. The focus of quantitative research was on gathering numerical data and then generalizing the data across

group of people. Methods of a quantitative approach are statistical or numerical and may include questionnaires, surveys and polls (Babbie, 2010 & Muijs, 2010). The goal of this quantitative study was to determine the relationship between supervision techniques and levels of vicarious trauma in practicing counselors.

To explain how supervision techniques can mitigate vicarious trauma, practicing counselors were identified within and outside the State of Alabama. The Alabama Counseling Association distributed the survey link to their over 2000 members. These members included community counselors, private practice/independent counselors, and school counselors, all with different levels of experience, all within the State of Alabama. The Alabama Network of Children's Advocacy Center's provided a listserv of email addresses from counselors who work at Child Advocacy Center's in Alabama. To reach counselors outside the State of Alabama, the Counselor Education and Supervision Network (CESNET) listserv was also included to survey participants.

An email was dispersed to counselors registered on the Alabama Counseling Association list-serve, the Counselor Education and Supervision Network, and Alabama Children Advocacy Centers. Before to taking the survey, participants were introduced to the study, and asked to read an informed consent letter about the research. The letter explained the purpose of the study, any risks involved and the benefits of participating in the study. Participants were informed that consent was provided if they choose to complete the attached surveys. All results were compiled in Qualtrics, in an aggregate manner.

The sampling procedure for this study constituted purposeful criterion sampling. Criterion sampling selects cases that meet a predetermined criterion of importance to the study.

This method was used because criterion sampling is helpful for understanding information from participants who have specific experience related to the study (Cohen & Crabtree, 2008).

Instrumentation

Brief Demographic Measure

A questionnaire was created to gather demographic information about participants and information about supervision techniques. Participants were asked demographic information including age, gender, education, and ethnicity. Additional questions inquired of practice setting, an area of specialization, the number of years they had served as a counselor, licensure, how many hours spent in direct client service, and client populations served in their primary practice setting.

Assessment of Supervision Interventions

To assess the use of supervision interventions, a measure was developed by this researcher based on methods that have been used to mediate trauma (Beck, 2011; Coles, Dartnall & Astbury, 2013; Gerding, 2012; Meichenbaum, 2007; Musser et. al, 2015; Newell & MacNeil, 2010; Trippany, Kress & Wilcoxon, 2004). The survey was constructed to include a series of questions about supervision techniques used and techniques taught by their supervisor. Operational definitions were provided in the directions of the survey to assist participants in understanding the constructs (e.g. vicarious trauma, psychoeducation, cognitive restructuring, self care, supervisory alliance). The survey was reviewed by a panel of seven experts in the counseling field who reviewed for content and ease of understanding questions, no modifications were recommended. This panel was established during a Survey Research course where doctoral students in the counseling field were assigned to review developed surveys. This resulted in a

total of 21 survey questions which inquire about the counselor's experience in each of the three supervision areas, psychoeducation, self care, and cognitive restructuring. Example questions include, "My supervisor provided sufficient information on how to use self care", "I understand educational material on vicarious trauma," and "I practice cognitive restructuring to prevent vicarious trauma in my own life." Questions can be read by participants themselves and completed in approximately five to ten minutes. Items on the scale are rated on a 5 point Likert scale, with responses reaching 1 (not at all), 2 (a little bit), 3 (moderately), 4 (quite a bit), and 5 (frequently).

Vicarious Trauma Scale (VTS)

The Vicarious Trauma Scale (VTS) was developed by Lila Petar Vrklevski and John Franklin (2008) in a study exploring vicarious trauma in the legal profession. The VTS assesses subjective levels of distress connected to working with clients who have experienced trauma. Items on the VTS are rated on a 7 point Likert scale, with responses reaching 1 (strongly disagree) to 7 (strongly agree). Example questions include "I find myself distress by listening to my clients' stories and situations," and "Sometimes I feel overwhelmed by the workload involved in my job" (Vrklevski & Franklin, 2008).

In studies where the VTS has been used, psychometric properties have been found to be strong. Studies conducted by Aparico et al., (2013), Purvis (2017), Michalopoulos and Aparicio (2012) and Vrklevski and Franklin (2008) reported internal consistency scores ranging from .77 to .88.

Post Traumatic Stress Disorder Checklist for the DSM-V (PCL-5)

The Post Traumatic Stress Checklist (PCL-5) was used to assess trauma symptoms in participants (Blevins, Weathers, Davis, Witte, & Domino, 2015). The PCL-5 contains 20 self-

report items reflecting the diagnostic criteria for PTSD from the DSM-V (APA, 2013) diagnostic criteria (criterion B, criterion C, criterion D). Participants are asked about their experiences with specific symptoms, specifically how much they have been bothered by the symptom over the past month. Response range from 1-Not at all to 5-Extremely. The scoring of the PCL-5 is broken into three PTSD criterion groups including re-experiencing symptoms, avoidance symptoms and alterations in cognition and mood. To meet the diagnostic criteria for PTSD the criteria must be moderately met in all three groups. A total score of 33 or higher on this assessment suggests that the individual may meet the criteria for the diagnosis of PTSD. Numerous studies have been conducted to demonstrate the validity and reliability of the PCL-5. One study indicated the PCL-5 to be a psychometrically sound self-report measure that can be used in a variety of clinical and research assessment tasks (Blevins & Weathers, 2015). A second study indicated satisfactory properties of the PCL-5 with Cronbach's alpha scores for internal consistency in an acceptable to good range (0.57-0.78). The results of the study also indicated convergent validity (Sveen, Bondjers & Willebrand, 2016). Additional recent studies have reported similar Cronbach alpha values, ranging from .76 to .97 (Armour et al., 2015; Frewen, Brown, Steuwe, & Lanius, 2015; Hoge, Riviere, Wilk, Herrell, & Weathers, 2014; Keane et al., 2014)

Data Analysis

Statistical analysis of the results was conducted through the Statistical Package for Social Sciences (SPSS). Regression analysis was used to measure the relationship between supervision techniques and levels of vicarious trauma. A regression analysis is a procedure used to determine which variables (supervision techniques) have an impact on levels of vicarious trauma in practicing counselors. A regression analysis was appropriate to answer the research questions regarding which supervision technique was most effective and the question regarding the

effectiveness of supervisory alliance. Two regression analyses were performed for the diagnostic criteria for vicarious trauma to assess which supervision techniques are associated with each diagnostic criteria of vicarious trauma. Using regression analysis is an efficient way of gathering data without threatening the reliability as much as other statistical measures (Suskie, 1996).

Descriptive and correlational analyses were conducted to understand the significance of the predictor variables in contributing to the dependent variable. The Pearsons Correlation Coefficient, the tolerance level, and the variance inflation factor values was assessed to make sure variables are not too closely related to one another.

Definition of Terms

Vicarious trauma-is “the transformation of the helper’s inner experience as a result of empathic engagement with survivor clients and their trauma material.” This transformation can result in a change in the worldview of the helper (Pearlman & Saakvitne, 1995). Questions used to measure vicarious trauma include, “I have repeated disturbing memories, thoughts or images of my client’s traumatic experience,” and “I have strong negative feelings such as fear, horror, anger, guilt or shame.”

Self Care-are decisions and actions an individual takes to improve his or her health (physical and mental), to prevent physical and mental health problems. Questions used to evaluate self care use include, “I practice physical self care (exercise, diet, sleep), “I practice emotional self care (spending time with friends and family, engaging in enjoyable activities),” and “my supervisor provided sufficient information on the forms of self care.”

Psychoeducation-teaching key information about vicarious trauma and its adverse effects on counselors. Questions used to measure psychoeducation use include, “I have

understanding the educational material on vicarious trauma,” and “my supervisor provided sufficient education about the negative effects of vicarious trauma.”

Cognitive Restructuring-a technique used to recognize and cope with intrusive thoughts or negative thought patterns. Questions used to measure cognitive restructuring include, “I practice cognitive restructuring to prevent vicarious trauma in my own life,” and “My supervisor provided sufficient information on ways to use cognitive techniques to prevent vicarious trauma.”

Supervision-“An intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person, monitoring the quality of professional services offered to the client, he, she or they see, and serving as a gatekeeper of those who are in the particular profession” (Bernard & Goodyear, 1998, p. 6).

Supervision strategies/interventions-supervision interventions are used by the supervisor to access the content the counselor discusses during session with clients, and to provide time to process the experience of the counselor. Interventions may include self care, psycho-education, cognitive processing, self report, role-playing and modeling (Boarders & Brown, 2005).

Chapter 3

Results

Introduction

The purpose of this quantitative study was to examine the relationship between levels of vicarious trauma and specific supervision strategies used during supervision. Additionally, this study investigated the relationship between levels of vicarious trauma and supervisory alliance between supervisor and counselor. The researcher for this study utilized a brief demographic questionnaire, the Posttraumatic Checklist (PCL5), the Vicarious Trauma Scale (VTS), a supervision strategy questionnaire, and a supervisory alliance questionnaire. The present study sought to determine the relationship between vicarious trauma symptoms and specific supervision strategies including self care, cognitive restructuring and psychoeducation. Furthermore, the relationship between vicarious trauma symptoms and supervisory alliance was examined. Linear regression was used to determine if supervision as a whole was related to lower levels of vicarious trauma (research question 1). Additional linear regression was used to determine the relationship between vicarious trauma symptoms and specific supervision strategies (research question 2). For research question 3, a linear regression was used to determine the relationship between vicarious trauma symptoms and supervisory alliance.

Demographics

As reported in Table 1, a total of 82 counselors participated in this study. Of the 82 participants, 80 participants reported their gender; 11 (13.9%) of participants indicated they identified as male and 69 (86%) of the participants indicated they identified as female. This

sample is representative of the national population with 73% of counselors are female, while 27% are male (Rocheleau, 2017). Current specialization in the counseling field was reported by 82 of the participants. Of the 82 that reported, 43 (53.7%) identified as clinical mental health counselors, 13 (16.2%) identified as school counselors, 15 (15%) identified as counselor educators, 5 identified as counselor psychologist (6.2%), 1 identified as a sports psychologist (1.2%), and 6 (7.5%) identified with other specializations.

Eighty participants reported current licensure in counseling. Of the 60 counselors, 64 (80%) reported being currently licensed, and 20 (20%) reported not being licensed in counseling. Eighty participants also reported on receiving supervision within the previous year. Of the 80 participants, 24 (30%) responded they had received supervision within the last year, and 56 (70%) are not receiving supervision within the last year.

The mean, standard deviation, and reliability statistics are reported in Table 2 for the Post Traumatic Checklist (PCL5), the Vicarious Trauma Scale (VTS), the supervisory alliance scale, and the supervision strategies scale.

Table 1

Demographic Information

Characteristic		N	Percentage
Gender	Male	11	13.9%
	Female	69	86.1%
Age	18-24	3	3.8%
	25-34	22	27.5%
	35-44	20	25.0%
	45-54	19	23.7%
	55-64	14	17.5%
	65-74	2	2.5%
	75-84	0	0.0%
85 and older	0	0.0%	

Race/Ethnicity	White	65	81.2%
	Black	6	7.5%
	Asian	4	5.0%
	Hispanic/Latino	2	2.5%
	Bi-racial/Multi-racial	1	1.2%
	Other	1	1.2%
	American Indian/Alaskan Native	1	1.2%
Area of Specialization	Clinical Mental Health	43	53.7%
	School Counseling	13	16.2%
	Counselor Education	15	15.0%
	Counseling Psychology	5	6.2%
	Sports Psychology	1	1.2%
	Other	6	7.5%
Licensed	Yes	64	80%
	No	16	20%
Populations Served	Intimate partner violence	7	9%
	Sexual Assault	7	9%
	Child Abuse	18	23%
	Crime victims	3	5%
	Natural disasters	0	0%
	Military	3	5%
	Grief/loss	18	23%
	Substance use	7	9%
	Severe mental illness	11	14%
	Other	2	3%

Table 2

Scale Reliability Statistics

Scale	N	Cronbach's Alpha	Mean	Standard Deviation
Posttraumatic Stress Scale (PCL5)	21	.932	1.42	.545
Vicarious Trauma Scale (VTS)	8	.744	4.26	.973
Supervision Technique: Self Care	8	.764	3.53	.755
Supervision Technique: Psychoeducation	7	.878	3.72	1.02
Supervision Technique: Cognitive Restructuring	3	.874	2.73	1.27
Supervisory Alliance	8	.962	1.87	.996

Research Question 1: Does supervision have an impact on levels of vicarious trauma?

Two multiple linear regressions were used to determine the relationship between supervision techniques (self care, psycho-education, and cognitive restructuring) and levels of vicarious trauma in practicing counselors. In the first regression, the Vicarious Trauma Scale (VTS) was entered as the dependent variable and each supervision technique was entered as the independent variables in a backward regression equation. An additional backward regression was used with the Posttraumatic Stress Scale (PCL5) as the dependent variable and supervision techniques as the independent variables. Results from the Pearson Correlation equation with the PCL-5 as the dependent variable, indicated a significant negative relationship between supervision techniques and levels of vicarious trauma. Results from the Pearson Correlation with VTS as a dependent variable indicated a weak negative correlation between levels of vicarious trauma relationships and supervision techniques. Correlations summaries can be viewed in Table 3.

The backward regression solution using the PCL-5 as the dependent variable indicated using all three supervision techniques (self-care, cognitive restructuring and psychoeducation) had a significant effect on levels of vicarious trauma ($p=.001$). Results from this regression denote supervision does have a significant impact on reducing the level of vicarious trauma in practicing counselors. Regression summaries can be viewed in Table 4 and Table 5.

Table 3

Correlation Summary PCL-5 and VTS vs. Supervision Techniques

	r	r	Significance
	PCL-5	VTS	
Self Care	-.532	-.206	<.001

Psycho-education	-0.164	-0.195	<.001
Cognitive Processing	-0.229	-0.127	<.001

Table 4

Regression Summary PCL-5 vs. Supervision Techniques

Scale	Full Model ^a		Restricted Model ^b	
	Beta	Semi partial	Beta	Semi partial
Self Care	-.587**	-.483	-.523***	-.523
Psycho-Education	.218	.129		
Cognitive Restructuring	-.097	-.057		

Note: *p<.05, **p<.01, ***p<.001

a-R²=.293, p=.002

b-R²=.274, p=<.001

Table 5

Regression Summary VTS vs. Supervision Techniques

Scale	Full Model ^a		Restricted Model ^b	
	Beta	Semi partial	Beta	Semi partial
Self Care	-.171	-.141	-.206	-.206
Psycho-Education	-.216	-.127		
Cognitive Restructuring	.148	.087		

Note: *p<.05, **p<.01, ***p<.001

a-R²=.059, p=.472

b-R²=.043, p=>.001

Research Question 2: Which supervision technique (self care, psycho-education, cognitive restructuring) is most correlated with low levels of vicarious trauma?

Backward linear regression was used to determine the relationship between each supervision technique and levels of vicarious trauma. One linear regression was completed using scores from the PCL-5 as the dependent variable. A second linear regression was completed using the scores from the VTS as the dependent variable. The backward linear regression with the PCL-5 as the dependent variable indicated self care to have the strongest relationship amongst the three supervision techniques. The correlation between self care and levels of vicarious trauma on the PCL was $-.532$, indicating the more self care was used the lower the level of vicarious trauma. In the backward regression model, psychoeducation and cognitive restructuring were eliminated, indicating self care had the most significant relationship with lower levels of vicarious trauma ($r = -.532, p = .010$). The backward linear regression with VTS as the dependent variable indicated a small negative correlation between self care and levels of vicarious trauma (-206), suggesting that the more self care a counselor practices, the less vicarious trauma the counselor likely experiences. Results from the VTS additionally confirm self care as the most effective supervision technique among the three evaluated. In the backward regression model, psychoeducation and cognitive restructuring were again eliminated, leaving self care; however, the significance ($.472$) was greater than $.05$. Results were trending towards self care but the results were not significant. Regression summaries can be viewed below in tables 6 and 7.

Table 6

Correlation Summary PCL-5 and VTS vs. Supervision Techniques

	r	r	Significance
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	PCL-5	VTS	
Self Care	-.532	-.206	<.001
Psycho-education	-.164	-.195	<.001
Cognitive Processing	-.229	-.127	<.001

Table 7

Regression Summary PCL-5 vs. Self Care

Scale	Full Model ^a		Restricted Model ^b	
	Beta	Semi partial	Beta	Semi partial
Self Care	-.587**	-.483	-.523***	-.523

Note: *p<.05, **p<.01, ***p<.001

a-R²=.293, p=.002

b-R²=.274, p=<.001

Table 8

Regression Summary VTS vs. Self Care

Scale	Full Model ^a		Restricted Model ^b	
	Beta	Semi partial	Beta	Semi partial
Self Care	-.171	-.141	-.206	-.206

Note: *p<.05, **p<.01, ***p<.001

a-R²=.059, p=.472

b-R²=.043, p=.538

Research Question 3: Does supervisory alliance between supervisor and counselor relate to levels of vicarious trauma?

A Pearson Correlation coefficient was computed to determine the relationship between levels of vicarious trauma and supervisory alliance between supervisor and counselor. The first correlation was completed using scores from the PCL-5 as the dependent variable. A second correlation was run using the scores from the VTS as the dependent variable. Pearson Correlation with the PCL-5 as the dependent variable indicated supervisory alliance was positively correlated with levels of vicarious trauma ($r=.485$), indicating the stronger the supervisory alliance, the higher the vicarious trauma symptoms. This correlation had a high medium effect size of .235 or 23.5%.

The Pearson Correlation with VTS as the dependent variable confirmed the results of the PCL-5 by indicating a positive relationship between supervisory alliance and levels of vicarious trauma, only the correlation had a smaller effect size of .024 or 2.4%. These results suggest the strength of the alliance between supervisor and counselor does not have a positive effect on levels of vicarious trauma.

Table 9

Correlation Summary PCL-5 and VTS vs. Supervisory Alliance

	r	r
	PCL-5	VTS
Supervisory Alliance	.485*	.156**

Note: * $p < .001$, ** $p > .001$

Summary

This study was conducted to examine the relationship between supervision techniques (self care, psychoeducation and cognitive restructuring) and levels of vicarious trauma in practicing counselors. Furthermore, this study aimed to examine the relationship between levels

of vicarious trauma and supervisory alliance in practicing counselors. To answer these questions, a Brief Demographic Questionnaire, a supervisor evaluation, supervision techniques survey, the Post-Traumatic Stress Checklist (PCL-5) and the Vicarious Trauma Scale (VTS) were used. Results from this study indicated that supervision overall does lessen symptoms of vicarious trauma. Furthermore, there was a strong correlation between self care and lower levels of vicarious trauma, suggesting that self care as a practice of supervision, had the strongest effect on levels of vicarious trauma compared to other supervision techniques such as cognitive restructuring and psychoeducation. Finally, the study found a strong supervisory alliance does not correlate with fewer symptoms of vicarious trauma in practicing counselors.

Chapter 4

Discussion

The purpose of this study was to determine if specific supervision techniques lessen the effects of vicarious trauma in practicing counselors. Additionally, this researcher aimed to establish if supervisory alliance influenced the levels of vicarious trauma in practicing counselors. Results from the Brief Demographic Questionnaire, a supervisor evaluation, a supervision techniques survey, the Posttraumatic Stress Checklist (PCL-5) and the Vicarious Trauma Scale will be discussed in this chapter.

Overview

Counselors are increasingly being exposed to the traumatic events of clients (Abassary & Goodrich, 2014). National surveys reveal over half the population has experienced one event that meets the DSM-IV criteria for Post Traumatic Stress Disorder (Yanos et al., 2013). The risk of developing PTSD appears to be even higher in those who suffer from mental health issues. Research has suggested that severely mentally ill individuals are at an increased risk for being exposed to traumatic events (Goodman et al., 2001). These numbers clearly illustrate the risk of counselors being exposed to the secondary trauma of their clients, resulting in possible vicarious trauma.

Symptoms of vicarious trauma in counselors are similar to that of Posttraumatic Stress Disorder, only the counselor is experiencing the traumatic event indirectly rather than directly. Pearlman and Saakvitne (1995) have defined vicarious trauma as “the transformation of the helper’s inner experience as a result of empathic engagement with survivor clients and their

trauma material.” Symptoms of vicarious trauma include the four diagnostic criteria of PTSD. Criterion A is the actual stressful event. Criterion B is re-experiencing symptoms, such as nightmares and flashbacks. Criterion C is avoidance symptoms, including avoiding thoughts or feelings associated with the trauma. Criterion D is negative alterations in the cognitions or moods of the individual, such as negative changes in thinking or mood changes since exposure to the traumatic event (ACA, 2017).

Exposure to traumatic events can change a counselor’s worldview, cause physical and emotional changes, disrupt a counselor’s self identity and negatively impact relationships in the counselor’s life. It is clear, vicarious trauma has a negative impact on the counselor, the clients of the counselor, ultimately contributing to the counselor leaving the profession of counseling. Therefore, it is imperative processes be implemented to mitigate the effects of vicarious trauma on practicing counselors.

One avenue for addressing vicarious trauma is that of supervision. Supervision of counselors is essential for counselors in training and practicing counselors. Supervision is first introduced as an important component when students are training to be a counselor. CACREP (2016) requires students who are participating in practicum or internship to engage in weekly supervision that averages one hour, as well as participate in group supervision on a weekly basis. CACREP (2016) views supervision as a valuable way to monitor the work of the supervisee, protect the clients of the supervisee, and continue to contribute to professional development of the supervisee by providing education and guidance. The American Counseling Association Code of Ethics (2014) speaks to the importance of supervision and how it is an opportunity to establish a “meaningful and respectful professional relationship.” Continued supervision can attend to the needs of a counselor while also protecting the welfare of the counselor’s clients.

Supervision can serve as a safe and supportive environment for counselors to process their thoughts and experiences with trauma, as well as an appropriate setting to provide education on vicarious trauma. Research has established using supervision in this manner can alleviate the effects of vicarious trauma and protect clients from potential harm (Abassary & Goodrich, 2014; Bell, Kulkarni & Dalton, 2003; Etherington, 2000; Knight, 2013; Lonn & Haiyasoso, 2016; Sommer 2008). However, research is lacking in addressing specific interventions to use during the supervisory process. Utilizing particular supervision interventions including self care, psychoeducation and cognitive restructuring may impact the levels of vicarious trauma in practicing counselors.

The current study was designed to determine if supervision has an impact on levels of vicarious trauma in practicing counselors. Furthermore, this researcher sought to determine if specific supervision strategies such as self care, psych-education and cognitive restructuring have a significant impact on levels of vicarious trauma in practicing counselors. Results from the study can be used to provide counselor educators and supervisors with essential tools to mitigate vicarious trauma in practicing counselors.

Discussion

According to PTSD United (2013), 70% of adults in the United States have experienced at least one traumatic event during their lifetime, and as many as 20% of those people proceed to develop a Post Traumatic Stress Disorder Diagnosis. Research has suggested that severely mentally ill individuals are at an increased risk for being exposed to trauma (Goodman et al., 2001). These numbers clearly illustrate the reality that counselors are likely to be working with clients who have experienced trauma and are thus at a risk of being exposed to the secondary

impact of this trauma.. It is critical to understand the dynamics that may mediate the experiences of VCT among counselors.

One of the significant findings of the current study was counselors who reported their supervisors used the strategies of self care, psychoeducation and cognitive restructuring in supervision reported lower levels of vicarious trauma symptoms. This finding is significant for counselor educators and supervisors because it indicates these three supervision strategies can contribute to lower levels of vicarious trauma in practicing counselors. These findings add to the current research on the effectiveness and necessity of supervision for counselors. Both ACA (2014) and CACREP (2016) have established the necessity and purpose of supervision for counselors. Supervision can serve as a safe and supportive environment for counselors to process their thoughts and experiences with trauma, as well as an appropriate setting to provide education on vicarious trauma.

Supervisors can recognize signs and symptoms of vicarious trauma in supervisees when they are able to meet weekly with their supervisee. Changes in the work behavior of the counselor, unwanted thoughts about client trauma, feeling overwhelmed, withdrawal in personal relationships and withdrawal in the supervisory relationship are all changes a supervisor should be attending to in supervision (Etherington, 2000). When a supervisor attends to these behaviors with techniques such as self care, psychoeducation and cognitive restructuring, then the supervisee may experience less vicarious trauma symptoms.

The second research question aimed to understand which of the three supervision techniques, self care, psychoeducation, or cognitive restructuring, was most significant in decreasing the symptoms of vicarious trauma in practicing counselors. Of the three supervision

strategies, self care, psychoeducation and cognitive restructuring, results indicated self care was most significantly related to lower levels of vicarious trauma in practicing counselors.

Findings from this present research study are consistent with current research findings on self care. Gerding (2012) found engaging in self care to reduce stress, subsequently, reducing vicarious trauma symptoms. Carello and Butler (2015) suggested supervisors should communicate the value self care holds and its ability to assist counselors in shifting their focus from what they cannot control, such as trauma in clients, to what they can control, such as taking care of themselves. Furthermore, the National Traumatic Stress Network encourages supervisors to support their supervisees being involved in self care groups to lessen the symptoms of vicarious trauma. The present study findings in combination with current research findings clearly indicate the importance of supervisors including self care in the practice of supervision to mitigate symptoms of vicarious trauma in practicing counselors.

The researcher of the current study sought to understand if a strong supervisory alliance between counselor and supervisor is related to fewer symptoms of vicarious trauma in practicing counselors. Results from this study indicated the supervisory alliance between counselor and supervisor was not related to lower levels of vicarious trauma in counselors. In fact, this study found a strong supervisory alliance being associated with higher levels of vicarious trauma in practicing counselors.

Findings from this present research study are inconsistent with existing research findings on supervisory alliance. Strong supervisory alliances encourage counselors to discuss and reflect on important issues like vicarious trauma that can arise with the counselor while treating clients. Weak supervisory alliances have contributed to ethical concerns due to the counselor not feeling comfortable or safe enough to discuss professional issues (Padaman, Shafranske, & Falender,

2015). Sommer and Cox (2008) conducted a qualitative study of counselors whose supervisors did not recognize vicarious trauma. The absence of support from the supervisor to the issue of vicarious trauma left counselors feeling guarded and less likely to be vulnerable. Lack of support from the supervisor can intensify the effects of vicarious trauma (Knight, 2013) resulting in ineffective supervision. Knight (2013) concluded the effects of vicarious trauma can be lessened with a supportive environment where counselors are validated and their feelings are normalized by their supervisor.

Implications for Counselor Educators and Supervisors

Results from this present study provide supervisors and counselor educators valuable information to utilize when promoting the health of their students and practicing counselors. Findings from this research study provide a foundation for understanding specific supervisory methods that can be used to mitigate vicarious trauma in practicing counselors. The current study established evidence that supervision is in fact effective in decreasing the symptoms of vicarious trauma in practicing counselors, supporting the need for counselors to receive specific supervision practices. Counselor educators and supervisors can develop ways of incorporating these three techniques into their supervision sessions, demonstrating the importance of these strategies to their supervisees. Furthermore, counselor educators and supervisors can model these practices in effort for supervisees to utilize these techniques on their own outside of supervision. A possible model for supervision encompassing these three techniques would be a beneficial map for supervisors and educators to use when addressing the symptoms of vicarious trauma in practicing counselors.

Furthermore, this study found self care to be the most effective of the three supervision techniques. Newell and MacNeil (2010) defined professional self care as skills and strategies

used by a counselor that attend to their personal, emotional and spiritual needs. Engaging in self care helps the counselor to balance between the demands of their own life and that of their client. Based on these findings, counselor educators and supervisors should promote and teach self care practices to practicing counselors to lessen symptoms of vicarious trauma.

The process of promoting self care in counselors begins with education. Supervisors and educators should provide counselors with a definition of self care and various examples of practices of self care. Literature has drawn attention to five areas of self care including spiritual, physical, emotional, professional, and psychological (Osofsky, 2011). Breaking each of these areas down for counselors can provide specific examples of how self care appears in important areas of our lives.

The second step in promoting self care in counselors is to assist the counselor in developing their own personal self care plan. Michenbaum (2007) recommended several self care behaviors for counselors. Behaviors included engaging in relaxation exercises in between clients and after leaving work, adequate sleep and exercise, taking vacations or attending personal counseling when needed, having an outlet for their emotional release outside of work and to incorporate activities that renew meaning in their lives in and outside of counseling with client (Michenbaum, 2007). Supervisors and educators can remind counselors of the education they received about self care and then gather personal ideas from the educational material. Counselors may benefit from educators and supervisors assisting them in developing specific activities for self care that are measurable and realistic for their lifestyle.

Finally, educators and supervisors can hold the counselor accountable for engaging in their self care plan each week. This can take place during weekly supervision meetings, phone calls or emails. A qualitative study by Sommer and Cox (2005) indicated self care on a regular,

weekly basis was helpful in lessening the effects of vicarious trauma. Furthermore, the effects of vicarious trauma can be lessened with a supportive environment (Knight, 2013) where counselors are held accountable for their personal self care practices.

This present research study sought to understand the relationship between supervisory alliance and symptoms of vicarious trauma. Results from both the PCL-5 and the VTS indicated a weak positive correlation between supervisory alliance and lower levels of vicarious trauma. These findings are in contrast with current research about the alliance between counselor and supervisor. Research has found a strong supervisory alliance encourages counselors to discuss and reflect on important issues like vicarious trauma that can arise with the counselor while treating clients. Weak supervisory alliances have contributed to ethical concerns due to the counselor not feeling comfortable or safe enough to discuss professional issues (Padaman, Shafranske, & Falender, 2015). Supervisory alliance plays an important role in the overall effectiveness of the counselor; however, it may not be as important a factor in reducing symptomology of vicarious trauma in counselors.

Limitations

One limitation of this present research study was the number of male participants (N=11). Females characteristically dominate the counseling profession; however, it would benefit to have more of a male presence in this study to determine the way males respond to supervision and the effect on symptoms of vicarious trauma in their lives. The results from this study are not as applicable to male lives.

Another limitation of this study was the use of the Vicarious Trauma Scale as a measure of vicarious trauma symptoms. The results from the use of this scale may have skewed the overall results of the study. The questionnaire is very brief with only seven questions to measure

vicarious trauma symptoms in counselors. This scale is still rather new and not as widely utilized as other measures. Using a different measure that is more developed for vicarious trauma symptoms may have provided a better understanding of supervision interventions and levels of vicarious trauma.

Finally, this study examined a select few supervision interventions for counselors. Supervisory alliance, self care, psychoeducation and cognitive restructuring are a limited selection of strategies that may relate to fewer symptoms of vicarious trauma. Other interventions and models of supervision exist that could possibly relate to lower levels of vicarious trauma in practicing counselors.

Future Recommendations for Research

Future research on decreasing the symptoms of vicarious trauma needs to focus on specific ways to implement self care into supervision practice. Now that we know self care is correlated with lower levels of vicarious trauma, further research into the development of a model for the integration of self care into supervision would be beneficial for supervisors, educators and practicing counselors. The model may include areas of supervision, ways to assist the supervisee in developing self care, and how to hold the supervisee accountable for the practice self care.

Conducting a qualitative study of counselors who are at risk for experiencing vicarious trauma and are currently participating in supervision would be beneficial for counselor educators and supervisors. It is important to obtain more detailed responses from participants regarding specific aspects of self care which have contributed to lessening their symptoms of vicarious trauma. This information can then be applied to developing a specific model for self care, targeted at reducing symptoms of vicarious trauma.

Furthermore, it is necessary researchers develop an assessment that thoroughly measures symptoms of vicarious trauma in counselors. To this researcher's knowledge, the Vicarious Trauma Scale is the only assessment that addresses specific vicarious trauma symptoms; however, the scale is very brief and does not adequately address symptomology. Other assessments are focused on Posttraumatic Stress symptomology, which is similar to signs of vicarious trauma, but not specifically related to vicarious trauma in counselors.

Finally, this study addressed three specific supervision interventions to utilize when addressing vicarious trauma. Future research is needed to examine other supervision strategies and models to discover if self care continues to be the most strongly correlated or if there are other supervision practices that would benefit counselors greater than self care.

Summary

This research study established an understanding of the relationship between symptoms of vicarious trauma and specific supervision interventions, such as psychoeducation, self care and cognitive restructuring. This study determined supervision is an effective way to lessen vicarious trauma symptoms in practicing counselors. Furthermore, this study identified the supervision intervention of self care to be the most strongly related to reducing vicarious trauma symptomology in counselors. Additional research is needed to design a self care model for supervision of counselors suffering from vicarious trauma. This model can be used by educators seeking to prepare counselors for work in high trauma populations, and be utilized by supervisors working with counselors suffering from vicarious trauma.

Chapter 5: Manuscript

Introduction and Background of the Problem

Invisible Wounds: Mitigating Vicarious Trauma in Practicing Counselors

Counselors are engaged in a profession for which they are expected to absorb the trauma of clients and the emotion associated with traumatic events. In training to be a counselor, counselors are taught to be empathetic, placing themselves in the client's position to better understand the feelings and thoughts of clients. In doing so, counselors are made an integral part of the healing process for clients, subsequently exposing themselves to intense details of the client's stories.

Negative consequences can occur if counselors are impaired from experiencing vicarious trauma as a result of listening to frequent traumatic stories. A compromised counselor risks harming their client and the profession of counseling. If the profession of counseling cannot prevent vicarious trauma then the profession will continue to lose valuable counselors, thus contributing to the problem of vicarious trauma, rather than preventing it from occurring. Therefore, it is essential counselor educators and supervisors begin to identify measures that will prevent the occurrence of vicarious trauma or lessen its effects in future and practicing counselors.

Research has established supervision to be an effective process to prevent or lessen the effects of vicarious trauma (Abassary & Goodrich, 2014; Bell, Kulkarni & Dalton, 2003; Etherington, 2000; Knight, 2013; Lonn & Haiyasoso, 2016; Sommer 2008); however, research is lacking in addressing specific interventions to use during the supervisory process. Particular

supervision interventions including self care, psychoeducation and cognitive restructuring, will be discussed in greater detail.

Vicarious Trauma and at Risk Populations

When a counselor works therapeutically with clients who have experienced trauma, the counselor then becomes exposed to the graphic details of trauma (Trippany, Kress & Wilcoxon, 2004). Symptoms of vicarious trauma can be similar to those of Post Traumatic Stress Disorder. The main difference being counselors experience the traumatic event indirectly rather than directly by listening to the client discuss the traumatic event. Pearlman and Saakvitne (1995) have defined vicarious trauma as “the transformation of the helper’s inner experience as a result of empathic engagement with survivor clients and their trauma material.” This transformation can result in a change in the worldview of the counselor, leading to a more negative outlook on life and those around them (Pearlman & Sakkvitne, 1995).

Symptoms of vicarious trauma in counselors include four of the diagnostic criterion for Post Traumatic Stress Disorder (APA, 2013). These symptoms are illustrated in the figure below.

Criterion A is the actual stressor which could be a person who was exposed to death, threatened death, serious injury or threaten sexual violence. The stressor can be experienced directly, as a witness, or repeated indirect exposure to the details of the traumatic event usually in the course of professional work (APA, 2013). Criterion B is intrusion symptoms/re-experiencing symptoms. Symptoms include traumatic nightmares, flashbacks, recurrent intrusive memories, elongated stress after exposure to a traumatic reminder, and physiological reactivity after the exposure to trauma related stimuli (APA, 2013). After repeated exposure to details of traumatic events, counselors may have nightmares or unwanted thoughts about the trauma enter their mind throughout the day (Lonn & Hyyiasos, 2016). Criterion C is avoidance symptoms, which

includes avoiding trauma related stimuli that causes trauma related thoughts or feelings, or avoiding external reminders such as people, places or activities that a remind of the trauma (APA, 2013). Criterion D is negative alterations in cognitions and mood. This includes negative changes in thinking and mood that started after the traumatic event(APA, 2013). For a counselor, this may mean the counselor stops trusting others they once trusted or may begin isolating themselves from family and friends. What was thought about the world at one time may no longer be true for the counselor.

Helm (2016) discusses how vicarious trauma can effect the emotional, cognitive, physical and behavioral aspects of a counselor's life. The emotional symptoms may include feeling anxious, depressed and numb to their own emotion and the emotion of others. Cognitively, a counselor may have cognitive distortions about the ability to trust others in the world. Schemas are disrupted when the counselor empathizes with the client's trauma (Baird and Jenkins, 2003).

Furthermore, physically, a counselor may feel tired, exhausted or have a lack of motivation (Helm, 2016). Behaviorally, a counselor may perhaps start to withdraw from loved ones, cry more often, or have less patience and more anger (Helm, 2016). The work behavior of the counselor may be effected as well, resulting in being tardy, increased absences, and making irresponsible decisions (ACA, 2017).

Etherington (2000) also describes the effects vicarious trauma as being disruptive to a counselor's self esteem and self identity. The counselor feels more vulnerable and fearful and as a result trusts others less. Counselors may also change their view about their role in life and the way they practice as a counselor (Canfield, 2008). Attitudes about the future may be more negative and their beliefs about the world are now counter to what they once were.

Vicarious trauma not only effects the person individually but the organization as well. The work performance of counselors is often negatively changed as a result. Increased conflict with staff, perfectionism, low motivation, poor communication, an increase in errors, being numb to clients and feeling hopeless about work are among the negative occupational effects of vicarious trauma (Stefura & Shatto, 2015). Knight (2013) indicated that vicarious trauma can be spread from one person to another in an organization, almost like a contagious disease, creating an atmosphere that is toxic and difficult for any employee to work successfully.

A key element in understanding vicarious trauma is awareness of what factors may contribute to the development of vicarious trauma in counselors. Research has found that working in the human service field is the largest risk factor for developing vicarious trauma because of the emotional demands of human service workers (Maslach, Schaufeli & Leiter, 2001; Maslach & Leiter, 1997). Counselors are among the many occupations within the human service field and are therefore in danger of being exposed to vicarious trauma. (Maslach, Schaufeli & Leiter, 2001; Maslach & Leiter, 1997).

More specific risk factors for vicarious trauma exist for counselors including high caseloads of primarily intense trauma cases (Meichenbaum, 2007), having an unresolved personal history of trauma (Baird & Kracen, 2006) and counselors who have a lack of experience in the counseling field. (Meichenbaum, 2007).

Vicarious Trauma and the Supervisory Process

Supervision of counselors is essential for counselors in training and practicing counselors. Supervision is first introduced as an important component when students are training to be a counselor. CACREP (2016) requires students who are participating in practicum or internship to engage in weekly supervision that averages one hour, as well as participate in group

supervision on a weekly basis. CACREP (2016) views supervision as a valuable way to monitor the work of the supervisee, protect the clients of the supervisee, and continue to contribute to professional development of the supervisee by providing education and guidance.

The American Counseling Association (2014) speaks to the role of supervisors in Standard F.2.a. in that supervisors must be appropriately trained to supervise counselors. This being the case, supervisors should be educated about specific issues such as vicarious trauma so to better advise counselors on how to prevent vicarious trauma from occurring their own lives. In this role, supervisors may recognize signs and symptoms of vicarious trauma in supervisees when they are able to meet weekly with their supervisee. Attending to these changes can provide an opportunity in supervision to educate supervisees about vicarious trauma and explore the possible symptoms the supervisee is experiencing (Etherington, 2000).

Supervision as a Mechanism to Address Vicarious Trauma

Supervision Intervention: Self Care

Taking time to care for oneself is essential to preventing vicarious trauma. Professional self care is defined as skills and strategies used by a counselor that attend to their personal, emotional and spiritual needs. Engaging in self care helps the counselor to balance between the demands of their own life and that of their client (Newell & MacNeil, 2010). Engaging in self care has been found to reduce stress, subsequently, reducing vicarious trauma symptoms (Gerding, 2012). Vicarious trauma can be prevented if supervisors teach supervisees to engage in self care early in their education and career as a professional counselor.

Supervisors are encouraged to promote self-care in counselors to mitigate the effects of vicarious trauma. Supervisors should communicate the value in self-care and its ability to help counselors shift their focus from what they cannot control, such as trauma in clients, to what they

can control, such as helping self (Carello & Butler, 2015). Literature has drawn attention to five areas of self care including spiritual, physical, emotional, professional and psychological (Osofsky, 2011).

Research and professional educational standards such as CACREP and ACA clearly state self care is essential for counselors to incorporate into their lives and practice as a counselor. Engaging in various self care practices can prevent the negative personal and professional effects of vicarious trauma. Doing so protects the well being of the counselor and the welfare of clients.

Supervision Interventions: Cognitive Behavioral Techniques

As stated previously, symptoms of vicarious trauma are similar to that of Post Traumatic Stress Disorder, including increased arousal, re-experiencing symptoms, avoidance and negative thinking. In treating PTSD, research has shown cognitive behavioral techniques to be effective in preventing the symptoms of PTSD from occurring or from being as intense. CBT techniques include cognitive restructuring and anxiety management techniques (Kearns, et., al, 2012). Many interventions for vicarious trauma include cognitive behavioral techniques such as cognitive restructuring (Murphy, 1996).

Cognitive restructuring is a core aspect to Cognitive Behavioral Therapy (CBT). Cognitive restructuring is taught during the therapeutic process, educating clients to recognize their negative or irrational thought patterns and then replacing with more positive thought patterns (Beck, 2011). The same process can be applied to supervision of counselors. In supervision, supervisors can first educate the counselor about cognitive restructuring and provide practice exercises. Once the skill has been acquired by the counselor, the supervisor should advise the counselor to monitor their self talk, taking note of negative thought patterns (Meichenbaum, 2007).

Meichenbaum (2007) suggested counselors should use their cognitive abilities when coping with vicarious trauma. The abilities he refers to are similar to those of cognitive restructuring. He states that counselors should use self talk and tell themselves they are not alone in their struggle with vicarious trauma. Supervisors can provide education on cognitive restructuring and practice ways for the counselor to modify their inaccurate thought patterns that causes anxiety and distress.

Supervision Interventions: Psycho-education

Psychoeducation has emerged as one of the most effective evidenced based therapeutic interventions. It is a highly useful intervention because of its applicability to different diagnoses and challenges (Lukens & McFarlane, 2004). Psychoeducation is a form of treatment used by counselors that integrates educational and psychotherapeutic interventions while emphasizing strength and empowerment in the person (Lukens & McFarlane, 2004). The principle behind psychoeducation is the more knowledgeable the person is the more positive outcomes in overall health of the person (Lukens & McFarlane, 2004).

Research has demonstrated that psychoeducation and training on trauma is imperative for counselors working with clients who have experienced trauma. Specifically, psychoeducation can provide counselors with information on coping skills and assist in decreasing the symptoms of post traumatic stress disorder (Trippany, Kress & Wilcoxon, 2004). Furthermore, research suggests counselors should engage in educational workshops on vicarious trauma, early warning signs and ways to prevent the trauma in themselves. Through psychoeducation, counselors can develop an awareness of their own risk factors and be able to recognize when those factors play a role in the development of vicarious trauma (Coles, Dartnall & Astbury, 2013).

Supervisory Alliance and Vicarious Trauma

Research has indicated the supervisory alliance between a supervisor and a counselor plays a pivotal role in the effectiveness of the counselor (Efstation, Patton, & Kardash, 1990; Ellis & Ladany, 1997; Goodyear & Bernard, 1998; Ladany, Ellis & Friedlander, 1999). A positive relationship between the supervisor and the counselor can contribute to respect and trust in the supervisory relationship (Ladany & Friedlander, 1995). Strong supervisory alliances encourage counselors to discuss and reflect on important issues like vicarious trauma that can arise with the counselor while treating clients. Weak supervisory alliances have contributed to ethical concerns due to the counselor not feeling comfortable or safe enough to discuss professional issues (Padaman, Shafranske, & Falender, 2015).

When the supervisor does not attend to vicarious trauma with the supervisor, it results in a weak supervisory relationship, leaving the counselor feeling the supervision was not helpful. A qualitative study conducted by Sommer and Cox (2008) shared stories from counselors whose supervisors did not recognize vicarious trauma. The lack of attention during supervision to the issue of vicarious trauma left counselors feeling guarded and less likely to be vulnerable. One participant stated, “supervision isn’t the way to go there, (pg. 127)” referring to the discussion of vicarious trauma. Lack of support from the supervisor can intensify the effects of vicarious trauma (Knight, 2013) resulting in ineffective supervision.

Clearly the research is deficient in identifying specific supervision techniques for preventing vicarious trauma in developing and practicing counselors. This study will provide information on techniques in supervision that are associated with preventing or lessening the effects of vicarious trauma in practicing counselors. Research gained from this study can be used by counselor educators and supervisors to educate students in counseling and practicing

counselors, on how to prevent vicarious trauma and maintain longevity in the profession of counseling.

The purpose of this quantitative survey research study is to examine the relationship between supervision techniques utilized in counseling supervision and the prevention of vicarious trauma in practicing counselors. The study is being conducted to assess which supervision techniques are correlated with low levels of vicarious trauma. The independent variables include supervision techniques, while the dependent variables are symptoms of vicarious trauma (re-experiencing, avoidance, intrusive thoughts and increased arousal).

Supervision interventions to be evaluated include providing psychoeducation on vicarious trauma, the implementation of self care, and cognitive restructuring which can be used to alter the thought process contributing to vicarious trauma. The operational definition for vicarious trauma is “the transformation of the helper’s inner experience as a result of empathic engagement with survivor clients and their trauma material.” This transformation can result in a change in the worldview of the helper (Pearlman & Saakvitne, 1995). Operation definitions of supervision techniques are also follows: Self care is defined as the actions people purposefully take that contribute to lower levels of stress and overall wellness of self (Bloomquist, Wood, Friendmeyer-Trainor& Kim, 2015). Psychoeducation is to teach key information about vicarious trauma and its adverse effects on counselors (Baulm, et. al., 2003/2014). Cognitive restructuring is a technique used to recognize and cope with intrusive thoughts or negative thought patterns (Traeger, 2013). With vicarious trauma, counselors are taught by supervisors to recognize their persistent negative thought patterns and beliefs about the world and others, and then replace the negative thinking with more positive thinking.

Research Questions

1. Does supervision have an impact on levels of vicarious trauma in practicing counselors?
2. Which supervision techniques is most correlated with lower levels of vicarious trauma?
3. Does supervisory alliance between supervisor and counselor relate to levels of vicarious trauma?

Participants

The participants for this study were practicing counselors or counselor educators who had experienced supervision within the last year. In order to participate in the study, participants had to be at least 19 years of age and be a counselor who has received supervision in the past.

Participants were recruited through various counseling listservs including the Alabama Counseling Association (ALCA), the American Counseling Association (ACA), the Alabama Network of Children's Advocacy Centers (ANCAC), and the Counselor Education and Supervision Network (CESNET). Each of these listservs represent counselors and counselor educators in possible high risk environments for vicarious trauma.

Procedures

Participants were provided information about the study and asked to click on the survey link through Qualtrics if interested in participating. Prior to participating in the survey, participants were asked to read an informed consent and then assent to the study. The informed consent notified participants there were no risks for harm associated with the study and that they may withdraw at any time during the study. The IRB approval was also attached for participants to review. Survey's completed by participants included a Brief Demographic Questionnaire, Evaluation of Supervisory Alliance, Supervision Techniques, the Posttraumatic Checklist (PCL5) and the Vicarious Trauma Scale (VTS).

Data Analysis

This study aimed to identify the relationship between symptoms of vicarious trauma in practicing counselors and supervision techniques utilized during supervision. The relationship

between symptoms of vicarious trauma and supervisory alliance was also examined. Symptoms of vicarious trauma were measured using the Vicarious Trauma Scale (VTS) and the Posttraumatic Stress Checklist (PCL-5). Supervision techniques used were measured through a supervision techniques assessment. The supervisory relationship was measured through a supervisor evaluation. Data was analyzed through SPSS, using descriptive statistics and linear regressions to determine if a relationship existed. Findings from this study are displayed in charts.

Results

The purpose of this quantitative study was to examine the relationship between levels of vicarious trauma and specific supervision strategies used during supervision as well as supervisory alliance between supervisor and counselor. The researcher for this study utilized a brief demographic questionnaire, the Posttraumatic Checklist (PCL5), the Vicarious Trauma Scale (VTS), a supervision strategy questionnaire, and a supervisory alliance questionnaire.

Demographics

A total of 82 counselors participated in this study. Of the 82 participants, 80 participants reported their gender; 11 (13.9%) of participants indicated they identified as male and 69 (86%) of the participants indicated they identified as female. Current specialization in the counseling field was reported by 82 of the participants. Of the 82 that reported, 43 (53.7%) identified as clinical mental health counselors, 13 (16.2%) identified as school counselors, 15 (15%) identified as counselor educators, 5 identified as counselor psychologist (6.2%), 1 identified as a sports psychologist (1.2%), and 6 (7.5%) identified with other specializations.

Eighty participants reported current licensure in counseling. Of the 60 counselors, 64 (80%) reported being currently licensed, and 20 (20%) reported not being licensed in counseling.

Eighty participants also reported on receiving supervision within the last year. Of the 80 participants, 24 (30%) responded they have received supervision within the last year, and 56 (70%) are not receiving supervision within the last year.

Instrumentation

A brief demographic questionnaire was created for the purpose of gathering demographic information about participations and information about supervision techniques. Participants were asked demographic information including age, gender, education, and ethnicity.

To assess the use of supervision interventions, a measure was developed by this researcher based on methods that have been used to mediate vicarious trauma. Participants were asked a series of questions about supervision techniques used and techniques taught by the supervisor.

The Vicarious Trauma Scale (VTS) was developed by Lila Petar Vrklevski and John Franklin (2008) in a study exploring vicarious trauma in the legal profession. The VTS assesses subjective levels of distress connected to working with clients who have experienced trauma. Items on the VTS are rated on a 7 point Likert scale, with responses reaching 1 (strongly disagree) to 7 (strongly agree).

The Post Traumatic Stress Checklist (PCL-5) is used to assess trauma symptoms in participants. THE PCL-5 contains 20 self report items reflecting the diagnostic criteria for PTSD in the DSM-V. The mean, standard deviation, and reliability statistics are reported in Table 2 for the Post Traumatic Checklist (PCL5), the Vicarious Trauma Scale (VTS), the supervisory alliance scale, and the supervision strategies scale.

Table 2

Scale Reliability Statistics

Scale	N	Cronbach's Alpha	Mean	Standard Deviation
Posttraumatic Stress Scale (PCL5)	21	.932	1.42	.545
Vicarious Trauma Scale (VTS)	8	.744	4.26	.973
Supervision Technique: Self Care	8	.764	3.53	.755
Supervision Technique: Psychoeducation	7	.878	3.72	1.02
Supervision Technique: Cognitive Restructuring	3	.874	2.73	1.27
Supervisory Alliance	8	.962	1.87	.996

Research Question 1: Does supervision have an impact on levels of vicarious trauma?

Two backward elimination regressions were used to examine the overall relationship between supervision techniques with the PCL-5 and the VTS to determine which supervision techniques were most influential. Results from the Pearson Correlation equation with both the PCL-5 and the VTS as the dependent variables, indicated a negative relationship between supervision techniques and levels of vicarious trauma. The backward regression equation using the PCL-5 as the dependent variable indicated using all three supervision techniques (self care, cognitive restructuring and psychoeducation) has a significant effect on levels of vicarious trauma that is not by chance ($p=.001$), with an r square value of .274. Results from this equation denote supervision does have a significant impact on reducing level of vicarious trauma in practicing counselors. Regression and correlation summaries can be viewed in Table 3.

Table 3

Regression and Correlation Summary

	PCL-5			VT		
Full Model	$R^2=.293^a$			$R^2=.059^c$		
	Beta	r	Semi partial	Beta	r	Semi partial
Self Care	-.587**	-.532	-.483	-.171	-.206	-.141
Psycho-Education	.218	-.164	.129	-.216	-.195	-.127

Cognitive Restructuring	-.097	-.229	-.057	.148	-.127	-.087
Restricted Model	R²=.274^b			R²=.043^d		
Self care	-.523***		-.523	-.206		-.206

Note: *p<.05, **p<.01, ***p<.001

a-R²=.293, p=.002, F=5.65

b-R²=.274, p=<.001, F=19.204

c- R²=.059, p=.472, F=.855

d-R²=.043, p=>.001, F=1.91

Research Question 2: Which supervision technique (self care, psycho-education, cognitive restructuring) is most correlated with low levels of vicarious trauma?

A backward linear regression was used to determine the relationship between each supervision technique and levels of vicarious trauma for both the PCL-5 and the VTS. The backward linear regression with the PCL-5 and the VTS as the dependent variables indicated self care to have the strongest relationship amongst the three supervision techniques. The correlation between self care and levels of vicarious trauma on the PCL was -.532, indicating the more self care used the lower the level of vicarious trauma. In the backward regression model, psychoeducation and cognitive restructuring were eliminated, indicating self care had the most significant relationship with lower levels of vicarious trauma (r=-.532, p=.010). Results from the VTS additionally confirm self care as the more effective supervision technique among the three evaluated. In the backward regression mode, psychoeducation and cognitive restructuring were again eliminated, leaving self care. Results are summarized in Table 3.

Research Question 3: Does supervisory alliance between supervisor and counselor relate to levels of vicarious trauma?

A Pearson Correlation coefficient was computed to determine the relationship between levels of vicarious trauma and supervisory alliance between supervisor and counselor with the

PCL-5 and the VTS. A positive relationship was found between supervisory alliance and PCL-5 ($r=.485$) and VTS ($r=.156$). These results suggest the strength of the alliance between supervisor and counselor does not have a positive effect on levels of vicarious trauma.

Discussion

The purpose of this research study was to first determine if supervision has an impact on levels of vicarious trauma. Second, the purpose was to determine which supervision intervention, self care, psychoeducation or cognitive restructuring, was most strongly correlated with levels of vicarious trauma. Finally, to determine if supervisory alliance influences levels of vicarious trauma. Results from each of these questions will be discussed.

Implications for Counselor Educators and Supervisors

The current study established evidence that supervision is in fact effective in decreasing the symptoms of vicarious trauma in practicing counselors. Counselor educators and supervisors can develop ways of incorporating self care into their supervision sessions, demonstrating the importance of these strategies to their supervisees. Furthermore, counselor educators and supervisors can model these practices in effort for supervisees to utilize these techniques on their own outside of supervision. A possible model for supervision encompassing these three techniques would be a beneficial map for supervisors and educators to use when addressing the symptoms of vicarious trauma in practicing counselors.

Furthermore, this study found self care to be the most effective of the three supervision techniques. Engaging in self care helps the counselor to balance between the demands of their own life and that of their client. Based on these findings, counselor educators and supervisors should promote and teach self care practices to counselors to lessen symptoms of vicarious trauma.

The process of promoting self care in counselors begins with education. Supervisors and educators should provide counselors with a definition of self care and various examples of practices of self care. Literature has drawn attention to five areas of self care including spiritual, physical, emotional, professional, and psychological (Osofsky, 2011). Breaking each of these areas down for counselors can provide specific examples of how self care appears in important areas of our lives.

The second step in promoting self care in counselors is to assist the counselor in developing their own personal self care plan. Supervisors and educators can remind counselors of the education they received about self care and then gather personal ideas from the educational material. Counselors may benefit from educators and supervisors assisting them in developing specific activities for self care that are measurable and realistic for their lifestyle.

Finally, educators and supervisors can hold the counselor accountable for engaging in their self care plan each week. This can take place during weekly supervision meetings, phone calls or emails. A qualitative study by Sommer and Cox (2005) indicated self care on a regular, weekly basis was helpful in lessening the effects of vicarious trauma. Furthermore, the effects of vicarious trauma can be lessened with a supportive environment (Knight, 2013) where counselors are held accountable for their personal self care practices.

This present research study sought to understand the relationship between supervisory alliance and symptoms of vicarious trauma. Results from both the PCL-5 and the VTS indicated a weak positive correlation between supervisory alliance and lower levels of vicarious trauma. These findings are in contrast with current research about the alliance between counselor and supervisor. Research has found a strong supervisory alliance encourages counselors to discuss and reflect on important issues like vicarious trauma that can arise with the counselor while

treating clients (Padaman, Shafranske, & Falender, 2015). Supervisory alliance plays an important role in the overall effectiveness of the counselor; however, it may not be as important a factor in reducing symptomology of vicarious trauma in counselors.

Limitations

One limitation of this present research study was the number of male participants (N=11). Females characteristically dominate the counseling profession; however, it would benefit to have more of a male presence in this study to determine the way males respond to supervision and the effect on symptoms of vicarious trauma in their lives. The results from this study are not as applicable to male lives.

Another limitation of this study was the use of the Vicarious Trauma Scale as measure of vicarious trauma symptoms. The results from the use of this scale may have skewed the overall results of the study. The questionnaire is very brief with only seven questions to measure vicarious trauma symptoms in counselors. This scale is still rather new and not as widely utilized as other measures. Using a different measure that is more developed for vicarious trauma symptoms may have provided a better understanding of supervision interventions and levels of vicarious trauma.

Finally, this study examined a select few supervision interventions for counselors. Supervisory alliance, self care, psychoeducation and cognitive restructuring are a limited selection of strategies that relate to fewer symptoms of vicarious trauma; however, these interventions are helpful in alleviating symptoms of vicarious trauma in counselors.

Future Recommendations for Research

Future research on decreasing the symptoms of vicarious trauma needs to focus on specific ways to implement self care into supervision practice. Now that we know self care is

correlated with lower levels of vicarious trauma, further research into the development of a model for the integration of self care into supervision would be beneficial for supervisors, educators and practicing counselors. The model may include areas of supervision, ways to assist the supervisee in developing self care, and how to hold the supervisee accountable for the practice self care.

Conducting a qualitative study of counselors who are at risk for experiencing vicarious trauma and are currently participating in supervision would be beneficial for counselor educators and supervisors. It is important to obtain more detailed responses from participants regarding specific aspects of self care which have contributed to lessening their symptoms of vicarious trauma. This information can then be applied to developing a specific model for self care, targeted at reducing symptoms of vicarious trauma.

Finally, it is necessary researchers develop an assessment that thoroughly measures symptoms of vicarious trauma in counselors. To this researcher's knowledge, the Vicarious Trauma Scale is the only assessment that addresses specific vicarious trauma symptoms; however, the scale is very brief and does not adequately address symptomology. Other assessments are focused on Posttraumatic Stress symptomology, which is similar to signs of vicarious trauma, but not specifically related to vicarious trauma in counselors.

Summary

This research study established an understanding of the relationship between symptoms of vicarious trauma and specific supervision interventions, such as psychoeducation, self care and cognitive restructuring. This study determined supervision is an effective way to lessen vicarious trauma symptoms in practicing counselors. Furthermore, this study identified the supervision intervention of self care to be the most strongly related to reducing vicarious trauma

symptomology in counselors. Additional research is needed to design a self care model for supervision of counselors suffering from vicarious trauma. This model can be used by educators seeking to prepare counselors for work in high trauma populations, and be utilized by supervisors working with counselors suffering from vicarious trauma.

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Appendix 1. IRB Approval

(NOTE: DO NOT AGREE TO PARTICIPATE UNLESS IRB APPROVAL INFORMATION WITH CURRENT DATES HAS BEEN ADDED TO THIS DOCUMENT).

INFORMATION LETTER for a Research Study entitled “Invisible Wounds: Preventing Vicarious Trauma in Practicing Counselors”

You are invited to participate in a research study. *The research is intended to identify clinical supervision techniques that are related to lower levels of vicarious trauma in practicing counselors. Participating in this study will contribute to preventing vicarious trauma in practicing counselors.* The study is being conducted by Margaret Taylor under the direction of Dr. Jamie Carney in the Auburn University Department of Special Education, Rehabilitation and Counseling. You were selected as a possible participant because you are a practicing counselor or counselor educator.

What will be involved if you participate? If you decide to participate in this research study, you will be asked to complete one surveys, sent by email. You will receive an email linking you to the survey. Your total time commitment will be approximately 10 minutes.

Are there any risks or discomforts? The risks associated with participating in this study are minimal. You may experience discomfort from thinking about possible vicarious trauma symptoms when answering survey questions.

Are there any benefits to yourself or others? If you participate in this study, you are contributing to the research on preventing vicarious trauma in practicing counselors. Preventing vicarious trauma in counselors will benefit the counseling profession by having healthier professionals that are at less risk for harming clients due to being impaired.

Will you receive compensation for participating? No

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.

Any data obtained in connect with this study will remain anonymous.

We will protect your privacy and the data you provide by collecting all data through the program Qualtrics. No identifying information will be asked of or gathered during the survey. Information obtained through your participation may be published in a professional journal or presented at a professional conference.

If you have any questions about this study, please contact Margaret Taylor at barnema@auburn.edu or Dr. Jamie Carney at carnejs@auburn.edu

If you have 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. IF YOU DECIDED TO PARTICIPATE, PLEASE CLICK ON THE LINK BELOW. YOU MAY PRINT A COPY OF THIS LETTER TO KEEP

Margaret A. Taylor 12-28-2017

Investigator Date

Dr. Jamie Carney 12-28-2017

Co-Investigator Date

The Auburn University Institutional Review Board has approved this document for use from January 03, 2018 to January 02, 2019. Protocol #17-492 EP 1801

[Link to Survey](#)

The Auburn University
Institutional Review Board has
approved this Document for use
from
01/03/2018 to 01/02/2019
Protocol # 17-492 EP 1801

**Add this approval information in
sentence form to your electronic
information letter!**

INFORMED CONSENT

for a Research Study entitled

“Invisible Wounds: Preventing Vicarious Trauma in Practicing Counselors”

You are invited to participate in a research study. *The research is intended to identify clinical supervision techniques that are related to lower levels of vicarious trauma in practicing counselors. Participating in this study will contribute to preventing vicarious trauma in practicing counselors.* The study is being conducted by Margaret Taylor under the direction of Dr. Jamie Carney in the Auburn University Department of Special Education, Rehabilitation and Counseling. You were selected as a possible participant because you are a practicing counselor or counselor educator.

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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.

Your privacy will be protected. Any information obtained in connection with this study will remain confidential. Information obtained through your participation may be published in a professional journal or presented at a professional conference.

If you have 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

Co-Investigator Date

Printed Name

Appendix 3. Brief Demographic Questionnaire

What is your age?

- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65-74
- 75-84
- 85 and older

What is your gender?

- Male
- Female
- Transgender
- Non-binary
- Other

How do you identify your race/ethnicity. Please choose all that apply

- White
- Black
- Pacific Islanders
- Asian
- Native Hawaiian
- American Indian
- Alaskan Native
- Hispanic/Latino
- Biracial/Multiracial
- Other

What is the highest level of education you have completed?

- Master's Degree
- Education Specialist Degree
- Doctoral Degree

Identify your area of specialization.

Are you currently licensed?

Yes

No

How many years have you practiced as a counselor?

On average, how many hours a week do you spend in direct counseling service?

What client populations do you serve in your primary setting? Please check all that apply? From 1 to 5, how much of these make up your caseload?

Intimate partner violence

Sexual assault/violence

Child abuse

Crime/terrorism victim

Natural disasters

Combat/military duty

Loss/grief/bereavement

Substance use

Severe mental illness

Appendix 4.

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am	0	1	2	3	4

bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?					
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “superalert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Appendix 5. Vicarious Trauma Scale

Vicarious Trauma Scale Items:

1. Strongly disagree
2. Disagree
3. Slightly disagree
4. Neither agree nor disagree
5. Slightly agree
6. Agree
7. Strongly agree

Please read the following statements and indicate on a scale of 1 (strongly disagree) to 7 (strongly agree) how much you agree with them.

	Strongly Disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly agree
My job involves exposure to distressing material and experiences							
My job involves exposure to traumatized or distressed clients.							
I find myself distressed by listening to my clients' stories and situations							
I find it difficult to deal with the content of my work.							
I find myself thinking about distressing							

material at home.							
Sometimes I feel helpless to assist my clients in the way I would like.							
Sometimes I feel overwhelmed by the workload involved in my job							
It is hard to stay positive and optimistic given some of the things I encounter in my work.							

Appendix 6. Supervision Techniques Assessment

Directions: Below are questions to assess the use of supervision strategies in the last year practicing as a counselor. Please respond to the following statements as honestly as possible.

1. Have you participated in supervision in the last year?

Yes

No

2. Have you discussed vicarious trauma in supervision within the last year?

Yes

No

3. Have you received training on vicarious trauma during supervision? If yes, please describe.

4. Have you discussed or identified your own experience of vicarious trauma in supervision? If yes, please identify ways your supervisor handled your experience of vicarious trauma in supervision.

5. My supervisor provided sufficient information on the forms of self-care.

1=Not at all 2=A little bit 3=Moderately 4=Quite a bit 5=Frequently

6. My supervisor provided sufficient information on the way to use of self-care.

1=Not at all 2=A little bit 3=Moderately 4=Quite a bit 5=Frequently

7. I practice physical self care (ex: exercise, healthy diet, sleep).

1=Not at all 2=A little bit 3=Moderately 4=Quite a bit 5=Frequently

8. I practice spiritual self care (ex: forms of worship and meditation)

1=Not at all 2=A little bit 3=Moderately 4=Quite a bit 5=Frequently

9. I practice emotional self care (ex: spending time with family and friends, engaging in enjoyable activities).

1=Not at all 2=A little bit 3=Moderately 4=Quite a bit 5=Frequently

10. I practice professional self care (ex: attending trainings, boundaries with clients)

1=Not at all 2=A little bit 3=Moderately 4=Quite a bit 5=Frequently

11. I practice psychological self care (ex: journaling, reading).

1=Not at all 2=A little bit 3=Moderately 4=Quite a bit 5=Frequently

12. My supervisor provided sufficient information about vicarious trauma.

1=Not at all 2=A little bit 3=Moderately 4=Quite a bit 5=Frequently

13. My supervisor provided sufficient education about the negative effects of vicarious trauma.

1=Not at all 2=A little bit 3=Moderately 4=Quite a bit 5=Frequently

14. My supervisor provided sufficient education about ways to prevent vicarious trauma.

1=Not at all 2=A little bit 3=Moderately 4=Quite a bit 5=Frequently

15. I understand the educational material on vicarious trauma.

1=Not at all 2=A little bit 3=Moderately 4=Quite a bit 5=Frequently

16. I understand the negative effects associated with vicarious trauma.

1=Not at all 2=A little bit 3=Moderately 4=Quite a bit 5=Frequently

17. I understand methods used to prevent vicarious trauma.

1=Not at all 2=A little bit 3=Moderately 4=Quite a bit 5=Frequently

18. My supervisor provided sufficient education on cognitive techniques used to prevent vicarious trauma.

1=Not at all 2=A little bit 3=Moderately 4=Quite a bit 5=Frequently

19. My supervisor provided sufficient information on ways to use cognitive techniques to prevent vicarious trauma.

1=Not at all 2=A little bit 3=Moderately 4=Quite a bit 5=Frequently

20. I practice cognitive restructuring to prevent vicarious trauma in my own life.

1=Not at all 2=A little bit 3=Moderately 4=Quite a bit 5=Frequently

Appendix 7. Supervisor Evaluation

Describe your relationship with your supervisor during the last year.

	Strongly agree	Agree	Neutral	Disagree	Strongly Disagree
My supervisor is encouraging, optimistic and motivational					
My supervisor is sensitive to individual differences (gender, ethnicity, culture and age)					
My supervisor demonstrates a commitment to the role of being a supervisor					
My supervisor is committed to being ethical and professional					
My supervisor is sensitive to my personal and professional needs					
My supervisor provides empathy, respect, genuineness and immediacy during supervision					
My supervisor has established a mutually trusting relationship with me					
My supervisor provides an appropriate balance of challenge and support					