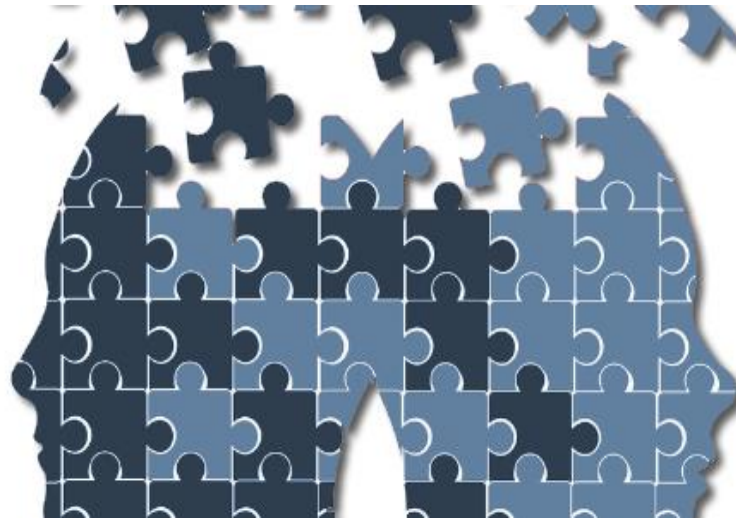




COMPETENCY-BASED SUPERVISION FOR THE 21ST CENTURY



Trauma-Informed Supervision

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Learning Objectives

- Define and discuss current best practices in trauma-informed care (TIC).
- Understand trauma-informed supervision as a parallel-process to TIC
- Develop a basic understanding of common trauma models and interventions.
- Recognize the correlation between Adverse Childhood Experience(s) and medical and psychological health and illness
- Understand risk factors and interventions for secondary traumatic stress experienced by clinicians.
- Understand and utilize the PROQOL Quality of Life scale.



FIRST: THE BACK DROP

The Importance of Context



Trauma-Informed Care (TIC)



Trauma-Informed Care (TIC)

Trauma-Informed Approach

The Four R's

Realization – Realize the potential effects that trauma has upon the systems of the body/mind, the individual, families and communities;

Recognize – Recognize the signs and symptoms of trauma;

Respond – The entire agency/organization responds with trauma-informed principles and practices

Resist Re-traumatization – For both clients and service professionals and volunteers



Core Principles of Trauma-Informed Care (TIC)

- Trustworthiness
- Empowerment
- Choice
- Collaboration
- Safety

(Herman, 1992; Shapiro, 2001)



SAMHSA's Six Key Principles of a Trauma-Informed Approach

A trauma-informed approach reflects adherence to six key principles rather than a prescribed set of practices or procedures. These principles may be generalizable across multiple types of settings, although terminology and application may be setting- or sector-specific:

1. Safety
 2. Trustworthiness and Transparency
 3. Peer support
 4. Collaboration and mutuality
 5. Empowerment, voice and choice
 6. Cultural, Historical, and Gender Issues
-
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1. Safety

- Throughout the organization, the staff and the people they serve feel physically and psychologically safe.
 - Professional and support staff are self-regulated
 - Clear articulation of expectations is provided
 - Seeking permission from client(s) is an expectation
 - A sense of care is felt
-
-



2. Trustworthiness and Transparency

Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of those receiving services.

Owning mistakes

Seeking negative feedback from clients (FIT:Miller & Duncan, 2013)

Client witnesses care staff stretching to assist and accommodate

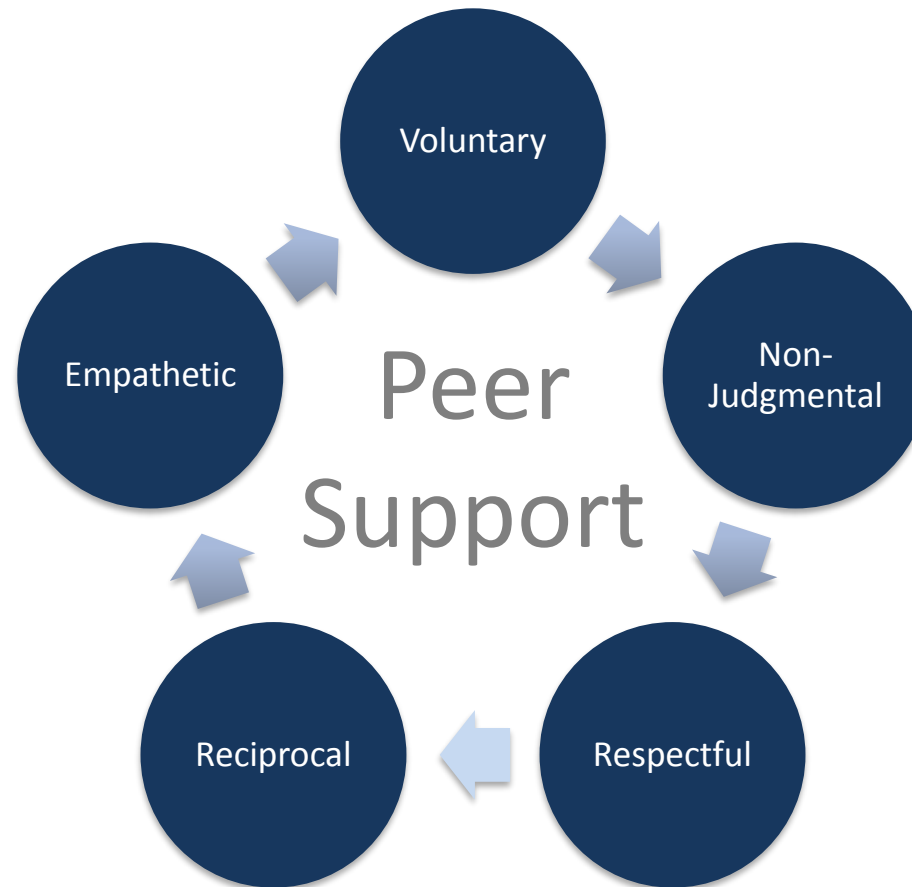
Maintain good boundaries while preserving relationship



3. Peer Support & Mutual Self-Help

Peer support and mutual self- help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, serving as models of recovery and healing, and maximizing a sense of empowerment.

Peer support = A flexible approach to building mutual, healing relationships among equals, based on core values





4. Collaboration and Mutuality

- Leveling of power differences between staff and clients; and among organizational staff from direct care staff to administrators.
 - There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.
 - The organization recognizes that everyone has a role to play in a trauma-informed approach.
 - **One does not have to be a therapist to be therapeutic.**
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5. Empowerment, Voice & Choice

- Throughout the organization and among the clients served, individuals' strengths are recognized, built on, and validated and new skills developed as necessary.
 - The organization aims to strengthen the staff's, clients', and family members' experience of choice and recognize that every person's experience is unique and requires an individualized approach.
 - This includes a belief in resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma.
 - This builds on what clients, staff, and communities have to offer, rather than responding to perceived deficits.
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6. Cultural, Historical, and Gender Issues

- Organization actively moves past cultural stereotypes and biases (e.g., based on race, ethnicity, sexual/affectional orientation, gender identity, age, SES/class, geography)
- Offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses **historical trauma (WHY DON'T THEY JUST . . .)**.

- What are some concrete ways we can “MOVE PAST” cultural stereotypes and biases?
 - How can we honor culture, history and gender issues?
-
-



Tri-Phasic Model

Herman, 1992



- **Safety** (Stabilization)
 - **Remembrance & Mourning**
 - Trauma Resolution
 - Desensitization & reprocessing
 - Metabolization of trauma
 - **Reconnection**
 - Present & future
-



Tri-Phasic Model

1. Safety & Stabilization
2. Remembrance & Mourning
3. (intermediate Skills)
4. Reconnection

Empowerment & Resilience Structure

1. **Preparation & Relationship
Psychoeducation & Skills
Building**
2. **Desensitization &
Integration**
3. **(Intermediate Skills)**
4. **Posttraumatic Growth &
Resilience**



“When the alarm bell of the emotional brain keeps signaling that you are in danger, no amount of insight will silence it.”



Bessel van der Kolk, MD



THE ADVERSE CHILDHOOD EXPERIENCE (ACE) STUDY

Collaboration between Kaiser Permanente's Department of Preventive Medicine in San Diego and the Center for Disease Control and Prevention (CDC)



ACE Study: Nadine Burke-Harris





The Adverse Childhood Experience (ACE) Questionnaire

- A 10-item self-report measure developed for the ACE study to identify childhood experiences of [abuse](#) and neglect. The study posits that childhood [trauma](#) and stress early in life, apart from potentially impairing social, emotional, and cognitive development, indicates a higher risk of developing [health problems](#) in adulthood.



Findings of the Study

- The study found that nearly 40% of participants had been exposed to two or more of the different categories, and 12.5% reported exposure to at least four categories. In other words, the study showed that adverse childhood experiences were more common than had previously been recognized or acknowledged by research and medical findings. The study also identified a direct link between the ACE score and adult [chronic illness](#), as well as emotional and social issues such as [depression](#), [domestic violence](#), and suicide.
 - **ACE Score of 4 or Higher**
 - 2x as likely to smoke
 - 7X as likely to be alcoholics
 - 6x as likely to have had sex before 15 y o
 - 12X more likely to a suicide attempt
 - 2x as likely to have cancer or heart disease
-



Your supervisee reports a client has a trauma history. Is your supervisee prepared to confirm that the symptoms reported are due to the trauma?

USE AN ASSESSMENT



Assessment Instruments

- **ACES:** Aversive Childhood Experiences Scale (Felitti, 1997) <http://traumadissociation.com/ace>
 - **TRS:** Trauma Recovery Scale (Gentry, 1996; 2013)
 - **PCL:** Posttraumatic Checklist (NCPTSD, 2014)
 - **SWLS:** Satisfaction With Life Scale (Deiner, 1989)
 - **CAPS-5:** Clinician Administered PTSD Scale (NCPTSD, 2014)
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Does your Supervisee Provide the First Four Essential Interventions in Trauma-Informed Care ?

Your supervisee must

- Self-regulate their emotional, psychological and physical arousal
- Create an environment of felt and real safety
- Assist the helpee (client) regulate in the helper's (clinician's) presence using relationship before rule
- Assist the helpee (client) regulate self when not with the helper



Trauma-Informed Supervision

- Refers to a supervisory process and relationship designed to enhance the knowledge and skills of the supervisee to provide trauma-informed services.

(Berger & Quiros, 2016)





Definitions of Trauma

- Negotiated between the supervisor and supervisee
- Negotiated between the supervisee and the client
- Imperative in parallel process and the relationship



Supervision for Trauma- Informed Practice

- Characteristics of Supervisee
- Characteristics of Supervisor
- Supervisory Relationship
- Contextual Aspects
- Challenges in Providing Supervision for Trauma-Informed Practice
- Perceived Effective Strategies for Trauma-Informed Practice

(Berger & Quiros, 2016)



Supervisee Characteristics

- Important to know the degree to which supervisees experience vicarious trauma.
- That is, the changes in the counselor's views about themselves and their social world as a result of working with survivors of trauma.



Supervisor Characteristics

- Formal training and practice experience
- Familiarity with trauma-related practice models and willingness to advocate for application
- An expansive definition of trauma (delete language of Big T/Little t Trauma) and awareness of sociopolitical traumatizing environments



Supervisory Relationship

- 1. Structure: Frequent and consistent supervisory meetings with a **readily available** supervisor.
 - 2. Model: Theoretical models that emphasize interpersonal relationships (e.g. object relations, systems, etc.) and the relational aspect of the therapeutic alliance (the supervisory bond; not the supervisory working alliance: SWA)
 - 3. Supervisory Style: Respectful, caring, and supportive
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Effective Strategies for Supervision

- Empowering: Autonomy – supervisees are active participants in the supervisory process
 - Attending to the relational component of the supervisory relationship: the “bond”
 - Creating emotionally safe and supportive place, leading to parallel process between supervisor, supervisee, and the client
 - Disclosing and discussing supervisee’s own trauma experience as it relates to the work
 - Advocating self-care (e.g. Ritual, Reduction of Activation, Safe Place, Bilateral Stimulation, Rest)
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Contextual Aspects

- 1. Population Served: The degree of social stigmatization of clients, their history of oppression, and exposure to diverse traumatic experiences
- 2. Agency Variables: Team work supports the ability of counselors to provide trauma-informed practice.



Co-Occurring Conditions

- Conversations with Supervisee
 - Trauma History of Client
 - Previous Diagnoses
 - Diagnostic Impression of supervisee
 - Can any of the diagnoses be more appropriately explained as trauma-centered or co-occurring with trauma?
 - Is there a cultural component to prior diagnoses?
-
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Challenges

- 1. Complexity of client situations
- 2. Involvements of clients concurrently with other systems that do not employ a trauma-informed lens (e.g. legal system, medical system)
- 3. Limited resources, including insufficient funding (staff and training) compromising the ability to develop and deliver needed services.
- 4. Alexithymia and Dissociation normalization.



Negative Impact

- Acknowledging the negative impact of the work is essential to help clinicians become aware of their own vulnerabilities, attend to self-care, and establish personal and organizational support networks.



Key Concepts in Trauma-Informed Supervision



- Vicarious Trauma
- Compassion Fatigue
- Posttraumatic Growth
- Vicarious Resilience

Had a check-up lately?





Various Trauma/Compassion Fatigue

The term vicarious trauma (Perlman & Saakvitne, 1995), sometimes also called compassion fatigue, is the latest term that describes the phenomenon generally associated with the “cost of caring” for others (Figley, 1982).

Other terms used for compassion fatigue are:

secondary traumatic stress (Stemm, 1995, 1997)

secondary victimization (Figley, 1982)

It is believed that counselors working with trauma survivors experience vicarious trauma because of the work they do.

Vicarious trauma is the emotional residue of exposure that counselors have from working with people as they are hearing their trauma stories and become witnesses to the pain, fear, and terror that trauma survivors have endured.



Posttraumatic Growth

A positive psychological change experienced as a result of adversity and other challenges in order to rise to a higher level of functioning. These circumstances represent significant challenges to the adaptive resources of the individual, and pose significant challenges to their way of understanding the world and their place in it.

Posttraumatic growth is not about returning to the same life as it was previously experienced before a period of traumatic suffering, but rather it is about undergoing significant 'life-changing' psychological shifts in thinking and relating to the world, that contribute to a personal process of change, that is deeply meaningful.



Vicarious Resilience

Vicarious Resilience (Hernandez, Engstrom and Gangsei, 2007), *is the positive effects on helping professionals who witness the healing, recovery, and resilience of persons who have survived severe [traumas](#) in their lives.*

Following in the tradition of [positive psychology](#), vicarious resilience is a strengths-focused concept that does not ignore or supplant the important phenomena of compassion fatigue or [burnout](#), but instead offers a counterbalance, a positive resource to be attended to and nurtured in helping professionals.





Professional Quality of Life Scale — PROQOL (Stamm, 2009)

- Measures
 - Compassion Satisfaction
 - Burnout
 - Secondary Traumatic Stress



I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.



- Maya Angelou



Intermediate Trauma Interventions

- Some, but certainly not all, trauma interventions frequently encountered in trauma work
 - EMDR
 - EFT
 - BrainSpotting
 - Play and Art Therapy



EMDR

- A structured therapy that encourages the patient to briefly focus on the trauma memory while simultaneously experiencing bilateral stimulation (typically eye movements), which is associated with a reduction in the vividness and emotion associated with the trauma memories.
- Eye Movement Desensitization and Reprocessing (EMDR) therapy (Shapiro, 2001) was initially developed in 1987 for the treatment of posttraumatic stress disorder (PTSD) and is guided by the Adaptive Information Processing model (Shapiro 2007). EMDR is an individual therapy typically delivered one to two times per week for a total of 6-12 sessions, although some people benefit from fewer sessions. Sessions can be conducted on consecutive days.





EMDR

- The Adaptive Information Processing model considers symptoms of PTSD and other disorders (unless physically or chemically based) to result from past disturbing experiences that continue to cause distress because the memory was not adequately processed. These unprocessed memories are understood to contain the emotions, thoughts, beliefs and physical sensations that occurred at the time of the event. When the memories are triggered these stored disturbing elements are experienced and cause the symptoms of PTSD and/or other disorders.
- Three prongs: Targets past experiences, current triggers and future potential challenges.
- Dual Attention Awareness



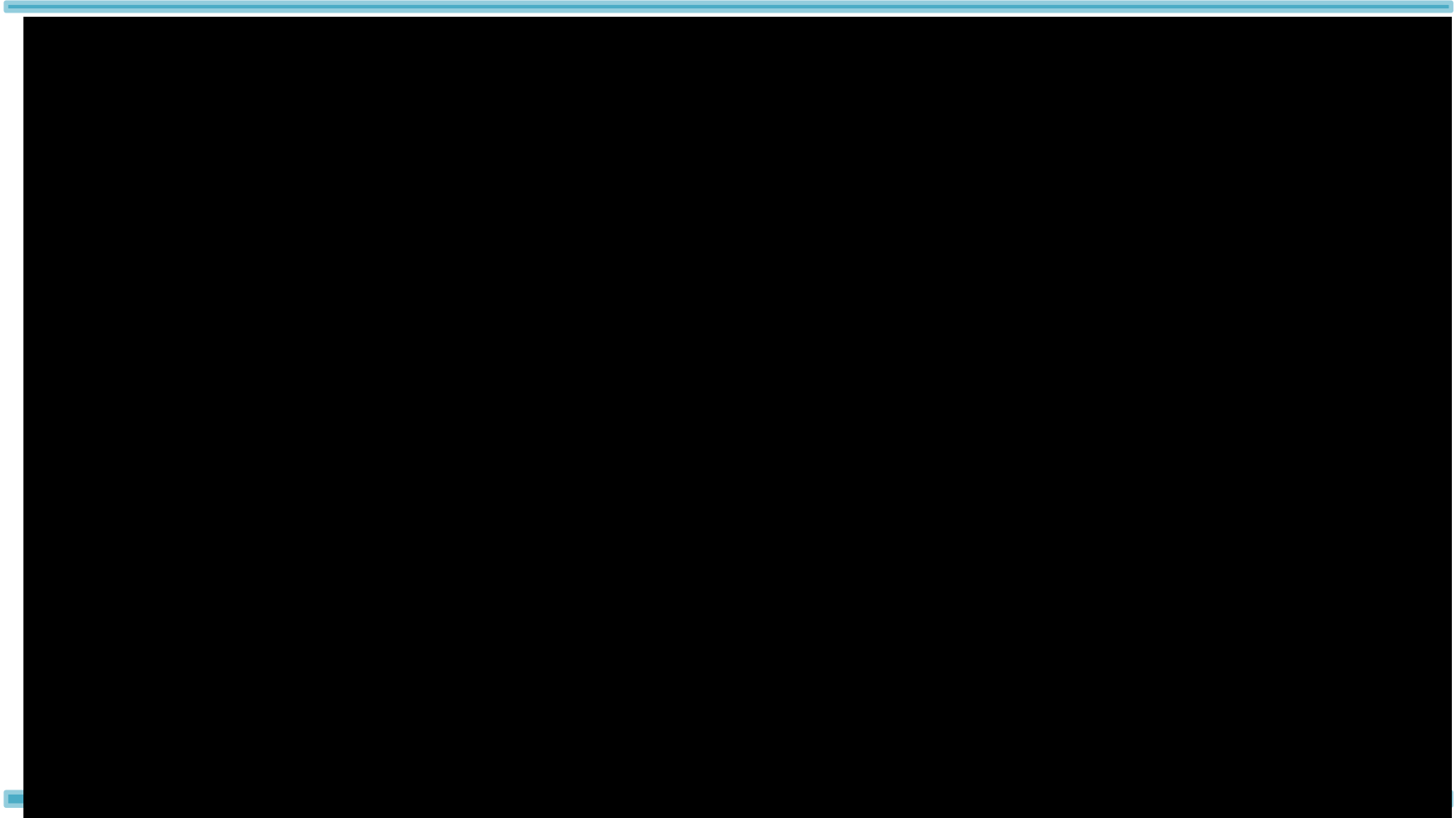


EMDR

EMDR therapy uses a structured eight-phase approach that includes:

- Phase 1: History-taking
- Phase 2: Preparing the client
- Phase 3: Assessing the target memory
 - Validity of Cognition (VOC) Scale
 - Subjective Units of Disturbance (SUD) scale
- Phases 4-7: Processing the memory to adaptive resolution
 - During this phase, the client focuses on the memory, while engaging in eye movements or other BLS. Then the client reports whatever new thoughts have emerged. The therapist determines the focus of each set of BLS using standardized procedures. Usually the associated material becomes the focus of the next set of brief BLS. This process continues until the client reports that the memory is no longer distressing.
 - Installation
 - Body Scan
 - Closure
- Phase 8: Evaluating treatment results

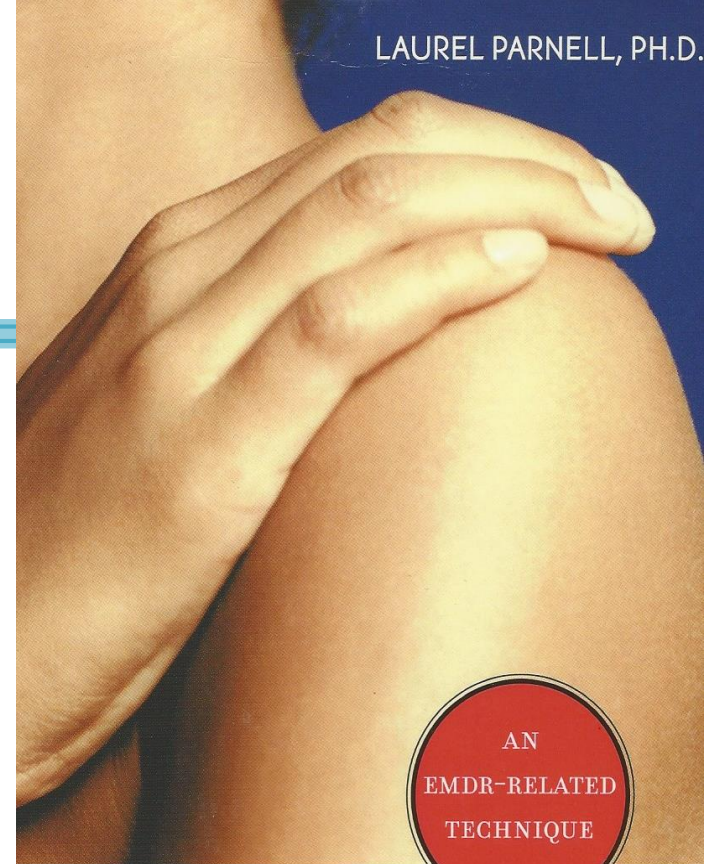
(<http://www.apa.org/ptsd-guideline/treatments/eye-movement-reprocessing.aspx>)



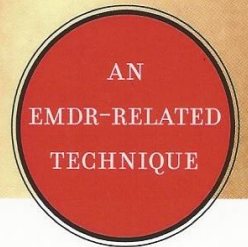


EFT – Tapping In

- Laurel Parnell – EMDR therapist created EFT (Emotional Freedom Techniques)
- Related to acupuncture and the use of body meridians.
- Use of guided imagery and affirmations in conjunction with tapping.



LAUREL PARNELL, PH.D.



Tapping In

A STEP-BY-STEP GUIDE TO
ACTIVATING YOUR HEALING RESOURCES
THROUGH BILATERAL STIMULATION

Reduce Anxiety
Sleep Better
Overcome Trauma



EFT Demonstration





BrainSpotting

According to therapist and creator David Grand, the direction in which people look or gaze can affect the way they feel.

During brainspotting, therapists help people position their eyes in ways that enable them to target sources of negative emotion.

With the aid of a pointer, trained brainspotting therapists slowly guide the eyes of people in therapy across their field of vision to find appropriate “brainspots,” with a brainspot being an eye position that activates a traumatic memory or painful emotion.



Arts-Based Interventions

- Coloring (mandalas, free form, guided) during trauma processing.
- Mask Making
- Modeling Clay (somatic)



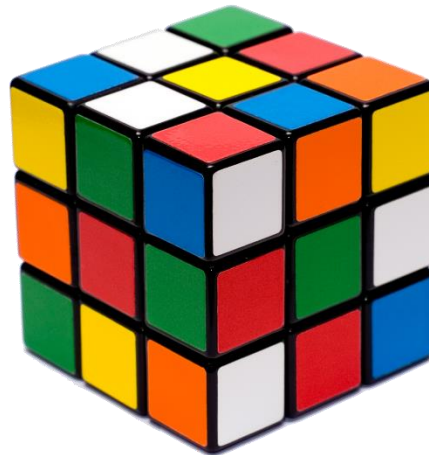


Trauma-Informed Care & Supervision

Q & A

Ernő Rubik, a professor from Budapest In Hungary, wanted to help his students understand three dimensional problems. His solution? The Rubik's Cube!

His solid cube did things that the world hadn't seen before. It twisted and turned yet it didn't break.



How does the construct of the Rubik's cube relate to
TIC and Trauma-Informed Supervision?