2 Building a Trauma-Informed Workforce

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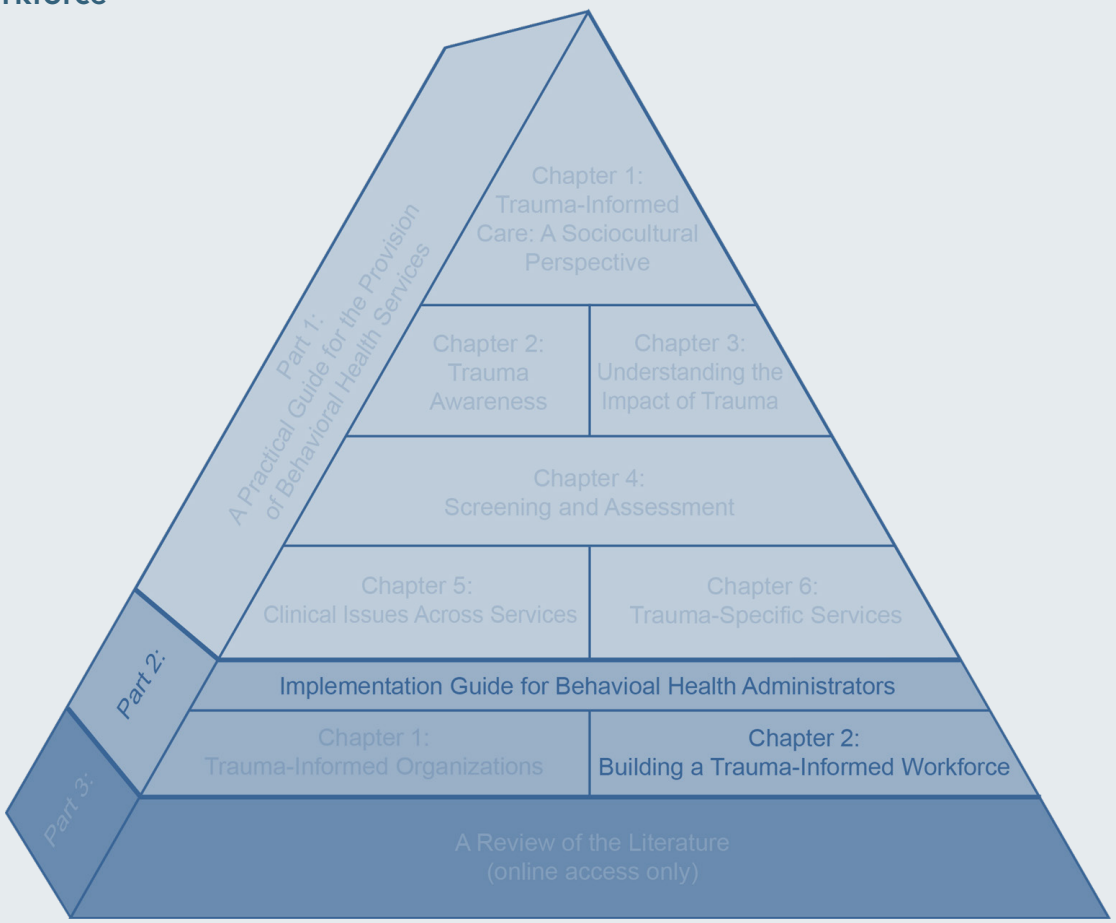
Introduction

For an organization to embrace a trauma-informed care (TIC) model fully, it must adopt a trauma-informed organizational mission and commit resources to support it. This entails implementing an agency-wide strategy for workforce development that is in alignment with the values and principles of TIC and the organization's mission statement. Without a fully trained staff, an organization will not be able to implement the TIC model. However, simply training behavioral health professionals in TIC is not enough. Counselors will not be able to sustain the kind of focus required to adopt and implement a trauma-informed philosophy and services without the ongoing support of administrators and clinical supervisors.

An organizational environment of care for the health, well-being, and safety of, as well as respect for, its staff will enhance the ability of counselors to provide the best possible trauma-informed behavioral health services to clients. This culture of care must permeate the organization from top to bottom. Behavioral health program administrators should aim to strengthen their workforce; doing so "requires creating environments that support the health and well-being, not only of persons with mental and substance use conditions, but of the workforce as well" (Hoge, 2007, p. 58). An organizational culture of care, safety, and respect demands activities that foster the development of trauma-informed counselors. This chapter focuses on key workforce development activities, such as:

- Recruiting, hiring, and retaining trauma-informed staff.
- Training behavioral health service providers on the principles of, and evidence-based and emerging best practices relevant to, TIC.
- Developing and promoting a set of counselor competencies specific to TIC.

TIC Framework in Behavioral Health Services—Building a Trauma-Informed Workforce



- Delineating the responsibilities of counselors and addressing ethical considerations specifically relevant to promoting TIC.
- Providing trauma-informed clinical supervision.
- Committing to prevention and treatment of secondary trauma of behavioral health professionals within the organization.

Addressing each of these areas is essential to building a trauma-informed workforce and an organizational culture that supports TIC.

Workforce Recruitment, Hiring, and Retention

An Action Plan for Behavioral Health Workforce Development (Hoge et al., 2007) emphasizes the importance of organization-wide support and active involvement in workforce recruitment, hiring, and retention in behavioral health systems. One of the key findings of this report is that the work environment itself in many behavioral health settings can be toxic to the workforce and may hinder the delivery of individualized, respectful, collaborative, and client-centered care to service recipients. Factors such as the downward pressure on organizations for higher productivity of counselors increase caseloads and decrease wages of behavioral health staff members and may create a high-stress environment that contributes to low morale and worker dissatisfaction. Other factors that often contribute to low retention of qualified counselors in behavioral health settings include the lack of professional career

ladders, fragile job security, the lack of clinical supervision, and an inability to influence the organization in which they are working (Hoge et al., 2007).

Added to this mix is the intensity of working with people with the co-occurring conditions of trauma-related mental and substance use disorders and the risk of secondary traumatization of counselors. In creating and sustaining a trauma-informed workforce, organizations need to foster a work environment that parallels the treatment philosophy of a trauma-informed system of care. Doing so allows counselors to count on a work environment that values safety, endorses collaboration in the making of decisions at all levels, and promotes counselor well-being.

Recruitment and Hiring in a Trauma-Informed System of Care

In a 2007 technical report (Jennings, 2007b), the National Center for Trauma-Informed Care identified several priorities for organizations with regard to recruitment and hiring trauma-informed staff, including:

- Active recruitment of and outreach to prospective employees who are trauma-informed or have formal education in providing trauma-informed or trauma-specific services in settings such as universities, professional organizations, professional training and conference sites, peer support groups, and consumer advocacy groups.
- Hiring counselors and peer support staff members with educational backgrounds and training in trauma-informed and/or trauma-specific services and/or lived experience of trauma and recovery.
- Providing incentives, bonuses, and promotions for staff members during recruitment and hiring that take into consideration prospective employees' trauma-related education, training, and job responsibilities.

In addition to hiring behavioral health professionals with formal professional education and training, organizations should also "routinely survey the demographics and other characteristics of the population served and recruit a workforce of similar composition" (Hoge et al., 2007, p. 297). Essentially, this means actively engaging in outreach to consumer advocacy groups, recovery-oriented programs, community and faith-based organizations, and former clients/consumers with the intention of recruiting potential employees whose knowledge and expertise comes from their lived experience of trauma, resilience, and recovery. Support staff members, peer support workers, counselors in training, and apprentices can be recruited from this population and offered incentives, such as tuition reimbursement, training stipends, and professional mentoring with the goal of developing a trauma-informed workforce from within the demographic served. Jennings (2007b) calls these staff members "trauma champions" who can provide needed expertise in a trauma-informed organization to promote trauma-informed policies, staff development, and trauma-based services consistent with the mission of the organization (p. 135).

Who Is a Trauma Champion?

"A champion understands the impact of violence and victimization on the lives of people seeking mental health or addiction services and is a front-line worker who thinks 'trauma first.' When trying to understand a person's behavior, the champion will ask, 'is this related to abuse and violence?' A champion will also think about whether his or her own behavior is hurtful or insensitive to the needs of a trauma survivor. The champion is there to do an identified job—he is a case manager or a counselor or a residential specialist—but in addition to his or her job, a champion is there to shine the spotlight on trauma issues."

Source: Harris & Fallot, 2001a, p. 8.

As with hiring behavioral health professionals who are in recovery from substance use disorders, the organization should be transparent and explicit in its recruitment and hiring practices of trauma survivors in recovery. The organization can be transparent by advertising the mission statement of the organization as part of the recruitment process and inviting applicants who are in recovery from trauma to apply. The needs of behavioral health staff members who are in recovery from both substance use and trauma-related conditions and working in a trauma-informed system of care should be addressed in the organization's ongoing training, clinical supervision, and staff development policies and practices.

Workforce Retention

Staff turnover is rampant in behavioral health settings. It is costly to the organization, and as a result, it is costly to clients. A strong therapeutic relationship with a counselor is one of the largest factors in an individual's ability to recover from the overwhelming effects of trauma. When behavioral health professionals leave an organization prematurely or in crisis as a result of chronic levels of high stress or secondary traumatization, clients must deal with disruptions in their relationships with counselors. Some of the organizational factors that contribute to chronic levels of high stress and often lead to high staff turnover include expecting counselors to maintain high caseloads of clients who have experienced trauma; not providing trauma-informed clinical supervision and training to counselors; and failing to provide adequate vacation, health insurance, and other reasonable benefits that support counselors' well-being. Other factors that may have a more profound impact on staff retention include failing to acknowledge the reality of secondary traumatization, promoting the view that counselors' stress reactions are a personal failure instead of a normal response to engaging with clients' traumatic material, and not supporting personal psychotherapy for counselors (Saakvitne, Pearlman, & Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy, 1996).

Research on promoting counselor retention in behavioral health settings demonstrates that

Advice to Administrators: Preventing Turnover and Increasing Workforce Retention

To prevent behavioral health staff turnover and increase retention of qualified, satisfied, and highly committed trauma-informed counselors, consider:

- Offering competitive wages, benefits, and performance incentives that take into account education, training, and levels of responsibility in providing trauma-informed or trauma-specific services.
- Creating a safe working environment that includes both the physical plant and policies and procedures to prevent harassment, stalking, and/or violence in the workplace and to promote respectful interactions amongst staff at all levels of the organization.
- Establishing an organizational policy that normalizes secondary trauma as an accepted part of working in behavioral health settings and views the problem as systemic—not the result of individual pathology or a deficit on the part of the counselor.
- Instituting reasonable, manageable caseloads that mix clients with and without trauma-related concerns.
- Letting staff offer input into clinical and administrative policies that directly affect their work experience.
- Providing vacation, health insurance (which includes coverage for psychotherapy/personal counseling), and other benefits that promote the well-being of the staff.
- Implementing regular, consistent clinical supervision for all clinical staff members.
- Providing ongoing training in trauma-informed services offered by the organization.

behavioral health staff members are interested in the same kind of work environment and benefits as employees in many other fields. They include a "living wage with healthcare benefits; opportunities to grow and advance; clarity in a job role; some autonomy and input into decisions; manageable workloads; administrative support without crushing administrative burden; basic orientation and training for assigned responsibilities; a decent and safe physical work environment; a competent and cohesive team of coworkers; the support of a supervisor; and rewards for exceptional performance" (Hoge et al., 2007, p. 18).

When an organization's administration values its staff by providing competitive salaries and benefits, a safe working environment, a reasonable and manageable workload, input into the making of clinical and administrative policy decisions, and performance incentives, it helps behavioral health workers feel connected to the mission of the organization and become dedicated to its sustainability and growth. This type of work environment demonstrates both a level of respect for counselors (similar to the level of respect a trauma-informed organization displays toward clients) and an appreciation for the complexity of their job responsibilities and the stress they face when working with people who have experienced trauma in their lives. To retain behavioral health professionals working in a trauma-informed setting, wages and performance incentives should be tied not only to education, training, and work experience, but also to levels of responsibility in working with clients who have experienced trauma.

Training in TIC

Training for all staff members is essential in creating a trauma-informed organization. It may seem that training should simply focus on new counselors or on enhancing the skill level of those who have no prior experience in working with trauma, but training should, in fact, be more systematic across the organization to develop fully sustainable trauma-informed services. All employees, including administrative staff members, should receive an orientation and basic education about the prevalence of trauma and its impact on the organization's clients. To ensure safety and reduction of harm, training should cover dynamics of retraumatization and how practice can mimic original sexual and physical abuse experiences, trigger trauma responses, and cause further harm to the person. Training for all employees must also educate them "about the impacts of culture, race, ethnicity, gender, age, sexual orientation, disability, and socioeconomic status on individuals' experiences of trauma" (Jennings, 2007a, p. 5).

All clinical and direct service staff members, regardless of level of experience, should receive more indepth training in screening and assessment of substance use and trauma-related disorders; the relationships among trauma, substance use disorders, and mental disorders; how to understand difficult client behaviors through a trauma-informed lens; how to avoid retraumatizing clients in a clinical setting; the development of personal and professional boundaries unique to clinical work with traumatized clients; how to identify the signs of secondary traumatization in themselves; and how to develop a comprehensive personal and professional self-care plan to prevent and/or ameliorate the effects of secondary traumatization in the workplace. All clinical staff members who work with traumatized clients should receive additional training in evidence-based and promising practices for the treatment of trauma (for information on locating training, see Appendix B.) This might include training done within the agency by experts in the field or training received by attending advanced trauma trainings. Administrators

should provide the time and financial resources to clinical staff members for this professional development activity. Jennings (2007a) suggests that, whenever possible, "trainings should be multi-system, inclusive of staff in mental health and substance abuse, health care, educational, criminal justice, social services systems and agencies, and promoting systems integration and coordination" (p. 5).

Moreover, criminal justice settings, schools, military/veteran programs, and other places in which behavioral health services are provided may benefit from approaches that are sensitive to the special circumstances and cultures of these environments. For example, in exploring trauma-informed correctional care, Miller and Najavits (2012, p. 1) observe:

> Prisons are challenging settings for trauma-informed care. Prisons are designed to house perpetrators, not victims. Inmates arrive shackled and are crammed into overcrowded housing units; lights are on all night, loud speakers blare without warning and privacy is severely limited. Security staff is focused on maintaining order and must assume each inmate is potentially violent. The correctional environment is full of unavoidable triggers, such as pat downs and strip searches, frequent discipline from authority figures, and restricted movement….This is likely to increase trauma-related behaviors and symptoms that can be difficult for prison staff to manage….Yet, if trauma-informed principles are introduced, all staff can play a major role in minimizing triggers, stabilizing offenders, reducing critical incidents, deescalating situations, and avoiding restraint, seclusion or other measures that may repeat aspects of past abuse.

The Need for Training

Behavioral health service providers working with clients who have mental, substance use, and trauma-related disorders need to have the best knowledge, skills, and abilities. Substance abuse counselors, in particular, require additional training and skill development to be able to extend trauma-informed services (within the

Case Illustration: Larry

Larry is a 28-year-old clinical social worker who just finished his master's program in social work and is working in a trauma-informed outpatient program for people with substance use disorders. He is recovering from alcohol use disorder and previously worked in a residential rehabilitation program as a recovery support counselor. There, his primary responsibilities were to take residents to Alcoholics Anonymous (AA) meetings, monitor their participation, and confront them about their substance use issues and noncompliance with the program's requirement of attendance at 12-Step meetings.

In Larry's new position as a counselor, he confronts a client in his group regarding her discomfort with attending AA meetings. The client reports that she feels uncomfortable with the idea that she has to admit that she is powerless over alcohol to be accepted by the group of mostly men. She was sexually abused by her stepfather when she was a child and began drinking heavily and smoking pot when she was 11 years old. The client reacts angrily to Larry's intervention.

In supervision, Larry discusses his concerns regarding the client's resistance to AA and the feedback that he provided to her in group. Beyond focusing supervision on Larry's new role as a counselor in a trauma-informed program, the clinical supervisor recommends that Larry take an interactive, multisession, computer-assisted training on the 12-Step facilitation (TSF) model. The TSF model introduces clients to and assists them with engaging in 12-Step recovery support groups. The agency has the computer-based training available in the office, and Larry agrees to use follow-up coaching sessions with his supervisor to work on implementation of the approach. The supervisor recognizes that Larry is falling back on his own recovery experience and the strategies he relied on in his previous counseling role. He will benefit from further training and coaching in an evidence-based practice that provides a nonaggressive, focused, and structured way to facilitate participation in recovery support groups with clients who have trauma histories.

limits of their professional licensure and scope of practice) to clients who have co-occurring substance use, trauma-related, or mental disorders. Many clinical practice issues in traditional substance abuse treatment are inconsistent with trauma-informed practice, which needs to be addressed with further training. Similarly, mental health clinicians often need training in substance abuse treatment, as they typically do not have backgrounds or experience in that domain. Moreover, several surveys indicate that clinicians consistently perceive the combination of trauma and substance abuse as harder to treat than either one alone (Najavits, Norman, Kivlahan, & Kosten, 2010). It is thus key to emphasize cross-training as part of TIC. Exhibit 2.2-1 addresses these issues and offers suggestions for additional training.

Exhibit 2.2-1: Clinical Practice Issues Relevant to Counselor Training in Trauma-Informed Treatment Settings

- Some substance abuse counseling strategies commonly used to work through clients' denial and minimization of their substance use issues may be inappropriate when working with trauma survivors (e.g., highly confrontational models can remind trauma survivors of emotional abuse).

  Training: The Stages of Change model of addiction treatment can help counselors shift from the traditional confrontation of denial to conceptualizing clients' ambivalence about changing substance use patterns as a normal part of the precontemplation stage of change. This method is a respectful cognitive–behavioral approach that helps counselors match counseling strategies to their assessment of where each client is in each stage of change, with the ultimate goal of helping clients make changes to health risk behaviors. (Connors, Donovan, & DiClemente, 2001).

- The 12-Step concept of powerlessness (Step 1) may seem unhelpful to trauma survivors for whom the emotional reaction to powerlessness is a major part of their trauma (particularly for victims of repetitive trauma, such as child abuse or intimate partner violence). It can be confusing and counterproductive to dwell on this concept of powerlessness regarding trauma when the therapeutic objective for trauma-informed counseling methods should be to help clients empower themselves. For people in recovery, powerlessness is a paradox, sometimes misunderstood by both counselors and clients, in that the acknowledgment of powerlessness often creates a sense of empowerment. Most clients, with support and respectful guidance from a counselor, will come to understand that powerlessness (as used in 12-Step programs) is not an inability to stand up for oneself or express a need, and it does not mean for one to be powerless in the face of abuse. With this understanding, clients may become more open to participating in 12-Step groups as a resource for their recovery from substance use disorders. When clients continue to struggle with this concept and decline to participate in 12-Step recovery efforts, they may benefit from referral to other forms of mutual-help programs or recovery support groups in which the concept of powerlessness over the substance of abuse is not such a significant issue.

  Training: The TSF model can help counselors develop a more supportive and understanding approach to facilitating clients' involvement in 12-Step recovery groups (if this is a client-generated recovery goal). "Although based on standard counseling models, TSF differs from them in several ways. These differences include TSF's strong emphasis on therapist support, discouragement of aggressive 'confrontation of denial' and therapist self-disclosure, and highly focused and structured format" (Sholomskas & Carroll, 2006, p. 939).

  Another well-intentioned, but often misguided, approach by counselors who have not had formal or extensive training is "digging" for trauma memories without a clear therapeutic rationale or understanding of client readiness. In doing so, the counselor may unintentionally retraumatize the client or produce other harmful effects. In early intervention, it is sufficient simply to acknowledge and validate the pain and suffering of the client without uncovering or exploring specific trauma memories. The counselor who is insufficiently trained in trauma-informed clinical

(Continued on the next page.)

Exhibit 2.2-1: Clinical Practice Issues Relevant to Counselor Training in Trauma-Informed Treatment Settings (continued)

practice may also press agendas that are ultimately unhelpful, such as insisting that the client forgive an abuser, pursue a legal case against a perpetrator, or engage in trauma treatment, even when the client may not be ready for such steps. These efforts are particularly inappropriate for clients in early recovery from substance use disorders. The first goal in treatment is stabilization

Training: The Seeking Safety model of treating substance abuse and posttraumatic stress disorder (PTSD) can help counselors focus on the primary goal of stabilization and safety in TIC. This model emphasizes safety as the target goal, humanistic themes such as honesty and compassion, and making cognitive–behavioral therapy accessible and interesting to clients who may otherwise be difficult to engage (Najavits, 2002a).

- Treatment should be client-centered; it should acknowledge the client's right to refuse counseling for trauma-related issues. It is important to discuss the advantages and disadvantages of exploring trauma-related concerns, and then, following an open discussion, to allow clients the right to choose their path. This discussion should be part of the informed consent process at the start of treatment. Clients also have the right to change their minds.

  Training: Motivational interviewing, a client-centered, nonpathologizing counseling method, can aid clients in resolving ambivalence about and committing to changing health risk behaviors including substance use, eating disorders, self-injury, avoidant and aggressive behaviors associated with PTSD, suicidality, and medication compliance (Arkowitz, Miller, Westra, & Rollnick, 2008; Kress & Hoffman, 2008). Training in MI can help counselors remain focused on the client's agenda for change, discuss the pros and cons of treatment options, and emphasize the personal choice and autonomy of clients.

In addition to the training needs of substance abuse counselors, all direct care workers in mental health settings, community-based programs, crisis intervention settings, and criminal justice environments should receive training in TIC. Guidelines for training in assisting trauma-exposed populations are presented in Exhibit 2.2-2.

Continuing Education

Research on the effectiveness of single-session didactic and/or skill-building workshops

Exhibit 2.2-2: Guidelines for Training in Mental Health Interventions for Trauma-Exposed Populations

After a year of collaboration in 2002, the Task Force on International Trauma Training of the International Society for Traumatic Stress Studies published a consensus-based set of recommendations for training. Core curricular elements of the recommended training include:

- Competence in listening.
- Recognition of psychosocial and mental problems to promote appropriate assessment.
- Familiarity with established interventions in the client population.
- Full understanding of the local context, including help-seeking expectations, duration of treatment, attitudes toward intervention, cost-effectiveness of intervention, and family attitudes and involvement.
- Strategies for solving problems on the individual, family, and community levels.
- Treatment approaches for medically unexplained somatic pain.
- Collaboration with existing local resources and change agents (e.g., clergy, traditional healers, informal leaders).
- Self-care components.

Source: Weine et al., 2002.

Advice to Administrators: Trauma-Informed Staff Training

- Establish training standards for the evidence-based and promising trauma-informed practice models (such as Seeking Safety) adopted by your organization.
- Bring expert trainers with well-developed curricula in TIC and trauma-specific practices into your organization.
- Select a core group of clinical supervisors and senior counselors to attend multisession training or certification programs. These clinicians can then train the rest of the staff.
- Use sequenced, longitudinal training experiences instead of single-session seminars or workshops.
- Emphasize interactive and experiential learning activities over purely didactic training.
- Provide ongoing mentoring/coaching to behavioral health professionals in addition to regular clinical supervision to enhance compliance with the principles and practices of TIC and to foster counselor mastery of trauma-specific practice models.
- Build organization-wide support for the ongoing integration of new attitudes and counselor skills to sustain constructive, TIC-consistent changes in practice patterns.
- Provide adequate and ongoing training for clinical supervisors in the theory and practice of clinical supervision and the principles and practices of TIC.
- Include information and interactive exercises on how counselors can identify, prevent, and ameliorate secondary traumatic stress (STS) reactions in staff trainings.
- Offer cross-training opportunities to enhance knowledge of trauma-informed processes throughout the system.

demonstrates that immediate gains in counselor knowledge and skills diminish quickly after the training event (Martino, Canning-Ball, Carroll, & Rounsaville, 2011). Consequently, organizations may be spending their scarce financial resources on sending counselors to this kind of training but may not be reaping adequate returns with regard to long-lasting changes in counselor skills and the development of trauma-informed and trauma-specific counselor competencies. Hoge et al. (2007) suggest the implementation of training strategies for behavioral health professionals that have proven to be effective in improving counselor skills, attitudes, and practice approaches. These strategies include: "interactive approaches; sequenced, longitudinal learning experiences; outreach visits, known as academic detailing; auditing of practice with feedback to the learner; reminders; the use of opinion leaders to influence practice; and patient-mediated interventions, such as providing information on treatment options to persons in recovery, which in turn influences the practice patterns of their providers" (p. 124).

Trauma-Informed Counselor Competencies

Hoge et al. (2007) identified a number of counselor competencies in behavioral health practices that are consistent with the skills needed to be effective in a trauma-informed system of care. They include person-centered planning, culturally competent care, development of therapeutic alliances, shared responsibility for decisions, collaboratively developed recovery plans, evidence-based practices, recovery- and resilience-oriented care, interdisciplinary- and team-based practice, and consumer/client advocacy. In addition, counselor competencies critical to the effective delivery of services to clients with trauma-related disorders include:

- Screening for and assessment of trauma history and trauma-related disorders, such as mood and anxiety disorders.
- Awareness of differences between trauma-informed and trauma-specific services.

- Understanding the bidirectional relationships among substance use and mental disorders and trauma.
- Engagement in person-centered counseling.
- Competence in delivering trauma-informed and trauma-specific evidence-based interventions that lessen the symptoms associated with trauma and improve quality of life for clients.
- Awareness of and commitment to counselor self-care practices that prevent or lessen the impact of secondary traumatization on behavioral health workers.

Exhibit 2.2-3 provides a checklist of competencies for counselors working in trauma-informed behavioral health settings. Administrators and clinical supervisors can use this checklist to assess behavioral health professionals' understanding of trauma awareness and counseling skills and determine the need for additional training and clinical supervision.

Counselor Responsibilities and Ethics

Treating all clients in an ethical manner is an expectation of all healthcare providers. It is of special importance when working with clients who have trauma-related disorders, as their trust in others may have been severely shaken. Counselors who work with traumatized individuals on a regular basis have special responsibilities to their clients because of the nature of this work. Administrators and clinical supervisors in trauma-informed organizations should develop policies that clearly define the counselors' job and should provide education about the role of counselors in the organization and their responsibilities to clients.

General Principles Regarding Counselor Responsibilities

The following are some general principles governing the responsibilities of counselors who provide behavioral health services for clients with histories of trauma:

- Counselors are responsible for routinely screening clients for traumatic experiences and trauma-related symptoms (Ouimette & Brown, 2003; see also Treatment Improvement Protocol [TIP] 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, Center for Substance Abuse Treatment [CSAT], 2005c).
- Counselors should offer clients with substance use and trauma-related disorders continuing mental health services if it is within their professional license and scope of practice to do so.
- Counselors are responsible for referring clients with substance use disorders and co-occurring trauma-related disorders to treatment that addresses both disorders when the treatment falls outside of the counselor's professional license and scope of practice (Ouimette & Brown, 2003).
- Counselors should refer clients with substance use disorders and co-occurring trauma-related disorders to concurrent participation in mutual-help groups if appropriate (Ouimette & Brown, 2003).
- Counselors have a responsibility to practice the principles of confidentiality in all interactions with clients and to respect clients' wishes not to give up their right to privileged communication.
- Counselors are responsible for educating clients about the limits of confidentiality and what happens to protected health information, along with the client's privilege, when the client signs a release of information or agrees to assign insurance benefits to the provider.
- Counselors must inform clients that treatment for trauma-related disorders is always voluntary.
- Counselors are responsible for being aware of their own secondary trauma and

Exhibit 2.2-3: Trauma-Informed Counselor Competencies Checklist

Trauma Awareness

___ Understands the difference between trauma-informed and trauma-specific services

___ Understands the differences among various kinds of abuse and trauma, including: physical, emotional, and sexual abuse; domestic violence; experiences of war for both combat veterans and survivors of war; natural disasters; and community violence

___ Understands the different effects that various kinds of trauma have on human development and the development of psychological and substance use issues

___ Understands how protective factors, such as strong emotional connections to safe and nonjudgmental people and individual resilience, can prevent and ameliorate the negative impact trauma has on both human development and the development of psychological and substance use issues

___ Understands the importance of ensuring the physical and emotional safety of clients

___ Understands the importance of not engaging in behaviors, such as confrontation of substance use or other seemingly unhealthy client behaviors, that might activate trauma symptoms or acute stress reactions

___ Demonstrates knowledge of how trauma affects diverse people throughout their lifespans and with different mental health problems, cognitive and physical disabilities, and substance use issues

___ Demonstrates knowledge of the impact of trauma on diverse cultures with regard to the meanings various cultures attach to trauma and the attitudes they have regarding behavioral health treatment

___ Demonstrates knowledge of the variety of ways clients express stress reactions both behaviorally (e.g., avoidance, aggression, passivity) and psychologically/emotionally (e.g., hyperarousal, avoidance, intrusive memories)

Counseling Skills

___ Expedites client-directed choice and demonstrates a willingness to work within a mutually empowering (as opposed to a hierarchical) power structure in the therapeutic relationship

___ Maintains clarity of roles and boundaries in the therapeutic relationship

___ Demonstrates competence in screening and assessment of trauma history (within the bounds of his or her licensing and scope of practice), including knowledge of and practice with specific screening tools

___ Shows competence in screening and assessment of substance use disorders (within the bounds of his or her licensing and scope of practice), including knowledge of and practice with specific screening tools

___ Demonstrates an ability to identify clients' strengths, coping resources, and resilience

___ Facilitates collaborative treatment and recovery planning with an emphasis on personal choice and a focus on clients' goals and knowledge of what has previously worked for them

___ Respects clients' ways of managing stress reactions while supporting and facilitating taking risks to acquire different coping skills that are consistent with clients' values and preferred identity and way of being in the world

___ Demonstrates knowledge and skill in general trauma-informed counseling strategies, including, but not limited to, grounding techniques that manage dissociative experiences, cognitive–behavioral tools that focus on both anxiety reduction and distress tolerance, and stress management and relaxation tools that reduce hyperarousal

(Continued on the next page.)

Exhibit 2.2-3: Trauma-Informed Counselor Competencies Checklist (continued)

___ Identifies signs of STS reactions and takes steps to engage in appropriate self-care activities that lessen the impact of these reactions on clinical work with clients

___ Recognizes when the needs of clients are beyond his or her scope of practice and/or when clients' trauma material activates persistent secondary trauma or countertransference reactions that cannot be resolved in clinical supervision; makes appropriate referrals to other behavioral health professionals

Source: Abrahams et al., 2010.

countertransference reactions and seeking appropriate help in responding to these reactions so that they do not interfere with the best possible treatment for clients.

TIC organizations have responsibilities to clients in their care, including:

- Protecting client confidentiality, particularly in relation to clients' trauma histories. Organizations should comply with the State and Federal laws that protect the confidentiality of clients being treated for mental and substance use disorders.
- Providing clients with an easy-to-read statement of their rights as consumers of mental health and substance abuse services, including the right to confidentiality (Exhibit 2.2-4).
- Providing quality clinical supervision to all counselors and direct-service workers, with an emphasis on TIC. Organizations should, at minimum, comply with State licensing requirements for the provision of clinical supervision to behavioral health workers.
- Establishing and maintaining appropriate guidelines and boundaries for client and counselor behavior in the program setting.
- Creating and maintaining a trauma-informed treatment environment that respects the clients' right to self-determination and need to be treated with dignity and respect.
- Maintaining a work environment that reinforces and supports counselor self-care.

All behavioral health professionals are responsible for abiding by professional standards of care that protect the client. Breaches of confidentiality, inappropriate conduct, and other violations of trust can do further harm to clients who already have histories of trauma. Many treatment facilities have a Client Bill of Rights (or a similar document) that describes the rights and responsibilities of both the counselors and the participants; it often is part of the orientation and informed consent process when a client enters treatment. However, simply reading and acknowledging the receipt of a piece of paper is not a substitute for the dialog that needs to happen in a collaborative therapeutic partnership. Administrators are responsible for providing clients with easy-to-read information describing counselor responsibilities and client rights. Clinical supervisors are responsible for helping counselors engage in a respectful dialog with clients about those rights and responsibilities as part of a comprehensive informed consent process.

Exhibit 2.2-4 is an excerpt from a Client Bill of Rights that outlines clients' right to confidentiality in plain language that is readable and easily understood.

Exhibit 2.2-4: Sample Statement of the Client's Right to Confidentiality From a Client Bill of Rights

Tri-County Mental Health Services is a trauma-informed mental health and substance abuse treatment agency in Maine. Below is a statement regarding clients' right to confidentiality and staff responsibility to protect that privilege; this statement is provided in a brochure outlining consumer rights that is easily accessible to service recipients at the agency and online.

Confidentiality

We will not give out information about you to anyone without your knowledge and permission. This includes written information from your record and verbal information from your providers. Additionally, we will not request any information about you without your knowledge and permission. A Release of Information Form allows you to say what information can be shared and with whom. You determine the length of time this is valid, up to one year.

Tri-County policies prevent any employee of the agency who does not have a direct need to know from having access to any information about you. The penalty for violation can include immediate dismissal.

Exceptions to this rule of confidentiality include times when a client is at immediate risk of harm to self or others, or when ordered by the court. We will make every effort to notify you in these instances.

Source: Tri-County Mental Health Services, 2008, pp. 6-7.

Ethics in Treating Traumatized Clients

All behavioral health professionals must conform to the ethical guidelines established by their profession's State licensing boards and/or certifying organizations. State licensing boards for substance abuse counseling, psychiatry, social work, psychology, professional counseling, and other behavioral health professions provide regulatory standards for ethical practice in these professions. These boards also have specific procedures for responding to complaints regarding the actions of professional caregivers. Additionally, national professional societies have standards for ethical practices. Members of these organizations are expected to practice within the boundaries and scope of these standards. Some of these standards are quite explicit, whereas others are more general; most approach professional ethics not as a rigid set of rules, but rather, as a process of making ethical decisions.

Clinical supervisors are responsible for informing counselors of their ethical responsibilities with regard to their own organization's policies and procedures, monitoring supervisees' reading and understanding the codes of ethics of professional organizations and State licensing boards, and promoting counselor understanding of ethics and how to make decisions ethically as a regular part of clinical supervision, team meetings, and counselor training. Administrators can support high ethical standards by creating an organization-wide ethics task group consisting of counselors, supervisors, and administrators who meet regularly to review and revise clinical policies in line with State and Federal law and professional codes of ethics. Administrators may also act as a support mechanism for counselors who need additional consultation regarding potential ethical dilemmas with clients. The Green Cross Academy of Traumatology provides ethical guidelines for the treatment of clients who have experienced trauma; these guidelines are adapted in Exhibit 2.2-5.

Exhibit 2.2-5: Green Cross Academy of Traumatology Ethical Guidelines for the Treatment of Clients Who Have Been Traumatized

Respect for the dignity of clients

- Recognize and value the personal, social, spiritual, and cultural diversity present in society, without judgment. As a primary ethical commitment, make every effort to provide interventions with respect for the dignity of those served.

Responsible caring

- Take the utmost care to ensure that interventions do no harm.
- Have a commitment to the care of those served until the need for care ends or the responsibility for care is accepted by another qualified service provider.
- Support colleagues in their work and respond promptly to their requests for help.
- Recognize that service to survivors of trauma can exact a toll in stress on providers. Maintain vigilance for signs in self and colleagues of such stress effects, and accept that dedication to the service of others imposes an obligation to sufficient self-care to prevent impaired functioning.
- Engage in continuing education in the appropriate areas of trauma response. Remain current in the field and ensure that interventions meet current standards of care.

Integrity in relationships

- Clearly and accurately represent your training, competence, and credentials. Limit your practice to methods and problems for which you are appropriately trained and qualified. Readily refer to or consult with colleagues who have appropriate expertise; support requests for such referrals or consultations from clients.
- Maintain a commitment to confidentiality, ensuring that the rights of confidentiality and privacy are maintained for all clients.
- Do not provide professional services to people with whom you already have either emotional ties or extraneous relationships of responsibility. The one exception is in the event of an emergency in which no other qualified person is available.
- Refrain from entering other relationships with present or former clients, especially sexual relationships or relationships that normally entail accountability.
- Within agencies, ensure that confidentiality is consistent with organizational policies; explicitly inform individuals of the legal limits of confidentiality.

Responsibility to society

- Be committed to responding to the needs generated by traumatic events, not only at the individual level, but also at the level of community and community organizations in ways that are consistent with your qualifications, training, and competence.
- Recognize that professions exist by virtue of societal charters in expectation of their functioning as socially valuable resources. Seek to educate government agencies and consumer groups about your expertise, services, and standards; support efforts by these agencies and groups to ensure social benefit and consumer protection.
- If you become aware of activities of colleagues that may indicate ethical violations or impairment of functioning, seek first to resolve the matter through direct expression of concern and offers of help to those colleagues. Failing a satisfactory resolution in this manner, bring the matter to the attention of the officers of professional societies and of governments with jurisdiction over professional misconduct.

Clients' universal rights

All clients have the right to:

- Not be judged for any behaviors they used to cope, either at the time of the trauma or after the trauma.
- Be treated at all times with respect, dignity, and concern for their well-being.
- Refuse treatment, unless failure to receive treatment places them at risk of harm to self or others.

(Continued on the next page.)

Exhibit 2.2-5: Academy of Traumatology Ethical Guidelines for the Treatment of Clients Who Have Been Traumatized (continued)

- Be regarded as collaborators in their own treatment plans.
- Provide their informed consent before receiving any treatment.
- Not be discriminated against based on race, culture, sex, religion, sexual orientation, socioeconomic status, disability, or age.
- Have promises kept, particularly regarding issues related to the treatment contract, role of counselor, and program rules and expectations.

Procedures for introducing clients to treatment

Obtain informed consent, providing clients with information on what they can expect while receiving professional services. In addition to general information provided to all new clients, clients presenting for treatment who have histories of trauma should also receive information on:

- The possible short-term and long-term effects of trauma treatment on the client and the client's relationships with others.
- The amount of distress typically experienced with any particular trauma treatment.
- Possible negative effects of a particular trauma treatment.
- The possibility of lapses and relapses when doing trauma work, and the fact that these are a normal and expected part of healing.

Reaching counseling goals through consensus

Collaborate with clients in the design of a clearly defined contract that articulates a specific goal in a specific time period or a contract that allows for a more open-ended process with periodic evaluations of progress and goals.

Informing clients about the healing process

- Clearly explain to clients the nature of the healing process, making sure clients understand.
- Encourage clients to ask questions about any and all aspects of treatment and the therapeutic relationship. Provide clients with answers in a manner they can understand.
- Encourage clients to inform you if the material discussed becomes overwhelming or intolerable.
- Inform clients of the necessity of contacting you or emergency services if they feel suicidal or homicidal, are at risk of self-injury, or have a sense of being out of touch with reality.
- Give clients written contact information about available crisis or emergency services.
- Inform clients about what constitutes growth and recovery and about the fact that some trauma symptoms may not be fully treatable.
- Address unrealistic expectations clients may have about counseling and/or the recovery process.

Level of functioning

- Inform clients that they may not be able to function at the highest level of their ability—or even at their usual level—when working with traumatic material.
- Prepare clients to experience trauma-related symptoms, such as intrusive memories, dissociative reactions, reexperiencing, avoidance behaviors, hypervigilance, or unusual emotional reactivity.

Source: Green Cross Academy of Traumatology, 2007. Adapted with permission.

Boundaries in therapeutic relationships

Maintaining appropriate therapeutic boundaries is a primary ethical concern for behavioral health professionals. Counselors working with clients who have substance use, trauma-related, and other mental disorders may feel challenged at times to maintain boundaries that create a safe therapeutic container. Some clients, especially those with longstanding disorders, bring a history of client–counselor relationships to counseling. Clients who have been traumatized may need help understanding the roles and responsibilities of both the counselor and the client. Clients with trauma-related conditions may also have special needs

Advice to Clinical Supervisors: Recognizing Boundary Confusion

Clinical supervisors should be aware of the following counselor behaviors that can indicate boundary confusion with clients:

- The counselor feels reluctant or embarrassed to discuss specific interactions with a client or details of the client's treatment in supervision or team meetings.
- The counselor feels possessive of the client, advocates with unusual and excessive vehemence for the client, or expresses an unreasonable sense of overresponsibility for the client.
- The counselor becomes defensive and closed to hearing ideas from the supervisor or the treatment team members about approaches to working with a client and/or exploring his or her own emotional reactions to a client.
- The clinician begins or increases personal self-disclosure to the client and is not able to identify legitimate clinical reasons for the self-disclosure.

in establishing appropriate boundaries in the counseling setting; they may be particularly vulnerable and not understand or appreciate the need for professional boundaries, including not engaging in dual relationships. For example, some clients might experience a counselor's boundary around not giving the client his or her personal phone number for emergency calls as a rejection or abandonment. Cultural considerations also influence therapeutic boundaries.

Administrators, in collaboration with clinical supervisors, are responsible for creating policies regarding counselor and client boundaries for various issues (e.g., giving and receiving gifts, counselor personal disclosure, and counselor roles and responsibilities when attending the same 12-Step meetings as clients); policies should be specific to their organization and conform to State and Federal law and behavioral health professional codes of ethics. Clinical supervisors are responsible for training counselors in the informed consent process and effective ways to discuss boundaries with clients when they enter treatment.

Guidelines for establishing and maintaining boundaries in therapeutic relationships, adapted from the Green Cross Academy of Traumatology, are given in Exhibit 2.2-6.

Clients with trauma histories may be especially vulnerable to counselor behaviors that are inconsistent or that are experienced by the client as boundary violations. Examples of such behavior include: being late for appointments, ending counseling sessions early, repeatedly and excessively extending the session time, canceling or "forgetting" appointments multiple times, spending time in the session talking about their own needs and life experiences, exploring opportunities for contact outside the therapeutic relationship (including making arrangements to meet at AA or other 12-Step recovery group meetings), and enforcing rules differently for one client than for another.

Due to the complex dynamics that can arise in the treatment of clients with trauma histories, regularly scheduled clinical supervision, where issues of ethics and boundaries can be discussed, is recommended for counselors. For more information on how clinical supervision can be effectively used, see TIP 52, *Clinical Supervision and the Professional Development of the Substance Abuse Counselor* (CSAT, 2009b).

Boundary crossing and boundary violation

Although guidelines and codes of ethics are useful tools in helping clinical supervisors and counselors understand the boundaries between counselors and clients, they are open to interpretation and are context-bound. Given these limitations, it is crucial to educate counselors

Exhibit 2.2-6: Boundaries in Therapeutic Relationships

Procedures for Establishing Safety

Roles and boundaries
Counselor roles and boundaries should be established at the start of the counseling relationship and reinforced periodically, particularly at times when the client is experiencing high stress.

Ongoing Relationships and the Issue of Boundaries

Dual relationships
Dual relationships and inappropriate interactions with clients are to be avoided. It is important to tell clients at the beginning of counseling that contact between the counselor and the client can only occur within the boundaries of the professional relationship. This information is part of the informed consent process. Relationships outside these boundaries include sexual or romantic relationships, a counselor also serving as a client's sponsor in 12-Step programs, and any kind of relationship in which the counselor exploits the client for financial gain.

Sexual contact
- Never engage in any form of sexual contact with clients.
- Do not reward sexualized behaviors with attention or reactivity.
- Directly clarify the boundaries of the therapeutic relationship, and address the underlying motivations of persisting sexualized behavior.
- Set limits on a client's inappropriate behaviors while maintaining an ethos of care. Maintain respect for the dignity and worth of the client at all times.
- Understand that a client's attempt to sexualize a therapeutic relationship may reflect an early history of abuse, difficulty understanding social norms, or a variety of psychological problems.
- Readdress the absolute inappropriateness of sexual and/or romantic behavior in a nonlecturing, nonpunitive manner.
- If sexual behavior between clients occurs in a treatment program, counselors should consult with a clinical supervisor. Document the nature of the contact and how the issue is addressed.
- If a counselor has sexual contact with a client, he or she should take responsibility by ceasing counseling practice, referring clients to other treatment providers, and notifying legal and professional authorities. If a counselor is at risk for engaging with a client sexually but has not acted on it, the counselor should immediately consult with a supervisor, colleague, or psychotherapist.

Boundaries
Counselors should use care with self-disclosure or any behaviors that may be experienced as intrusive by the client, including:
- Personal disclosures made for the counselor's own gratification.
- Sexualized behavior with the client.
- Excessively intrusive questions or statements.
- Interrupting the client frequently.
- Violating the client's personal space.
- Interpersonal touch, which might activate intrusive memories or dissociative reactions or be experienced as a boundary violation by the client.
- Being consistently late for appointments or allowing outside influences (such as telephone calls) to interrupt the client's time in a counseling session.

Source: Green Cross Academy of Traumatology, 2007. Adapted with permission.

in TIC settings regarding the boundary issues that may arise for clients who have been traumatized and to give counselors a conceptual framework for understanding the contextual nature of boundaries. For example, it would be useful for clinical supervisors to discuss with

counselors the distinction between boundary crossings and boundary violations in clinical practice. Gutheil and Brodsky (2008) define boundary crossing as a departure from the customary norms of counseling practice in relation to psychological, physical, or social space "that are harmless, are nonexploitative, and may even support or advance the therapy" (p. 20). Examples of boundary crossings include taking phone calls from a client between sessions if the client is in crisis or telling a client a story about the counselor's recovery from trauma (without offering specific personal information or graphic/detailed description of the trauma) with the intention of offering hope that it is possible to recover.

Gutheil and Brodsky (2008) define boundary violations as boundary crossings that are unwanted and dangerous and which exploit the client, stating that "some boundary crossings are inadvisable because of their intent (i.e., they are not done in the service of the patient's well-being and growth, involve extra therapeutic gratification for the therapist) and/or their effect (i.e., they are not likely to benefit the patient and entail a significant risk of harming the patient)" (pp. 20–21). An example of a boundary violation would be when a counselor invites a client to attend the same AA meetings the counselor attends or shares drinking and drugging "war stories" for the counselor's own gratification. Two key elements in understanding when a boundary crossing becomes a boundary violation are the intent of the counselor and the damaging effect on the client. Maintaining a standard of practice of nonexploitation of the client is the primary focus for clinical supervisors and counselors in determining when boundary crossings become boundary violations.

Context is also an important consideration in determining the acceptability of boundary crossings. For example, it may be acceptable for a counselor in a partial hospitalization program for serious mental illness to have a cup of coffee at the kitchen table with a resident, whereas for a counselor in an outpatient mental health program, having a cup of coffee with a client at the local coffee shop would be a much more questionable boundary crossing.

Case Illustration: Denise

Denise is a 40-year-old licensed professional counselor working in an inpatient eating disorder program. She has had extensive training in trauma and eating disorder counseling approaches and has been working as a clinician in mental health settings for 15 years. Denise is usually open to suggestions from her supervisor and other treatment team members about specific strategies to use with clients who have trauma histories and eating disorders. However, in the past week, her supervisor has noticed that she has become defensive in team meetings and individual supervision when discussing a recently admitted young adult who was beaten and raped by her boyfriend; subsequently, the client was diagnosed with PTSD and anorexia. When the clinical supervisor makes note of the change in Denise's attitude and behavior in team meetings since this young woman was admitted, initially Denise becomes defensive, saying that the team just doesn't understand this young woman and that the client has repeatedly told Denise, "You're the only counselor I trust."

The clinical supervisor recognizes that Denise may be experiencing secondary traumatization and boundary confusion due to working with this young woman and to the recent increase in the number of clients with co-occurring trauma-related disorders on her caseload. After further exploration, Denise reveals that her own daughter was raped at the same age as the young woman and that hearing her story has activated an STS reaction in Denise. Her way of coping has been to become overly responsible for and overprotective of the young woman. With the nonjudgmental support of her supervisor, Denise is able to gain perspective, recognize that this young woman is not her daughter, and reestablish boundaries with her that are appropriate to the inpatient treatment setting.

Clinical Supervision and Consultation

Organizational change toward a TIC model doesn't happen in isolation. Ongoing support, supervision, and consultation are key ingredients that reinforce behavioral health professionals' training in trauma-informed and trauma-specific counseling methods and ensure compliance with practice standards and consistency over time. Often, considerable energy and resources are spent on the transition to new clinical and programmatic approaches, but without long-range planning to support those changes over time. The new treatment approach fades quickly, making it hard to recognize and lessening its reliability.

Advice to Clinical Supervisors and Administrators: Adopting an Evidence-Based Model of Clinical Supervision and Training

Just as adopting evidence-based clinical practices in a trauma-informed organization is important in providing cost-effective and outcome-relevant services to clients, adopting an evidence-based model of clinical supervision and training clinical supervisors in that model can enhance the quality and effectiveness of clinical supervision for counselors. This will ultimately enhance client care.

One of the most commonly used and researched integrative models of supervision is the discrimination model, originally published by Janine Bernard in 1979 and since updated (Bernard & Goodyear, 2009). This model is considered a competence-based and social role model of supervision; it includes three areas of focus on counselor competencies (intervention, conceptualization, and personalization) and three possible supervisor roles (teacher, counselor, and consultant).

Counselor competencies:

- Intervention: The supervisor focuses on the supervisee's intervention skills and counseling strategies used with a particular client in a given session.
- Conceptualization: The supervisor focuses on how the supervisee understands what is happening in a session with the client.
- Personalization: The supervisor focuses on the personal style of the counselor and countertransference responses (i.e., personal reactions) of the counselor to the client.

Supervisor roles:

- Teacher: The supervisor teaches the supervisee specific counseling theory and skills and guides the supervisee in the use of specific counseling strategies in sessions with clients. The supervisor as teacher is generally task-oriented. The supervisor is more likely to act as a teacher with beginning counselors.
- Counselor: The supervisor does not act as the counselor's therapist, but helps the counselor reflect on his or her counseling style and personal reactions to specific clients. The supervisor as counselor is interpersonally sensitive and focuses on the process and relational aspects of counseling.
- Consultant: The supervisor is more of a guide, offering the supervisee advice on specific clinical situations. The supervisor as consultant invites the counselor to identify topics and set the agenda for the supervision. The supervisor is more likely to act as a consultant with more advanced counselors.

This model of supervision may be particularly useful in working with counselors in TIC settings, because the supervisor's response to the supervisee is flexible and specific to the supervisee's needs. In essence, it is a counselor-centered model of supervision in which the supervisor can meet the most relevant needs of the supervisee in any given moment.

For a review of other theories and methods of clinical supervision, refer to TIP 52, *Clinical Supervision and Professional Development of the Substance Abuse Counselor* (CSAT, 2009b).

Ongoing supervision and consultation supports the organizational message that TIC is the standard of practice. It normalizes secondary traumatization as a systemic issue (not the individual pathology of the counselor) and reinforces the need for counselor self-care to prevent and lessen the impact of secondary traumatization. Quality clinical supervision for direct care staff demonstrates the organization's commitment to implementing a fully integrated, trauma-informed system of care.

Supervision and Consultation

Historically, there was an administrative belief that counselors who had extensive clinical experience and training would naturally be the best clinical supervisors. However, research does not support this idea (Falender & Shafranske, 2004). Although a competent clinical supervisor needs to have an extensive clinical background in the treatment of substance use, trauma-related, and other mental disorders, it is also essential for any counselor moving into a supervisory role to have extensive training in the theory and practice of clinical supervision before taking on this role. In particular, clinical supervisors in trauma-informed behavioral health settings should be educated in how to perform clinical supervision (not just administrative supervision) of direct service staff and in the importance of providing continuous clinical supervision and support for staff members working with individuals affected by trauma. Clinical

Case Illustration: Arlene

Arlene is a 50-year-old licensed substance abuse counselor who has a personal history of trauma, and she is actively engaged in her own recovery from trauma. She is an experienced counselor who has several years of training in trauma-informed and trauma-specific counseling practices. Her clinical supervisor, acting in the role of consultant, begins the supervision session by inviting her to set the agenda. Arlene brings up a clinical situation in which she feels stuck with a client who is acting out in her Seeking Safety group (for more information on Seeking Safety, see Najavits, 2002a).

Arlene reports that her client gets up suddenly and storms out of the group room two or three times during the session. The supervisor, acting in the role of the counselor and focusing on personalization, asks Arlene to reflect on the client's behavior and what feelings are activated in her in response to the client's anger. Arlene is able to identify her own experience of hyperarousal and then paralysis as a stress reaction related to her prior experience of domestic violence in her first marriage. The supervisor, acting in the role of teacher and focusing on conceptualization, reminds Arlene that her client is experiencing a "fight-or-flight" response to some experience in the group that reminds her of her own trauma experience. The supervisor then suggests to Arlene that her own reactions are normal responses to her previous history of trauma, and that when her client is angry, Arlene is not reexperiencing her own trauma but is being activated by the client's traumatic stress reaction to being in group. In this way, the supervisor highlights the parallel process of the client–counselor's stress reactions to a perceived threat based on prior trauma experiences.

The supervisor, acting again as a consultant and focusing on personalization this time, invites Arlene to reflect on the internal and external resources she might be able to bring to this situation that will help remind her to ground herself so she can lessen the impact of her stress reactions on her counseling strategy with this client. Arlene states that she can create a list of safe people in her life and place this list in her pocket before group. She can use this list as a touchstone to remind her that she is safe and has learned many recovery skills that can help her stay grounded, maintain her boundaries, and deal with her client's behavior. The clinical supervisor, acting as a consultant and now focusing on intervention, asks Arlene if she has some specific ideas about how she can address the client's behavior in group. Arlene and the clinical supervisor spend the remainder of the session discussing different options for addressing the client's behavior and helping her feel safer in group.

supervision in a TIC organization should focus on the following priorities:

- General case consultation
- Specialized consultation in specific and unusual cases
- Opportunities to process clients' traumatic material
- Boundaries in the therapeutic and supervisory relationship
- Assessment of secondary traumatization
- Counselor self-care and stress management
- Personal growth and professional development of the counselor

Supervision of counselors working with traumatized clients should be regularly scheduled, with identified goals and with a supervisor who is trained and experienced in working with trauma survivors. The styles and types of supervision and consultation may vary according to the kind of trauma work and its context. For instance, trauma counseling in a major natural disaster would require a different approach to supervision and consultation than would counseling adults who experienced childhood developmental trauma or counseling clients in an intensive early recovery treatment program using a manualized trauma-specific counseling protocol.

Competence-based clinical supervision is recommended for trauma-informed organizations. Competence-based clinical supervision models identify the knowledge and clinical skills each counselor needs to master, and they use targeted learning strategies and evaluation procedures, such as direct observation of counselor sessions with clients, individualized coaching, and performance-based feedback. Studies on competence-based supervision approaches have demonstrated that these models improve counselor treatment skills and proficiency (Martino et al., 2011).

Whichever model of clinical supervision an organization adopts, the key to successful trauma-informed clinical supervision is the recognition that interactions between the supervisor and the counselor may parallel those between the counselor and the client. Clinical supervisors need to recognize counselors' trauma reactions (whether they are primary or secondary to the work with survivors of trauma) and understand that a confrontational or punitive approach will be ineffective and likely retraumatize counselors.

Clinical supervisors should adopt a respectful and collaborative working relationship with counselors in which role expectations are clearly defined in an informed consent process similar to that used in the beginning of the counselor–client relationship and in which exploring the nature of boundaries in both client–counselor and counselor–supervisor relationships is standard practice. Clear role boundaries, performance expectations, open dialog, and supervisor transparency can go a long way toward creating a safe and respectful relationship container for the supervisor and supervisee and set the stage for a mutually enhancing, collaborative relationship. This respectful, collaborative supervisory relationship is the main source of training and professional growth for the counselor and for the provision of quality care to people with behavioral health disorders.

Secondary Traumatization

The demands of caregiving exact a price from behavioral health professionals that cannot be ignored; otherwise, they may become ineffective in their jobs or, worse, emotionally or psychologically impaired. In a study of Master's level licensed social workers, 15.2 percent of respondents to a survey reported STS as a result of indirect exposure to trauma material at a level that meets the diagnostic criteria for PTSD. This rate is almost twice the rate of PTSD in the general population. The author

STS is a trauma related stress reaction and set of symptoms resulting from exposure to another individual's traumatic experiences rather than from exposure directly to a traumatic event.

concluded that behavioral health professionals' experience of STS is a contributing factor in staff turnover and one reason why many behavioral health service professionals leave the field (Bride, 2007). Secondary traumatization of behavioral health workers is a significant organizational issue for clinical supervisors and administrators in substance abuse and mental health treatment programs to address.

To prevent or lessen the impact of secondary traumatization on behavioral health professionals, clinical supervisors and administrators need to understand secondary trauma from the ecological perspective described in Part 1, Chapter 1 of this TIP. The organization itself creates a social context with risk factors that can increase the likelihood of counselors experiencing STS reactions, but it also contains protective factors that can lessen the risk and impact of STS reactions on staff members. Organizations can lessen the impact of the risk factors associated with working in trauma-informed organizations by mixing caseloads to contain clients both with and without trauma-related issues, supporting ongoing counselor training, providing regular clinical supervision, recognizing counselors' efforts, and offering an empowering work environment in which counselors share in the responsibility of making decisions and can offer input into clinical and program policies that affect their work lives.

When organizations support their counselors in their work with clients who are traumatized, counselors can be more effective, more productive, and feel greater personal and professional satisfaction. In addition, counselors develop a sense of allegiance toward the organization, thus decreasing staff turnover. If organizations do not provide this support, counselors can become demoralized and have fewer emotional and psychological resources to manage the impact of clients' traumatic material and outward behavioral expressions of trauma on their own well-being. Providing counselors with the resources to help them build resilience and prevent feeling overwhelmed should be a high priority for administrators and clinical supervisors in TIC organizations.

Risk and Protective Factors Associated With Secondary Traumatization

Clinical and research literature on trauma describes a number of factors related to the development of secondary trauma reactions and psychological distress in behavioral health professionals across a wide range of practice settings, as well as individual and organizational factors that can prevent or lessen the impact of STS on staff. The risk and protective factors model of understanding secondary trauma is based on the ecological perspective

Advice to Clinical Supervisors: Recognizing Secondary Traumatization

Some counselor behaviors that demonstrate inconsistency to clients may be outward manifestations of secondary traumatization, and they should be discussed with counselors through a trauma-informed lens. It is imperative that clinical supervisors provide a nonjudgmental, safe context in which counselors can discuss these behaviors without fear of reprisal or reprimand. Clinical supervisors should work collaboratively with supervisees to help them understand their behavior and engage in self-care activities that lessen the stress that may be contributing to these behaviors.

outlined in Part 1, Chapter 1 of this TIP. The terms "compassion fatigue," "vicarious traumatization," "secondary traumatization," and "burnout" are used in the literature, sometimes interchangeably and sometimes as distinct constructs. As stated in the terminology portion of the "How This TIP Is Organized" section that precedes Part 1, Chapter 1, of this TIP, the term "secondary traumatization" refers to traumatic stress reactions and psychological distress from exposure to another individual's traumatic experiences; this term will be used throughout this section, although the studies cited may use other terms.

Risk factors

Individual risk factors that may contribute to the development of STS in behavioral health professionals include preexisting anxiety or mood disorders; a prior history of personal trauma; high caseloads of clients with trauma-related disorders; being younger in age and new to the field with little clinical experience or training in treating trauma-related conditions; unhealthy coping styles, including distancing and detachment from clients and co-workers; and a lack of tolerance for strong emotions (Newall & MacNeil, 2010). Other negative coping strategies include substance abuse, other addictive behaviors, a lack of recreational activities not related to work, and a lack of engagement with social support. A recent study of trauma nurses found that low use of support systems, use of substances, and a lack of hobbies were among the coping strategies that differed between nurses with and without STS (Von Rueden et al., 2010). Other researchers found that clinicians who engaged in negative coping strategies, such as alcohol and illicit drug use, were more likely to experience intrusive trauma symptoms (Way, Van Deusen, Martin, Applegate, & Janle, 2004).

Numerous organizational factors can contribute to the development of STS in counselors who work with clients with trauma-related disorders. These risk factors include organizational constraints, such as lack of resources for clients, lack of clinical supervision for counselors, lack of support from colleagues, and lack of acknowledgment by the organizational culture that secondary traumatization exists and is a normal reaction of counselors to client trauma (Newall & MacNeil, 2010). In a study of 259 individuals providing mental health counseling services, counselors who spent more time in session with clients with trauma-related disorders reported higher levels of traumatic stress symptoms (Bober & Regehr, 2006). Counselors may be more at risk for developing secondary traumatization if the organization does not allow for balancing the distribution of trauma and nontrauma cases amongst staff members.

Protective factors

Much of the clinical and research literature focuses on individual factors that may lessen the impact of STS on behavioral health professionals, including male gender, being older, having more years of professional experience,

Advice to Clinical Supervisors: Recognizing STS in Counselors Who Are In Recovery

For counselors who are in recovery from a substance use or mental disorder, the development of STS may be a potential relapse concern. As Burke, Carruth, and Prichard (2006) point out, "a return to drinking or illicit drug use as a strategy for dealing with secondary trauma reactions would have a profoundly detrimental effect on the recovering counselor" (p. 292). So too, secondary trauma may ignite the reappearance of depressive or anxiety symptoms associated with a previous mental disorder. Clinical supervisors can address these risk factors with counselors and support them in engaging with their own recovery support network (which might include a peer support group or an individual counselor) to develop a relapse prevention plan.

having specialized training in trauma-informed and trauma-specific counseling practices, lacking a personal trauma history, exhibiting personal autonomy in the workplace, using positive personal coping styles, and possessing resilience or the ability to find meaning in stressful life events and to rebound from adversity (Sprang, Clark, & Whitt-Woosley, 2007). Some of these factors, like positive personal coping styles and the ability to find meaning in adversity, can be developed and enhanced through personal growth work, psychotherapy, engagement with spiritual practices and involvement in the spiritual community, and stress reduction strategies like mindfulness meditation. A recent multimethod study of an 8-week workplace mindfulness training group for social workers and other social service workers found that mindfulness meditation increased coping strategies, reduced stress, and enhanced self-care of the participants; findings suggested that workers were more likely to practice stress management techniques like mindfulness at their place of work than at home (McGarrigle & Walsh, 2011). Organizations can support counselors' individual efforts to enhance positive personal coping styles, find meaning in adversity, and reduce stress by providing time for workers during the workday for personal self-care activities, like mindfulness meditation and other stress reduction practices.

One of the organizational protective factors identified in the literature that may lessen the negative impact of secondary traumatization on behavioral health professionals is providing adequate training in trauma-specific counseling strategies, which increases providers' sense of efficacy in helping clients with trauma-related disorders and reduces the sense of hopelessness that is often a part of the work (Bober & Regehr 2006). One study found that specialized trauma training enhanced job satisfaction and reduced levels of compassion fatigue, suggesting that "knowledge and training might provide some protection against the deleterious effects of trauma exposure" (Sprang et al., 2007, p. 272). Another protective factor that may lessen the chances of developing secondary traumatization is having a diverse caseload of clients. Organizations "must determine ways of distributing workload in order to limit the traumatic exposure of any one worker. This may not only serve to reduce the impact of immediate symptoms but may also address the potential longitudinal effects" (Bober & Regehr, 2006, p. 8).

Emotional support from professional colleagues can be a protective factor. A study of substance abuse counselors working with clients who were HIV positive found that workplace support from colleagues and supervisors most effectively prevented burnout (Shoptaw, Stein, & Rawson, 2000). This support was associated with less emotional fatigue and depersonalization, along with a sense of greater personal accomplishment. In a study of domestic violence advocates, workers who received more support from professional peers were less likely to experience secondary traumatization (Slattery & Goodman, 2009).

In addition, counselor engagement in relationally based clinical supervision with a trauma-informed supervisor acts as a protective agent. Slattery and Goodman (2009) note that "for the trauma worker, good supervision can normalize the feelings and experiences, provide support and information about the nature and course of the traumatic reaction, help in the identification of transference and countertransference issues, and reveal feelings or symptoms associated with the trauma" (p. 1362). Workers who reported "engaging, authentic, and empowering relationships with their supervisors" were less likely to experience STS (p. 1369). Thus, it is not simply the frequency and regularity of clinical supervision,

but also the quality of the supervision and the quality of the supervisor–counselor relationship that can lessen the impact of STS on behavioral health professionals.

Engagement with a personal practice of spirituality that provides a sense of connection to a larger perspective and meaning in life is another protective factor that can lessen the impact of STS on counselors (Trippany, Kress, & Wilcoxon, 2004). Although recovering counselors may look to support groups for connection to a spiritual community, other behavioral health professionals might find support for enhancing spiritual meaning and connection in church, a meditation group, creative endeavors, or even volunteer work. The key is for counselors to develop their own unique resources and practices to enhance a sense of meaningful spirituality in their lives. Clinical supervisors should be aware of spiritual engagement as a protective factor in preventing and lessening the impact of STS and should support clinicians in including it in their self-care plans, but they should take care not to promote or reject any particular religious belief system or spiritual practice.

Another protective factor that may lessen the impact of workers' STS is a culture of empowerment in the organization that offers counselors a sense of autonomy, a greater ability to participate in making decisions about clinical and organizational policies, and obtaining support and resources that further their professional development. Slattery & Goodman (2009) surveyed 148 domestic violence advocates working in a range of settings. The authors found that those workers "who reported a high level of shared power were less likely to report posttraumatic stress symptoms, despite their own personal abuse history or degree of exposure to trauma" (p. 1370). To the degree that organizations can provide a cultural context within which behavioral health professionals have autonomy and feel empowered, they will be able to lessen the impact of STS on their professional and personal lives. Self-efficacy and empowerment are antidotes to the experience of powerlessness that often accompanies trauma.

Strategies for Preventing Secondary Traumatization

The key to prevention of secondary traumatization for behavioral health professionals in a trauma-informed organization is to reduce risk and enhance protective factors. Organizational strategies to prevent secondary traumatization include:

- Normalize STS throughout all levels of the organization as a way to help counselors feel safe and respected, enhancing the likelihood that they will talk openly about their experiences in team meetings, peer supervision, and clinical supervision.
- Implement clinical workload policies and practices that maintain reasonable standards for direct-care hours and emphasize balancing trauma-related and nontrauma-related counselor caseloads.
- Increase the availability of opportunities for supportive professional relationships by promoting activities such as team meetings, peer supervision groups, staff retreats, and counselor training that focuses on understanding secondary traumatization and self-care. Administrators and clinical supervisors should provide time at work for counselors to engage in these activities.
- Provide regular trauma-informed clinical supervision that is relationally based. Supervisors should be experienced and trained in trauma-informed and trauma-specific practices and provide a competence-based model of clinical supervision that promotes counselors' professional and personal development. Supervision limited to case consultation or case management is insufficient to

reduce the risk for secondary traumatization and promote counselor resilience.

- Provide opportunities for behavioral health professionals to enhance their sense of autonomy and feel empowered within the organization. Some of these activities include soliciting input from counselors on clinical and administrative policies that affect their work lives, including how to best balance caseloads of clients with and without histories of trauma; inviting representatives of the counseling staff to attend selected agency board of directors and/or management team meetings to offer input on workforce development; and inviting counselors to participate in organizational task forces that develop trauma-informed services, plan staff retreats, or create mechanisms to discuss self-care in team meetings. Administrators and clinical supervisors should assess the organization's unique culture and develop avenues for counselor participation in activities that will enhance their sense of empowerment and efficacy within the organization.

Exhibit 2.2-7 highlights some specific strategies that individual counselors can engage in to prevent secondary traumatization.

Assessment of Secondary Traumatization

Counselors with unacknowledged STS can harm clients, self, and family and friends by becoming unable to focus on and attend to their needs or those of others. They may feel helpless or cynical and withdraw from support systems. Exhibit 2.2-8 describes some emotional, cognitive, and behavioral signs that may indicate that a counselor is experiencing secondary traumatization. Clinical supervisors should be familiar with the manifestations of STS in their counselors and should address signs of STS immediately.

Stamm (2009–2012) has developed and revised a self-assessment tool, the Professional Quality of Life Scale (ProQOL), that measures indicators of counselor compassion fatigue and compassion satisfaction. Compassion fatigue "is best defined as a syndrome consisting of a combination of the symptoms

Exhibit 2.2-7: Counselor Strategies To Prevent Secondary Traumatization

Strategies that counselors can use (with the support and encouragement of supervisors and administrators) to prevent secondary traumatization include:

- ***Peer support*:** Maintaining adequate social support, both personally and professionally, helps prevent isolation and helps counselors share the emotional distress of working with traumatized individuals.
- ***Supervision and consultation*:** Professional consultation will help counselors understand secondary traumatization, their own personal risks, the protective factors that can help them prevent or lessen its impact, and their countertransference reactions to specific clients.
- ***Training*:** Ongoing professional training can improve counselors' understanding of trauma and enhance a sense of mastery and self-efficacy in their work.
- ***Personal psychotherapy or counseling*:** Being in counseling can help counselors become more self-aware and assist them in managing the psychological and emotional distress that often accompanies working with clients who have trauma histories in a number of behavioral health settings.
- ***Maintaining balance in one's life*:** Balancing work and personal life, developing positive coping styles, and maintaining a healthy lifestyle can enhance resilience and the ability to manage stress.
- ***Engaging in spiritual activities that provide meaning and perspective*:** Connection to a spiritual community and spiritual practices (such as meditation) can help counselors gain a larger perspective on trauma and enhance resilience.

Exhibit 2.2-8: Secondary Traumatization Signs

The following are some indicators that counselors may be experiencing secondary traumatization.

Psychological distress
- Distressing emotions: grief, depression, anxiety, dread, fear, rage, shame
- Intrusive imagery of client's traumatic material: nightmares, flooding, flashbacks of client disclosures
- Numbing or avoidance: avoidance of working with client's traumatic material
- Somatic issues: sleep disturbances, headaches, gastrointestinal distress, heart palpitations, chronic physiological arousal
- Addictive/compulsive behaviors: substance abuse, compulsive eating, compulsive working
- Impaired functioning: missed or canceled appointments, decreased use of supervision, decreased ability to engage in self-care, isolation and alienation

Cognitive shifts
- Chronic suspicion about others
- Heightened sense of vulnerability
- Extreme sense of helplessness or exaggerated sense of control over others or situations
- Loss of personal control or freedom
- Bitterness or cynicism
- Blaming the victim or seeing everyone as a victim
- Witness or clinician guilt if client reexperiences trauma or reenacts trauma in counseling
- Feeling victimized by client

Relational disturbances
- Decreased intimacy and trust in personal/professional relationships
- Distancing or detachment from client, which may include labeling clients, pathologizing them, judging them, canceling appointments, or avoiding exploring traumatic material
- Overidentification with the client, which may include a sense of being paralyzed by one's own responses to the client's traumatic material or becoming overly responsible for the client's life

Frame of reference
- Disconnection from one's sense of identity
- Dramatic change in fundamental beliefs about the world
- Loss or distortion of values or principles
- A previous sense of spirituality as comfort or resource decreases or becomes nonexistent
- Loss of faith in something greater
- Existential despair and loneliness

Sources: Figley, 1995; Newall & MacNeil, 2010; Saakvitne et al., 1996.

of secondary traumatic stress and professional burnout" (Newall & MacNeil, 2010, p. 61). Although secondary traumatization as a reaction to exposure to clients' trauma material is similar to PTSD, burnout is a more general type of psychological distress related to the pressures of working in high-stress environments over time. Burnout may be a result of secondary traumatization and/or a contributing factor in the development of secondary traumatization. The ProQOL includes STS and burnout scales that have been validated in research studies (Adams, Figley, & Boscarino, 2008; Newall & MacNeil, 2010).

This tool can be used in individual and group clinical supervision, trainings on self-care, and team meetings as a way for counselors to check in with themselves on their levels of stress and potential signs of secondary traumatization.

Case Illustration: Gui

Gui is a 48-year-old licensed substance abuse counselor who has worked in a methadone maintenance clinic for 12 years. He originally decided to get his degree and become a counselor because he wanted to help people and make a difference in the world. Over the past 6 months, he has felt fatigued a great deal, gets annoyed easily with both clients and coworkers, and has developed a cynical attitude about the world and the people who come to the clinic for help. During this time, the clinic has been forced to lay off a number of counselors due to funding cutbacks. As a result, Gui and the remaining counselors have had a 20 percent increase in the number of weekly client contact hours required as part of their job duties. In addition, the level and severity of clients' trauma-related and other co-occurring disorders, poverty, joblessness, and homelessness has increased.

Gui is a valued employee, and when Gui discusses his thoughts that he might want to leave the clinic with his clinical supervisor, the supervisor listens to Gui's concerns and explores the possibility of having him fill out the ProQOL to get a pulse on his stress level. Gui agrees and is willing to discuss the results with his supervisor. He is not surprised to see that he scores above average on the burnout scale of the instrument but is very surprised to see that he scores below average on the secondary traumatic stress scale and above average on the compassion satisfaction scale. He begins to feel more hopeful that he still finds satisfaction in his job and sees that he is resilient in many ways that he did not acknowledge before.

Gui and the clinical supervisor discuss ways that the supervisor and the organization can lessen the impact of the stress of the work environment on Gui and support the development of a self-care plan that emphasizes his own ability to rebound from adversity and take charge of his self-care.

The compassion satisfaction scale allows counselors to reflect on their resilience and reminds them of why they choose to work with people with substance use and trauma-related disorders, despite the fact that this work can lead to secondary traumatization. The compassion satisfaction subscale reminds counselors that they are compassionate, that one of the reasons they are in a helping profession is that they value service to others, and that helping brings meaning and fulfillment to their lives. Exhibits 2.2-9 through 2.2-11 present the most recent version of the ProQOL.

Addressing Secondary Traumatization

If a counselor is experiencing STS, the organization should address it immediately. Clinical supervisors can collaborate with counselors to devise an individualized plan that is accessible, acceptable, and appropriate for each counselor and that addresses the secondary stress reactions the counselor is experiencing, providing specific self-care strategies to counteract the stress. Decisions about strategies for addressing secondary traumatization should be based on the personal preferences of the counselor, the opportunity for an immediate intervention following a critical incident, and the counselor's level of awareness regarding his or her experience of STS. Counselors may need to talk about what they are experiencing, feeling, and thinking. These experiences can be processed in teams, in consultations with colleagues, and in debriefing meetings to integrate them effectively (Myers & Wee, 2002).

If a critical incident evokes secondary traumatization among staff—such as a client suicide, a violent assault in the treatment program, or another serious event—crisis intervention should be available for workers who would like to participate. Any intervention should be voluntary and tailored to each worker's individual needs (e.g., peer, group, or individual sessions); if possible, these services should be offered continuously instead of just one time.

Exhibit 2.2-9: PRoQOL Scale

COMPASSION SATISFACTION AND COMPASSION FATIGUE (PRoQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *past 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

___ 1. I am happy.
___ 2. I am preoccupied with more than one person I *[help]*.
___ 3. I get satisfaction from being able to *[help]* people.
___ 4. I feel connected to others.
___ 5. I jump or am startled by unexpected sounds.
___ 6. I feel invigorated after working with those I *[help]*.
___ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
___ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
___ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
___ 10. I feel trapped by my job as a *[helper]*.
___ 11. Because of my *[helping]*, I have felt "on edge" about various things.
___ 12. I like my work as a *[helper]*.
___ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
___ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
___ 15. I have beliefs that sustain me.
___ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
___ 17. I am the person I always wanted to be.
___ 18. My work makes me feel satisfied.
___ 19. I feel worn out because of my work as a *[helper]*.
___ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
___ 21. I feel overwhelmed because my case [work] load seems endless.
___ 22. I believe I can make a difference through my work.
___ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
___ 24. I am proud of what I can do to *[help]*.
___ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
___ 26. I feel "bogged down" by the system.
___ 27. I have thoughts that I am a "success" as a *[helper]*.
___ 28. I can't recall important parts of my work with trauma victims.
___ 29. I am a very caring person.
___ 30. I am happy that I chose to do this work.

Source: Stamm, 2012. Used with permission.

Exhibit 2.2-10: Your Scores on the ProQOL: Professional Quality of Life Screening

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental healthcare professional.

Compassion Satisfaction _____
Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____
Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____
The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a healthcare professional.

Source: Stamm, 2012. Used with permission.

Exhibit 2.2-11: What Is My Score and What Does It Mean?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

*You Wrote	Change to
1	5
2	4
3	3
4	2
5	1

3. ____
6. ____
12. ____
16. ____
18. ____
20. ____
22. ____
24. ____
27. ____
30. ____
Total : _____

The sum of my Compassion Satisfaction questions is	So my score equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score.

*1. ____ = ____
*4. ____ = ____
8. ____
10. ____
*15. ____ = ____
*17. ____ = ____
19. ____
21. ____
26. ____
*29. ____ = ____
Total : _____

The sum of my Burnout questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add the[m] up. When you have added them up you can find your score on the table to the right.

2. ____
5. ____
7. ____
9. ____
11. ____
13. ____
14. ____
23. ____
25. ____
28. ____
Total : _____

The sum of my Secondary Trauma questions is	So my score equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Source: *Stamm, 2012. Used with permission.*

The objective of debriefing a critical incident that evokes STS reactions in counselors is to help them dissipate the hyperarousal associated with traumatic stress and prevent long-term aftereffects that might eventually lead to counselor impairment. Because clinical supervisors may also be experiencing secondary traumatization, it is advisable for administrators to invite an outside trauma consultant into the organization to provide a safe space for all staff members (including clinical supervisors) to address and process the critical stress incident. For noncrisis situations, secondary traumatization should be addressed in clinical supervision. Clinical supervisors and counselors should work collaboratively to incorporate regular screening and self-assessment of STS into supervision sessions.

Advice to Clinical Supervisors: Advantages and Disadvantages of Using Psychometric Measures

Using a psychometric measure such as the ProQOL has advantages and disadvantages. It is important to understand that all tests measure averages and ranges but do not account for individual circumstances.

If you use the ProQOL in clinical supervision, present it as a self-assessment tool. Let counselors opt out of sharing their specific results with you and/or your team if it is administered in a group. If counselors choose to share scores on specific items or scales with you, work collaboratively and respectfully with them to explore their own understanding of and meanings attached to their scores. If this tool is not presented to supervisees in a nonjudgmental, mindful way, counselors may feel as if they have failed if their scores on the secondary traumatization scale are above average or if their scores on the compassion satisfaction scale are below average. High scores on the compassion fatigue and burnout scales do not mean that counselors don't care about their clients or that they aren't competent clinicians. The scores are simply one way for you and your supervisees to get a sense of whether they might be at risk for secondary traumatization, what they can do to prevent it, how to address it, and how you can support them.

The potential benefits of using a self-assessment tool like the ProQOL in clinical supervision are that it can help counselors:

- Reflect on their emotional reactions and behaviors and identify possible triggers for secondary traumatization.
- Assess their risk levels.
- Examine alternative coping strategies that may prevent secondary traumatization.
- Understand their own perceptions of themselves and their job satisfaction, affirming what they already know about their risk of secondary traumatization and their compassion satisfaction.
- Reflect on different factors that might contribute to unexpected low or high scores, such as the day of the week, the intensity of the workload, whether they have just come back from the weekend or a vacation, and so forth.
- Increase self-awareness and self-knowledge, because scores on specific items or scales bring to consciousness what is often outside of awareness.
- Realize how resilient they are emotionally, mentally, physically, and spiritually.
- Become aware of and open up conversations about self-care and self-care activities and resources, such as supportive coworkers, team members, and social networks outside of work.

If used regularly, self-assessment tools can help counselors and clinical supervisors monitor STS levels, indicate significant positive and negative changes, and suggest action toward self-care in specific areas. Clinical supervisors should fill out the ProQOL and review results with their own supervisors, a peer supervisor, or a colleague before administering it to supervisees. Doing so enables supervisors to gauge their own reactions to the self-assessment and anticipate potential reactions from supervisees.

Advice to Clinical Supervisors: Is it Supervision or Psychotherapy?

Although there are some aspects of clinical supervision that can be therapeutic and parallel the therapeutic and emotional support that occurs between the counselor and the client, clinical supervision is not therapy. As a result, it is important for clinical supervisors to maintain appropriate boundaries with supervisees when addressing their STS reactions at work.

When does the process in supervision cross over into the realm of practicing therapy with a supervisee? One clear indicator is if the supervisor begins to explore the personal history of the counselor and reflects directly on that history instead of bringing it back to how the counselor's history influences his or her work with a particular client or with clients with trauma histories in general. Clinical supervisors should focus only on counselor issues that may be directly affecting their clinical functioning with clients. If personal issues arise in clinical supervision, counselors should be encouraged to address them in their own counseling or psychotherapy.

Exhibit 2.2-12: Clinical Supervisor Guidelines for Addressing Secondary Traumatization

1. Engage counselors in regular screening/self-assessment of counselors' experience of STS.
2. Address signs of STS with counselors in clinical supervision.
3. Work collaboratively with counselors to develop a comprehensive self-care plan and evaluate its effectiveness on a regular basis.
4. Provide counselors a safe and nonjudgmental environment within which to process STS in individual and group supervision or team meetings.
5. Provide counselors with a safe and nonjudgmental place within which to debrief critical stress incidents at work; bring in an outside consultant if needed.
6. Support and encourage counselors to engage in individual counseling or psychotherapy, when needed, to explore personal issues that may be contributing to secondary traumatization at work.

When STS issues arise, the clinical supervisor should work with counselors to review and revise their self-care plans to determine what strategies are working and whether additional support, like individual psychotherapy or counseling, may be warranted.

Exhibit 2.2-12 outlines some guidelines for clinical supervisors in addressing secondary trauma in behavioral health professionals working with clients who have substance use, mental, and trauma-related disorders.

Counselor Self-Care

In light of the intensity of therapeutic work with clients with co-occurring substance use, mental, and trauma-related disorders and the vulnerability of counselors to secondary traumatization, a comprehensive, individualized self-care plan is highly recommended. Balance is the key to the development of a self-care plan—a balance between home and work, a balance between focusing on self and others, and a balance between rest and activity (Saakvitne, Perlman, & Traumatic Stress Institute/ Center for Adult & Adolescent Psychotherapy 1996). Counselor self-care is also about balancing vulnerability, which allows counselors to be present and available when clients address intensely painful content, with reasonable efforts to preserve their sense of integrity in situations that may threaten the counselors' faith or worldview (Burke et al., 2006). A comprehensive self-care plan should include activities that nourish the physical, psychological/mental, emotional/relational, and spiritual aspects of counselors' lives.

The literature on counselor self-care advocates for individual, team, and organizational strategies that support behavioral health professionals working with clients who have

Case Illustration: Carla

Carla is a 38-year-old case manager working in an integrated mental health and substance abuse agency. She provides in-home case management services to home-bound clients with chronic health and/or severe mental health and substance abuse problems. Many of her clients have PTSD and chronic, debilitating pain.

Both her parents had alcohol use disorders, and as a result, Carla became the caretaker in her family. She loves her job; however, she often works 50 to 60 hours per week and has difficulty leaving her work at work. She often dreams about her clients and wakes up early, feeling anxious. She sometimes has traumatic nightmares, even though she was never physically or sexually abused, and she has never experienced the trauma of violence or a natural disaster. She drinks five cups of coffee and three to four diet sodas every day and grabs burgers and sweets for snacks while she drives from one client to the next. She has gained 20 pounds in the past year and has few friends outside of her coworkers. She has not taken a vacation in more than 2 years. She belongs to the Catholic church down the street, but she has stopped going because she says she is too busy and exhausted by the time Sunday rolls around.

The agency brings in a trainer who meets with the case management department and guides the staff through a self-assessment of their current self-care practices and the development of a comprehensive self-care plan. During the training, Carla acknowledges that she has let her work take over the rest of her life and needs to make some changes to bring her back into balance. She writes out her self-care plan, which includes cutting back on the caffeine, calling a friend she knows from church to go to a movie, going to Mass on Sunday, dusting off her treadmill, and planning a short vacation to the beach. She also decides that she will discuss her plan with her supervisor and begin to ask around for a counselor for herself to talk about her anxiety and her nightmares. In the next supervision session, Carla's supervisor reviews her self-care plan with her and helps Carla evaluate the effectiveness of her self-care strategies. Her supervisor also begins to make plans for how to cover Carla's cases when she takes her vacation.

substance use and trauma-related disorders. Counselors are responsible for developing comprehensive self-care plans and committing to their plans, but clinical supervisors and administrators are responsible for promoting counselor self-care, supporting implementation of counselor self-care plans, and modeling self-care. Counselor self-care is an ethical imperative; just as the entire trauma-informed organization must commit to other ethical issues with regard to the delivery of services to clients with substance use, mental, and trauma-related disorders, it must also commit to the self-care of staff members who are at risk for secondary traumatization as an ethical concern. Saakvitne and colleagues (1996) suggest that when administrators support counselor-self-care, it is not only cost-effective in that it reduces the negative effects of secondary traumatization on counselors (and their clients), but also promotes "hope-sustaining behaviors" in counselors, making them more motivated and open to learning, and thereby improving job performance and client care.

A Comprehensive Self-Care Plan

A self-care plan should include a self-assessment of current coping skills and strategies and the development of a holistic, comprehensive self-care plan that addresses the following four domains:

1. Physical self-care
2. Psychological self-care (includes cognitive/mental aspects)
3. Emotional self-care (includes relational aspects)
4. Spiritual self-care

Activities that may help behavioral health workers find balance and cope with the stress

Advice to Clinical Supervisors: Spirituality

The word "spiritual" in this context is used broadly to denote finding a sense of meaning and purpose in life and/or a connection to something greater than the self. Spiritual meanings and faith experiences are highly individual and can be found within and outside of specific religious contexts.

Engaging in spiritual practices, creative endeavors, and group/community activities can foster a sense of meaning and connection that can counteract the harmful effects of loss of meaning, loss of faith in life, and cognitive shifts in worldview that can be part of secondary traumatization. Counselors whose clients have trauma-related disorders experience fewer disturbances in cognitive schemas regarding worldview and less hopelessness when they engage in spiritually oriented activities, such as meditation, mindfulness practices, being in nature, journaling, volunteer work, attending church, and finding a spiritual community (Burke et al., 2006). Clinical supervisors can encourage counselors to explore their own spirituality and spiritual resources by staying open and attuned to the multidimensional nature of spiritual meaning of supervisees and refraining from imposing any particular set of religious or spiritual beliefs on them. A strong sense of spiritual connection can enhance counselors' resilience and ability to cope with the sometimes overwhelming effects of clients' trauma material and trauma-related behavior (including suicidality) on counselors' faith in life and sense of meaning and purpose.

Modeling Self-Care

"Implementing interventions was not always easy, and one of the more difficult coping strategies to apply had to do with staff working long hours. Many of the staff working at the support center also had full-time jobs working for the Army. In addition, many staff chose to volunteer at the Family Assistance Center and worked 16- to 18-hour days. When we spoke with them about the importance of their own self-care, many barriers emerged: guilt over not working, worries about others being disappointed in them, fear of failure with respect to being unable to provide what the families might need, and a 'strong need to be there.' Talking with people about taking a break or time off proved problematic in that many of them insisted that time off was not needed, despite signs of fatigue, difficulty concentrating, and decreased productivity. Additionally, time off was not modeled. Management, not wanting to fail the families, continued to work long hours, despite our requests to do otherwise. Generally, individuals could see and understand the reasoning behind such endeavors. Actually making the commitment to do so, however, appeared to be an entirely different matter. In fact, our own team, although we kept reasonable hours (8 to 10 per day), did not take a day off in 27 days. Requiring time off as part of membership of a Disaster Response Team might be one way to solve this problem."

—Member of a Disaster Response Team at the Pentagon after September 11

Source: Walser, 2004, pp. 4–5.

of working with clients with trauma-related disorders include talking with colleagues about difficult clinical situations, attending workshops, participating in social activities with family and friends, exercising, limiting client sessions, balancing caseloads to include clients with and without trauma histories, making sure to take vacations, taking breaks during the workday, listening to music, walking in nature, and seeking emotional support in both their personal and professional lives (Saakvitne et al., 1996). In addition, regular clinical supervision and personal psychotherapy or counseling can be positive coping strategies for lessening the impact of STS on counselors. Still, each counselor is unique, and a self-care approach that is helpful to one counselor may not be helpful to another. Exhibits 2.2-13 and 2.2-14 offer tools for self-reflection to help counselors discover which specific self-care activities might best suit them. The worksheet can be used privately by counselors or by clinical supervisors as an exercise in individual supervision, group supervision, team meetings, or trainings on counselor self-care.

Exhibit 2.2-13: Comprehensive Self-Care Plan Worksheet

Name: Date:	Personal	Professional/Workspace
Physical		
Psychological/Mental		
Emotional/Relational		
Spiritual		

Source: Burke, 2006. Used with permission.

Review the questions in Exhibit 2.2-14, and then write down specific self-care strategies in the form (given in Exhibit 2.2-13) that you're confident you will practice in both personal and professional realms.

The *Comprehensive Self-Care Worksheet* is a tool to help counselors (and clinical supervisors) develop awareness of their current coping strategies and where in the four domains they need to increase their engagement in self-care activities. Once completed, clinical supervisors should periodically review the plan with their supervisees for effectiveness in preventing and/or ameliorating secondary traumatization and then make adjustments as needed.

Essential Components of Self-Care

Saakvitne and colleagues (1996) describe three essential components, the "ABCs," of self-care that effectively address the negative impact of secondary traumatization on counselors:

1. **Awareness** of one's needs, limits, feelings, and internal/external resources. Awareness involves mindful/nonjudgmental attention to one's physical, psychological, emotional, and spiritual needs. Such attention requires quiet time and space that supports self-reflection.
2. **Balance** of activities at work, between work and play, between activity and rest, and between focusing on self and focusing on others. Balance provides stability and helps counselors be more grounded when stress levels are high.
3. **Connection** to oneself, to others, and to something greater than the self. Connection decreases isolation, increases hope, diffuses stress, and helps counselors share the burden of responsibility for client care. It provides an anchor that enhances counselors' ability to witness tremendous suffering without getting caught up in it.

Exhibit 2.2-14: Comprehensive Self-Care Plan Worksheet Instructions

Use the following questions to help you engage in a self-reflective process and develop your comprehensive self-care plan. Be specific and include strategies that are accessible, acceptable, and appropriate to your unique circumstances. Remember to evaluate and revise your plan regularly.

Physical
What are non-chemical things that help my body relax?
What supports my body to be healthy?

Psychological/Mental
What helps my mind relax?
What helps me see a bigger perspective?
What helps me break down big tasks into smaller steps?
What helps me counteract negative self-talk?
What helps me challenge negative beliefs?
What helps me build my theoretical understanding of trauma and addictions?
What helps me enhance my counseling/helping skills in working with traumatized clients?
What helps me become more self-reflective?

Emotional/Relational
What helps me feel grounded and able to tolerate strong feelings?
What helps me express my feelings in a healthy way?
Who helps me cope in positive ways and how do they help?
What helps me feel connected to others?
Who are at least three people I feel safe talking with about my reactions/feelings about clients?
How can I connect with those people on a regular basis?

Spiritual
What helps me find meaning in life?
What helps me feel hopeful?
What sustains me during difficult times?
What connects me to something greater?

Source: Burke, 2006. Used with permission.

Clinical supervisors can help counselors review their self-care plans through the ABCs by reflecting on these questions:

1. Has the counselor accurately identified his or her needs, limits, feelings, and internal and external resources in the four domains (physical, psychological/mental, emotional/relational, spiritual)?
2. Has the counselor described self-care activities that provide a balance between work and leisure, activity and rest, and a focus on self and others?
3. Has the counselor identified self-care activities that enhance connection to self, others, and something greater than self (or a larger perspective on life)?

Supervisors should make their own self-care plans and review them periodically with their clinical supervisors, a peer supervisor, or a colleague.

Commitment to Self-Care

One of the major obstacles to self-care is giving in to the endless demands of others, both at work and at home. It is therefore essential for counselors with the support of clinical supervisors to become "guardians of [their] boundaries and limits" (Saakvitne et al., 1996, p 136). Creating a daily schedule that includes breaks for rest, exercise, connection with coworkers, and other self-care activities can support counselors in recognizing that they are valuable individuals who are worthy of taking the time to nourish and nurture themselves, thus increasing commitment to self-care. Another way to support counselors in committing to self-care is for supervisors and administrators to model self-care in their own professional and personal lives.

Understanding that counselor self-care is not simply a luxury or a selfish activity, but rather, an ethical imperative (Exhibit 2.2-15) can foster counselors' sense of connection to their own values and accountability to the people they serve as competent and compassionate caregivers. Clinical supervisors and administrators can reinforce this sense of accountability while supporting counselors by providing a caring, trauma-informed work environment

Exhibit 2.2-15: The Ethics of Self-Care

The Green Cross Academy of Traumatology was originally established to serve a need in Oklahoma City following the April 19, 1995, bombing of the Alfred P. Murrah Federal Building. Below are adapted examples of the Academy's code of ethics with regard to worker self-care.

Ethical Principles of Self-Care in Practice
These principles declare that it is unethical not to attend to your self-care as a practitioner, because sufficient self-care prevents harming those we serve.

Standards of self-care guidelines:
- Respect for the dignity and worth of self: A violation lowers your integrity and trust.
- Responsibility of self-care: Ultimately it is your responsibility to take care of yourself—and no situation or person can justify neglecting this duty.
- Self-care and duty to perform: There must be a recognition that the duty to perform as a helper cannot be fulfilled if there is not, at the same time, a duty to self-care.

Standards of humane practice of self-care:
- Universal right to wellness: Every helper, regardless of her or his role or employer, has a right to wellness associated with self-care.
- Physical rest and nourishment: Every helper deserves restful sleep and physical separation from work that sustains them in their work role.
- Emotional rest and nourishment: Every helper deserves emotional and spiritual renewal both in and outside the work context.
- Sustenance modulation: Every helper must utilize self-restraint with regard to what and how much they consume (e.g., food, drink, drugs, stimulation) since improper consumption can compromise their competence as a helper.

Commitment to self-care:
- Make a formal, tangible commitment: Written, public, specific, measurable promises of self-care.
- Set deadlines and goals: The self-care plan should set deadlines and goals connected to specific activities of self-care.
- Generate strategies that work and follow them: Such a plan must be attainable and followed with great commitment and monitored by advocates of your self-care.

Source: Green Cross Academy of Traumatology, 2010. Adapted with permission.

that acknowledges and normalizes secondary traumatization and by offering reasonable resources that make it possible for counselors to do their work and take care of themselves at the same time. Preventing secondary traumatization and lessening its impact on counselors once it occurs is not only cost-effective with regard to decreasing staff turnover and potential discontinuity of services to clients; it is also the ethical responsibility of a trauma-informed organization.