TRAUMA INFORMED SUPERVISION

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Introductions
- Mental Health
- Child Abuse and Neglect
- Families
- Drug and Alcohol
- Intellectual Developmental Disabilities
- Medical
- Homelessness
- Criminal Justice System
- Clinical Social Work
- Refugee
- Immigration

Supervisors?
Word of Caution

Case Study
• A scenario from the past or present that we can discuss throughout our training today, that is related to the challenges of supervision?

What are some of the positives of supervision?
Adverse Childhood Experience Study
in the late 1990s, over 17,000 participants provided information about their childhood.
The higher the ACE score the more likely a person was to suffer,
- chronic obstructive pulmonary disease (from smoking),
- hepatitis,
- heart disease,
- fractures,
- diabetes,
- obesity,
- alcoholism,
- intravenous drug use,
- depression,
- suicide,
- teen pregnancy,
- sexually transmitted diseases, and
- poor job performance.
(Center for Disease Control)

ACE Study

- The higher the ACE score the greater impact on a person’s physical, emotional, and social health.
- Many ACE-related problems tend to be co-morbid or co-occurring.
- The majority of participants were white and college educated.
  - (Center for Disease Control)

ACE Pyramid
(Center for Disease Control)
Finding Your ACE score

While you were growing up, during your first 18 years of life:
1. Did a parent or other adult in the household often or very often:
   - Swear at you, insult you, put you down, or humiliate you?
   or
   - Act in a way that made you afraid that you might be physically hurt?
2. Did a parent or other adult in the household often or very often:
   - Push, grab, slap, or throw something at you?
   or
   - Ever hit you so hard that you had marks or were injured?
3. Did an adult or person at least 5 years older than you ever:
   - Touch or fondle you or have you touch their body in a sexual way?
   or
   - Attempt or actually have oral, anal, or vaginal intercourse with you?
4. Did you often or very often feel that:
   - No one in your family loved you or thought you were important or special?
   or
   - Your family didn’t look out for each other, feel close to each other, or support each other?

Finding Your ACE score

5. Did you often or very often feel that ...
   - You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   - Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
6. Were your parents ever separated or divorced?
7. Was your mother or stepmother:
   - Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   - Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   - Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
10. Did a household member go to prison?

(Center for Disease Control)
ACE’s and SW students

162 MSW students at one metropolitan university completed the Adverse Childhood Experiences (ACE) Survey during their final semester.

- The results show that nearly 80% of the students reported at least 1 ACE and
- 56% noted two or more
- 27.3% had 4 or more ACEs.
- Only 22.4% of the students had no adverse experiences.

(Gilin & Kauffman, 2015)
Social Workers

- Social workers are often attracted to social work as a result of their own unresolved personal conflicts and a need to resolve these through actively helping others (Rochford, 2007).

Trauma and the Brain

- The hippocampus processes trauma memories by recycling the memory, mostly at night via dreams, which takes place over weeks or months.
- It then transfers the integrated stored memory to another part of the brain.
- High levels of stress hormones cause the hippocampus to shrink or under-develop, resulting in impaired function.
- Childhood trauma exaggerates this effect.
- The trauma memory therefore remains unprocessed in the hippocampus, disintegrated, fragmented, and feels ‘current’ rather than in the past.
Amygdala

- The brain’s ‘fear center’.
- The amygdala helps to store memories, particularly emotions and physical sensations.
- It also controls activation of stress hormones – the body’s fight or flight response.
- In PTSD, the amygdala becomes over-reactive causing frequent or near constant high levels of stress hormones.

Pre-frontal Cortex

The pre-frontal cortex
- helps us to assess threats,
- manage emotion,
- plan responses, and
- control impulses.

It is the center of rational thinking.

Childhood trauma causes under-development of the pre-frontal cortex, which results in impaired ability to assess threat through rational thinking, manage emotions, and control impulses.

Current triggers

- Hippocampus recalls part of fragmented and disintegrated memory – thought, image etc.
- Pre-frontal cortex unable to rationalize or determine that situation is not a current threat. Difficulty in managing emotions or controlling impulses
- Attempts to escape or avoid distressing memories and feelings mean the memory is never processed, so symptoms remain.
What is Trauma?

“Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual well-being” (SAMHSA, 2012, p. 2).
Trauma

- “Trauma can affect individuals, families, groups, communities, specific cultures, and generations.
- It generally overwhelms an individual’s or community’s resources to cope, and it often ignites the “fight, flight, or freeze” reaction at the time of the event(s).
- It frequently produces a sense of fear, vulnerability, and helplessness” (SAMHSA, 2014, p 2).

Fight, Flight, or Freeze Response to Stress

Trauma

- Learn the Signs and Symptoms of PTSD, with Dr. Bessel van der Kolk

https://youtu.be/zoCMwrl_d_E

Early Childhood Maltreatment

- Early experiences are especially impactful because the brain is still developing and these experiences help to determine how the brain is “wired” from even before birth (Center on the Developing Child at Harvard University, 2010).

Let's raise children who won't have to recover from their childhoods.
- Pam Leo
**Outcome of Childhood Trauma**

Often this presents in complex interrelated problems such as:
- Lack of safety, trust, and chronic hyperarousal.
- Lack of emotional management.
- Learning problems.
- Inability to give words to feelings.
- Abusive power relationships (increase the likelihood they will be bullied, bully others, or both).
- Injustice and narcissism (preoccupied with crime and punishment, vengeance, and fulfilling and self-gratifying needs).
- Failure to grieve, foreshortened future.

(Bloom, 2014)

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**Trauma**

- Different types of trauma
- Affects people differently

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**Trauma**

- Includes childhood maltreatment,
- Hate-based crimes as a member of an oppressed group,
- Experiences in the military,
- Sexual assaults,
- War,
- Natural disasters,
- Terrorism,
- Domestic violence,
- Physical assault,
- Car accident,
- School shooting.

(John, n.d.)
Traumatized Clients

Clients who are traumatized present in:
- schools,
- drug treatment facilities,
- mental health settings,
- child welfare,
- criminal justice,
- medical settings,
- and others.

Secondary Trauma

"The expectation that we can be immersed in suffering and loss and not be touched by it is as unrealistic as expecting to walk through water without getting wet" (Remen 1996).

Secondary Trauma/Vicarious Trauma

Secondary traumatic stress is a risk we incur when we engage empathically with an adult or child who has been traumatized (Perry, 2014).

- Intensely feeling the traumatic event through another person.
Burn Out: An attitude of mind characterized by an array of symptoms that include

- depression,
- emotional exhaustion,
- physical and psychological fatigue,
- feelings of helplessness,
- depersonalization of clients,
- decreased feeling of personal accomplishments, and
- a lack of enthusiasm about work and even life in general.

Burn Out

- The worker experiencing burnout is often short tempered, apathetic, cynical and discouraged and sometimes uses substances to excess.
- Burnout is a condition that begins gradually and becomes progressively worse (Perry, 2014).

Vicarious Trauma

https://youtu.be/wDSh20nhM
Empathy

- Provide employees with an expanded description of the meaning of “empathy,” as described by Rothschild and Rand (2006).
- They wrote that being empathic does not require workers to fully visualize the experiences of abuse and neglect that their clients have suffered.
- In fact, it can be harmful to workers to picture themselves or someone that they love experiencing the same trauma that a client endured and it can increase the risk the workers will suffer from intrusive images later.
- Informed by brain research on the role of mirror neurons, Rothschild and Rand suggested that social workers should become aware of whether they are imitating client expressions or postures that could cause them to identify too strongly with their client’s feelings (pp. 42–43).

Secondary Trauma

There are several reasons why professionals working with maltreated or traumatized clients are at increased risk of developing secondary trauma.

- Empathy.
- Insufficient Recovery Time.
- Unresolved Personal Trauma.
- Children are the Most Vulnerable Members of Our Society.
- Isolation and Systemic Fragmentation.
- Lack of Systemic Resources.

(Perry, 2014)

Symptoms of Vicarious Trauma

- Fatigue
- Sleep Problems
- Cynicism
- Hopelessness
- Numbing
- Easily angered or irritated
- Easily Startled
- Hypervigilance
- Relationship/boundary issues
- Physical ailments
- Intrusive thoughts about client trauma histories.
- Diminished joy in other areas of life.
- Minimization
Symptoms of Vicarious Trauma

- Loss of motivation
- Feeling you are not doing enough
- Absences from pro-bono responsibilities
- Feeling trapped in your job
- Lack of satisfaction in work
- Diminished confidence
- Blaming others
- Silencing clients

(American Counseling Association, 2011)

Secondary Trauma

- The supervisor in any system is in a pivotal position to assist workers in preventing the development of secondary trauma.
- To be effective in their role as unit leader, supervisors must be able to handle stress well themselves while providing encouragement and emotional support to their workers.
- Supervisors need to be aware of the extent to which their workers have become separated from the original meaning and purpose of their work.
- When the work demands exceed the worker’s endurance and their ability to cope, they are at an increased risk for developing secondary trauma (Perry, 2014).

Secondary Traumatic Stress (STS) Core Competencies for Supervisors

- Knowledge of the signs, symptoms, and risk factors for STS and systems supports to combat it.
- Knowledge and capacity to self-assess, monitor, and address the supervisor’s STS.
- Knowledge of how to encourage employees in sharing emotional experience of doing trauma work in a safe and supportive manner.
- Skills to assist employees to emotionally re-regulate after difficult encounters: able to assess the effectiveness of intervention, monitor progress, and make appropriate referrals.
- Knowledge of Psychological First Aid or other supportive approaches after emergency crisis.

(National Child Traumatic Stress Network, nd.)
STS Core Competencies

- Ability to both model and coach supervisees in using a trauma lens to guide case conceptualization and service delivery.
- Knowledge of resiliency factors and ability to structure resilience-building into individual and group supervision.
- Distinguish between expected changes in supervisees perspective and cognitive distortions related to indirect trauma exposure.
- Ability to use appropriate self-disclosure in supervisory sessions to enhance the supervisees ability to recognize, acknowledge, and respond to the impact of indirect trauma.

(National Child Traumatic Stress Network, nd.)

Counter Transference

Two views about countertransference.

- **Freudian view:** those emotional reactions which stem from the unresolved and unconscious conflicts of the social worker that arise in response to the feelings expressed within the transference by the client (Dalenberg, 2008).
- **Universal view:** the entire repertoire of emotional responses to the client and hence, can be referred to as a universal view.
- As such, social workers’ emotional reactions can stem from either the clients’ transferred feelings or the actual traumatic event itself, both being examples of countertransference (Danielli, 1994).

An Integrative View

It may therefore be helpful to consider an integrative view.

- An integrative view suggests most strong emotional reactions to the client constitute classification as a countertransference reaction.
- In addition, this view also suggests that if reflected upon in sufficient depth, such reactions will present at least some connection and resonance with earlier childhood experience of the social worker which remains unresolved to at least a minimal degree thus incorporating the classical view.
- Within an integrative view both social worker and the clients’ subjectivities are acknowledged and are believed to jointly create countertransference (Gabbard, 2001).
Supervisor’s role

- Help workers be aware of their countertransference to their clients.
- In working with clients with trauma the worker’s countertransference may make them want to avoid or be defensive.
- Countertransference can be part of secondary trauma.
- Building self-awareness for the worker is key here.
- A supervisor can help the worker use their work with clients to help them have vicarious post-traumatic growth.

(Gibbons, Murphy, and Joseph, 2011)

Vicarious Post-traumatic Growth

- “Posttraumatic growth refers to the constellation of positive changes that people may experience following exposure to psychological trauma, and consists of three broad dimensions” (Gibbons, Murphy, and Joseph, 2011).
  1. Relationships are enhanced: value friends and family more, increased compassion and altruism toward others.
  2. Develop improved views of themselves: resilient, strong, yet accepting of vulnerabilities and limitations.
  3. Change in personal philosophy: fresh appreciation for each new day, renegotiating what really matters, and a realization life is finite (Tedeschi, Park, & Calhoun., 1998; Tedeschi & Calhoun, 2004).

Vicarious Post-traumatic Growth

- Supervision is key.
- When workers feel valued and their work load is manageable more likely to experience post-traumatic growth (Gibbons, Murphy, & Joseph, 2011).
What can happen in an organization that is not trauma-informed?

A “trauma-organized system” becomes fundamentally and unconsciously organized around the impact of chronic and toxic stress, even when this undermines the essential mission of the system (Bloom, 2012).

Organizations, like individuals, can be traumatized, and the result of traumatic experience can be as devastating for organizations as it is for individuals.

Many of our social service organizations are functioning as trauma-organized systems and are still unaware of the multiple ways in which their adaptation to chronic stress has created a state of dysfunction that can prohibit the recovery of the clients and cause harm to many of the people who work within it. (Bloom, 2012)

Leaders can become more authoritarian and punitive, and workers respond with more aggressive and passive-aggressive behavior.

Despite this apparent deterioration, there is a likelihood that chronically stressed organizations will simply continue to repeat the past. (Bloom, 2012)
What can happen in an organization that is not trauma-informed?

- Many sources of chronic workplace stress can result in organizations that are chronically hyper aroused and have lost the capacity to manage emotions, similar to clients who are served.

Group Activity

- With a partner make a list of things you do when you don’t feel safe.
- This can be lack of safety as it pertains to your emotional, physical, social, or spiritual well-being.
- You do not need to share an experience with each other just your reaction to lack of safety.

Group Activity

What helps you to feel secure when you don’t feel safe?
Lack of Basic Safety

- The exposure to traumatizing events among human service workers is extremely high.
- One of the consequences is a loss of a feeling of safety.
- Neither the staff nor the administrators feel particularly safe with their clients or even with each other.
- This lack of safety may present as a lack of physical safety, abusive behavior on the part of managers and/or staff, and a pervasive mistrust of the organization. (Bloom, 2014)

Silencing of Dissent

- Empirical data shows that organizational silence emerges out of workers’ fear to speak up about issues or problems they encounter at work.
- These underground topics become the “undiscussables” in an organization, covering a wide range of areas including decision-making, managerial incompetence, and poor organizational performance (Bloom, 2014).

Employees

- Most people in the United States will experience a traumatic event at some point in their life.
- People who have experienced toxic stress in early childhood enter the work force, they don’t leave these experiences at the door.
- Since the 1980’s work environments have become increasingly violent.
- After law enforcement, people working in the mental health sector in the United States, are the most likely to be victimized while at work (Bloom, 2015).
Employees

- In many social service agencies the turnover rate is at 50%.
- If we want to keep good workers we must create organizations where their deficits are minimized and their strengths maximized.
- Infusing knowledge about the effects of trauma on individuals, families, communities and organizations must also include assisting our employees to be able to survive and thrive in the field of social work.
- (Bloom, 2015)

Finding a New Path Forward

ACE study started a paradigm shift to what we now know as trauma-informed care.

Trauma-informed lens

- **Instead of what is wrong with you?**
  - We ask
- **What has happened to you?**
- (Bloom, 2013)
  - This is a lens we wear at work, home, in the community, at all times.
Trauma-Informed Care

- "A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings." (SAMHSA, 2012, p. 4).

- A trauma-informed perspective views trauma-related symptoms and behaviors as an individual’s best and most resilient attempt to manage, cope with, and rise above his or her experience of trauma.
- Some individuals’ means of adapting and coping have produced little difficulty; the coping and adaptive strategies of others have worked in the past but are not working as well now.
- Some people have difficulties in one area of life but have effectively negotiated and functioned in other areas.
  Shift your perspective from pathology to resiliency. (SAMHSA, 2014)

Group Activity

- What is the most important thing for you to receive from your supervisor?
- What is the most important thing for you to receive from your supervisee?
Group Activity

- Focus on one thing about your work that does not feel trauma-informed?
- Focus on one thing about your work that does feel trauma-informed.

(Bloom, 2016)

Principles of a Trauma-Informed Approach

- Safety
- Trustworthiness and transparency
- Collaboration and mutuality
- Peer support
- Empowerment
- Voice and choice
- Cultural humility

(SAMHSA, 2012, 2018)
Safety

- Psychological safety: the ability to be safe within oneself, to rely on one’s ability to self-protect and keep oneself out of harm’s way.
- Social safety: the sense of feeling safe with others, including corrective experiences.
- Moral safety: confronts hypocrisy, ongoing struggles with integrity and honesty.

(Bloom, 2013)

The Four R's of TIC

1. Realize
   All people at all levels have a basic reaction about trauma and how it affects individuals and communities.

2. Recognize
   People within organizations are able to recognize the signs and symptoms of trauma.

3. Respond
   Programs, organizations, and community are responsive to trauma in a trauma-informed approach.

4. Resist Re-Traumatization
   Organizations practice to identify trauma and transform trauma into organizational and systemic revitalization.

The Road to Trauma-Informed Care (TIC)

Trauma Informed Care is a shift in organizational culture, where an emphasis is placed on understanding, respecting, and appropriately responding to the effects trauma at all levels.

(Bloom, 2013)
SAMSHA Strategies for TIC

- Strategy #1: Show Organizational and Administrative Commitment to TIC
- Strategy #2: Use Trauma-Informed Principles in Strategic Planning
- Strategy #3: Review and Update Vision, Mission, and Value Statements
- Strategy #4: Assign a Key Staff Member to Facilitate Change
- Strategy #5: Create a Trauma-Informed Oversight Committee
- Strategy #6: Conduct an Organizational Self-Assessment of Trauma Informed Services
- Strategy #7: Develop an Implementation Plan
- Strategy #8: Develop Policies and Procedures to Ensure Trauma-Informed Practices and To Prevent Retraumatization

SAMSHA Strategies Continued

- Strategy #9: Develop a Disaster Plan
- Strategy #10: Incorporate Universal Routine Screenings
- Strategy #11: Apply Culturally Responsive Principles
- Strategy #12: Use Science-Based Knowledge
- Strategy #13: Create a Peer-Support Environment
- Strategy #14: Obtain Ongoing Feedback and Evaluations
- Strategy #15: Change the Environment To Increase Safety
- Strategy #16: Develop Trauma-Informed Collaborations

Building a Trauma Informed Workforce

- Trauma Champions
- Recruitment and Retention
- Staff Development
  - Training
  - Supervision
  - Consultation
- Attending to Secondary Traumatization
- Self Care
Trauma Champion

- Understands the impact of violence and victimization on the lives of people seeking mental health or addiction services
- Is a front-line worker who thinks ‘trauma first.’
- Will ask, ‘is this related to abuse and violence’?
- Will also think about whether his or her own behavior is hurtful or insensitive to the needs of a trauma survivor.
- Is there to do an identified job, but in addition is there to shine the spotlight on trauma issues.

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.

Staff 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.
Staff Training

- 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.

Example of a Trauma Informed Organization: The Sanctuary Model

A Sanctuary program should be a strong, resilient, tolerant, caring, knowledge-seeking, cohesive, and nonviolent community where
- staff are thriving,
- people trust each other to do the right thing, and
- clients are making progress in their own recovery within the context of a truly safe and connected community.

(Bloom, 2013)

Sanctuary Model

- Decreased staff turnover,
- decreased use of coercive measures,
- decreased critical incidents, staff injuries, and client injuries,
- greater client and staff satisfaction.

(Bloom, 2013)
Sanctuary Model

- Such a community fully recognizes the ever present possibility of violence and attends to protecting its social system against the spread of violence in any form – physical, psychological, social or moral.

- Communication is open, direct and honest and people trust that they will find out information that they need to make good decisions.

- If someone feels that their trust has been betrayed, they are willing to give the other person the "benefit of the doubt", and find out what happened.

(Bloom, 2013)

Sanctuary Model

- Members of a Sanctuary community are curious about human behavior and do not assume that everyone is motivated in the same way.

- They are accustomed to listening deeply and to being heard by others.

- Every effort is made to include anyone affected by a decision in the decision-making process and as a result people feel free to dissent, to raise troubling concerns.

(Bloom, 2013)

Sanctuary Model

- A Sanctuary community is able to have safe and useful conflict as a means of learning and growing.

- Conflicts are seen as a resource and are generally well-managed with emotional intelligence and open communication.

(Bloom, 2013)
Sanctuary Model

- Everyone in a Sanctuary community recognizes that "hurt people hurt people" and that therefore, creating and sustaining a just environment is vital to everyone's safety and well-being.

- In full recognition of the vulnerability to loss that everyone experiences, a Sanctuary community honors individual and group losses, while using a vision of the future to prevent stagnation and to promote continued development.

Tool in the Supervisory Relationship

- The administrator, supervisor, worker, and client can play any of these roles.
- An application of the victim/victimizer/bystander dynamic to the supervision process can contribute to a resolution of impasses in the treatment and/or the supervision relationships. (Miehls, 2009)

Trauma Informed Supervision Strategies

- Schedule formal supervision.
- Maintain appropriate boundaries.
- Be trustworthy and transparent.
- Nonjudgmental listening, empathy, and validation.
- Reflective supervision (how is supervision going for you) listen to what the worker says.
- Collaboration and mutuality.
- Positive team-building.
- Empowerment, voice, and choice.
- Noncritical feedback.
- Being present, physically & emotionally.
- Be willing to be flexible and process what is going on in the world.
Trauma Informed Supervision Strategies

- Access to resources.
- Advocate for manageable caseloads.
- Structure peer consultation model.
- Educate them about trauma and vicarious trauma. (Rutgers University, 2017)
- Integrate and emphasize self care.
- Remember workers will give you the material you need.
- Be careful, too often supervision is task oriented.
- Ensure you do “no harm” be careful not to retraumatize.
- Remember you are not their therapist, you can talk to them about their trauma and life experience and how it is effecting their work and suggest therapy if you feel it would be beneficial to them.

Case Study: Rebecca

Rebecca is a 26 year old MSW social worker intern. Her field placement is at an adult inpatient psychiatric hospital. She has moved to the area from out west to attend a university in the Northeast section of the United States. Prior to her admittance to graduate school she was a case manager for the mentally ill. She is an excellent student and seems to have good clinical judgment. Her field instructor has been pleased with her work. Most of Rebecca’s time at her internship is spent interviewing clients to complete a biopsychosocial for the treatment team. She has found this difficult as her clients often present with very complex trauma. She is concerned about her ability to manage her emotions when interviewing the clients and reported to her field liaison that often the information shared is so sad she has to be careful not to cry in front of the client. She gave a specific incident where she was interviewing a gentleman and he reported being sexually abused for several years when he was a young child by his adoptive father. The student reported she wanted to “sob” when she heard this. She stated she did not but she is afraid she may not be able to control these sad feelings as she continues to hear the clients reports of trauma.
Questions

References

References


References

- Substance Abuse and Mental Health Services Administration. (2012). SAMHSA’s working definition of trauma and principles and guidance for a trauma-informed approach (Draft). Rockville, MD: Substance Abuse and Mental Health Services Administration.