

Current Issues

Vicarious Traumatization, Trauma-Sensitive Supervision, and Counselor Preparation

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Counselor educators have an ethical responsibility to prepare counselors and supervisors to detect and resolve vicarious traumatization in themselves and their supervisees. This article reviews relevant literature on vicarious traumatization and strategies to mitigate it. Also included is a review of the American Counseling Association's (2005) *ACA Code of Ethics* and the Council for Accreditation of Counseling and Related Educational Programs' (2007) proposed 2009 standards as each relates to trauma counseling and vicarious traumatization. Specific counselor preparation practices are suggested.

Traumatic events occur more frequently than many people would like to believe. Aside from random violent crimes, school shootings, and domestic violence, people can be traumatized by human-created tragedies, such as war and terrorist attacks, or by a variety of natural disasters. Although many counselors will never work in a rape crisis center, a Veteran's Administration hospital, or other agency in which crisis is the primary focus, the likelihood of encountering clients with trauma-related issues is still high. Collins and Collins (2005) noted examples of traumatic events with wide-scale impact, including the September 11, 2001, terrorist attacks; the Littleton, Colorado, school shooting; the January 2001 El Salvador earthquake; and the frequent reports of sexual abuse within the Roman Catholic church. Two recent events can be added to this list: the 2004 Sumatra tsunami, which killed tens of thousands in Asia, and Hurricane Katrina, which devastated much of the U.S. Gulf Coast in 2005. Trauma can also have a historical basis that requires multicultural sensitivity. Dass-Brailsford (2007) pointed out that intergenerational and multicultural trauma can have deleterious effects on Native Americans, African Americans, and Japanese Americans. Trippany, White Kress, and Wilcoxon (2004) also discussed the prevalence of traumatic events, noting that "counselors in virtually all settings work with clients who are survivors of trauma" (p. 31).

Clients who are traumatized can be encountered in the office or in response to a disaster. Members of the American Counseling Association

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(ACA) will most likely remember the requests for counselors to help after the September 11 terrorist attacks and after Hurricane Katrina. Given the prevalence of diverse traumatic experiences that may lead individuals to seek counseling and the likelihood that most counselors will encounter clients who are traumatized, it seems imperative that counselors are adequately prepared. Although trauma-related events affect both individuals and the counselors who work with them, this article focuses on the effects of *vicarious* exposure to trauma. It has a fourfold purpose: (a) to ensure that vicarious traumatization remains a topic of discussion in the counseling profession, (b) to point out that the literature reports methods of mitigating the effects of vicarious exposure to trauma, (c) to introduce the idea that counselor educators have an ethical responsibility to provide specific training in this area to prevent potential harm to clients and counselors, and (d) to recommend counselor preparation practices.

Posttraumatic Stress Disorder (PTSD) and Vicarious Traumatization

Individuals exposed to extreme stressors may develop PTSD. The *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; American Psychiatric Association [APA], 2000) indicates that individuals with PTSD usually experience problems in three areas: (a) persistent reexperiencing of the traumatic event via flashbacks, dreams, and other unwanted recollections, as well as persistent psychological or physiological distress with exposure to cues related to the trauma; (b) persistent avoidance of stimuli or cues related to the traumatic event; and (c) persistent symptoms of increased arousal, such as hypervigilance and exaggerated startle response. It is important to acknowledge that PTSD not only affects those directly experiencing the traumatic event but also may affect those who witness or learn about the event (APA, 2000). Therefore, traumatic events create a ripple effect in that primary survivors as well as close associates, such as family members and counselors, can experience trauma-related symptoms (Figley, 1995, 2002).

Although many counselors will be exposed to vicarious trauma, there are different responses and not all of these counselors will experience vicarious traumatization. For example, one sexual violence counselor may be relatively unaffected by her clients' stories, whereas another counselor in a similar situation may experience any combination of the PTSD symptoms described earlier, such as intrusive thoughts of particular client stories, avoidance of related stimuli (e.g., avoiding films or television programs that portray sexual violence), or hypervigilance (e.g., constantly checking to ensure that doors are locked). A variety of terms have been used to describe the deleterious effects experienced by some professionals who provide services to those directly affected by traumatic stressors. McCann and Pearlman (1990) suggested the term *vicarious traumatization*. Figley (1995, 1999) credited Joinson with first using the term *compassion fatigue* to refer to burnout among nurses. Other authors have preferred the use of the terms *secondary traumatic stress*

or *secondary traumatic stress disorder* (Catherall, 1999; Kassam-Adams, 1999). A common thread among these various descriptors is summarized by Pearlman (1999): Vicarious traumatization is “neither a reflection of inadequacy on the part of the therapist nor of toxicity or badness on the part of the client. It is best conceptualized as a sort of occupational hazard” (p. 52). Skovholt (2001) similarly noted that members of the helping professions are exposed to a number of hazards, including practitioner emotional trauma. Knowing about such hazards in advance and being prepared to deal with them are critical to counselor well-being.

Research on Vicarious Traumatization

A growing body of research offers information about the experiences of counselors who work with clients who are traumatized. Early studies identified similar effects on practitioners who worked with trauma survivors. Hodgkinson and Shepherd (1994) discovered that social workers responding to large-scale catastrophes experienced statistically significant levels of cognitive disturbance evidenced by intrusive, unpleasant thoughts and depressive symptoms. Pearlman and Mac Ian (1995) learned that sexual violence counselors experienced elevated levels of trauma symptoms. Schauben and Frazier (1995) found that counselors with a higher percentage of sexual violence survivors on their caseloads experienced “more disruptions in their basic schemas about themselves and others, more symptoms of PTSD, and more self-reported vicarious trauma” (p. 57).

Research within the past decade has continued to clarify the effects of vicarious exposure to trauma. Kassam-Adams (1999) discovered that counselors with a greater number of clients with sexual trauma issues self-reported more trauma-related symptoms at “a level that in traumatized persons would suggest the need for clinical attention” (p. 41). Similarly, Chrestman (1999) found that counselors involved with clients who are traumatized demonstrated increased levels of trauma symptomatology. Iliffe and Steed (2000) noted physical effects such as nausea, headaches, and exhaustion and psychological distress such as feelings of horror and intrusive imagery in counselors who worked with survivors or perpetrators of domestic violence. Sommer and Cox (2005, 2006) described similar physical and emotional reactions in counselors who worked with sexual violence survivors and perpetrators who had also been victimized. Wee and Myers (2002) investigated the reactions of mental health workers who provided counseling to survivors of the 1995 Oklahoma City bombing. They noted that most participants exhibited symptoms that fell in the midrange of PTSD diagnosis. Both Chrestman’s and Iliffe and Steed’s participants noted activities related to hypervigilance aimed at keeping themselves and loved ones safe from harm. Finally, Meldrum, King, and Spooner’s (2002) investigation indicated that 18% of general mental health workers (regardless of settings or client population) throughout Australia “are experiencing symptoms which in quantity, quality, and intensity are equivalent to those experienced by people who meet criteria for a diagnosis of PTSD” (p. 99).

Some characteristics seem to influence the effects of secondary traumatic stress on direct care providers. For instance, Chrestman (1999) found that as professional experience, income, and postgraduate training increased, trauma symptoms decreased, whereas greater involvement with direct client services and higher numbers of clients with trauma-related difficulties led to increased reports of trauma symptoms. Woodard Meyers and Cornille (2002) found that both a longer history in the field and working more than 40 hours per week resulted in elevated levels of trauma symptoms. Additionally, female participants reported more physical and emotional trauma symptoms than did their male counterparts. Wee and Myers (2002) indicated that participants with administrative responsibilities and those with more months in service exhibited the most severe symptoms. Pearlman and Mac Ian (1995) found that sexual violence counselors with a personal history of sexual abuse tended to exhibit the highest levels of trauma-related symptoms. In their study, participants with fewer than 2 years of experience in the field demonstrated more trauma-related symptoms than did those with more years of experience. Sommer and Cox (2005) noted that collaborative supervision that actively addressed vicarious traumatization and a supportive work environment seemed to influence participants' abilities to cope with their work.

Trauma-Sensitive Supervision

Supervision practices that actively address vicarious traumatization have been strongly encouraged (Chrestman, 1999; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995; Trippany et al., 2004; Woodard Meyers & Cornille, 2002) but not always described in detail; however, trauma-sensitive supervision guidelines exist. Pearlman and Saakvitne (1995) recommended four components necessary for successful supervision of trauma counselors, namely, a strong theoretical grounding in trauma therapy, attention to both the conscious and unconscious aspects of treatment, a mutually respectful interpersonal climate, and educational components that directly address vicarious traumatization (p. 360). Building on Pearlman and Saakvitne's work, Etherington (2000) noted that supervisors of trauma counselors should be alert to changes in counselors' behavior with and reactions to clients, intrusions of client stories in counselors' lives, signs of burnout and feelings of being overwhelmed, signs of withdrawal in either the counseling or the supervisory relationship, and signs of stress and an inability to engage in self-care. Rosenbloom, Pratt, and Pearlman (1999) suggested that supervision for trauma counselors should be ongoing and not restricted to prelicensure training. They noted that "supervision should foster an atmosphere of respect, safety, and control for the therapist who will be exploring the difficult issues evoked by trauma therapy" (Rosenbloom et al., 1999, p. 77). Sommer and Cox (2005) reported that trauma-sensitive supervision should include time for talking about the effects of the work and related personal feelings; directly address vicarious traumatization; and use a collaborative, strength-based approach. Sommer and Cox (2006) also noted that

the use of stories in supervision can facilitate meaning making and self-reflection in trauma counselors.

In addition to trauma-sensitive supervision, other recommendations for mitigating vicarious traumatization focus on personal self-care and work-related strategies. Pearlman (1999) pointed to the importance of a healthy lifestyle as well as continuing education in the area of trauma. Several authors have suggested that agencies implement practices to diminish vicarious traumatization, such as reducing client caseloads, increasing vacation and sick leave, providing opportunities for counselors to engage in nonclinical aspects of trauma work, and offering mental health care for counselors (Chrestman, 1999; Kassam-Adams, 1999; Rosenbloom et al., 1999; Rudolph & Stamm, 1999; Schauben & Frazier, 1995; Trippany et al., 2004; Woodard Meyers & Cornille, 2002). Sommer and Cox (2005) noted that agencies should structure schedules to allow ample time for supervision and should avoid dual relationships in which the supervisor is also the agency director. Munroe (1999) also pointed to the importance of a supportive agency environment when he stated, "It is not sufficient for employers . . . to instruct therapists to take care of themselves off the job; active preventive measures should be a regular part of the work environment" (p. 216).

Ethical Standards and Council for Accreditation of Counseling and Related Educational Programs (CACREP) Accreditation Standards

It seems that educators have an ethical obligation to inform counselors regarding the dangers inherent in working with clients who are traumatized. Munroe (1999) reviewed the APA's guidelines for training and noted, "Not only should we be concerned about warning candidates of the potential harm of being exposed to trauma, but that we should also train them how to cope with this exposure" (p. 215). The *ACA Code of Ethics* (ACA, 2005) implies a similar need for counselor educators to address vicarious traumatization. Several standards have relevant implications. Standard C.2.a. and Standard C.2.b. note that counselors should practice only after receiving relevant education, training, and supervised experience. Similarly, Standard F.2.a. points out that supervisors must be adequately trained. The likelihood that most counselors will work with clients who are traumatized is high (Munroe, 1999; Pearlman & Saakvitne, 1995; Trippany et al., 2004), and trauma-sensitive supervision has been noted as a key factor in mitigating vicarious traumatization. This being the case, it seems that counselor educators should prepare future counselors and supervisors to be aware of the signs of vicarious traumatization in counselors as well as the measures that have been suggested to ameliorate it.

If counselor educators fail to train counselors and supervisors in this area, they contribute to the problem. Standard A.4.a. and Standard F.1.a. charge counselors and supervisors to avoid harm and to monitor the welfare of both clients and trainees. Standard F.8.b. offers

a similar directive for counselors-in-training. Other standards also support the present argument. Both Standard A.11.b. and Standard C.2.g. address the need for counselors to be alert to any signs of personal impairment and to avoid providing services in such instances. Counselors are also encouraged to be alert to signs of impairment in their colleagues and supervisors and to “intervene as appropriate to prevent imminent harm to clients” (Standard C.2.g.). When counselors-in-training, practicing counselors, and supervisors are not prepared to detect the warning signs of vicarious traumatization in counselors, counselors may develop symptoms related to traumatic stress. Clients may, in turn, be harmed by counselors who encourage clients to avoid traumatic material or who may simply be unable to be present with clients because of exhaustion (Catherall, 1999; Munroe, 1999). An additional problem is that counselors who experience vicarious traumatization and do not receive assistance may leave the field (Figley, 1995; Harris, 1995), resulting in less skilled professionals remaining and organizations that must train new employees.

One final group of ethical standards is relevant to this discussion. Standard D.1.h. instructs counselors to take action when agency policies may be damaging to clients or limit the effectiveness of services. Standard H.2.c. specifies that when organizational policies seem to conflict with the *ACA Code of Ethics* (ACA, 2005), counselors should address this discrepancy. Standard A.6.a. encourages counselors to advocate at institutional levels when they observe practices that may limit client growth and development. Organizations that fail to actively address issues related to vicarious traumatization via agency policies and supervision may be at fault for fostering conditions that impede client services. Counselors and supervisors have the opportunity to advocate for organizational changes that would benefit clients as well as the counselors who work with them.

Requiring counselor educators to prepare counselors to deal with the effects of vicarious exposure to trauma seems to be a logical and ethical beginning to ensure that counseling professionals have adequate preparation in this area. CACREP seems to agree. In Draft 3 of the proposed 2009 CACREP standards (CACREP, 2007), three of the eight core CACREP areas address crisis counseling, including information about counselor well-being. In the Professional Orientation and Ethical Practice section, Standard II.F.1.c. states that counselors should receive training in “counselors’ roles and responsibilities as members of an interdisciplinary emergency management response team during a local, regional or national crisis, emergency or disaster” (p. 9), and Standard II.F.1.d. includes “self-care strategies appropriate to the counselor role” (p. 9). Standards II.F.3.c. and II.F.3.f. in the Human Growth and Development section state that counselor educators are to address the effects of trauma and disaster across the life span. In the Helping Relationships section, Standard II.F.5.g. discusses how counselors should have “an understanding of multidisciplinary immediate, intermediate and long term responses to crises, emergencies and disasters, including the use of psychological first aid strategies” (p.

11). Besides the eight core CACREP areas, standards related to crises also appear in program descriptions for addiction counseling, career counseling, clinical mental health counseling, college counseling and student development, and school counseling, as well as in the section on doctoral standards for counselor education and supervision.

Standards in the *ACA Code of Ethics* (ACA, 2005) direct counselor educators to infuse material related to multiculturalism and diversity (Standard F.6.b.) and ethical considerations (Standard F.6.d.) throughout counselor education curriculum. This same approach could prove useful in the area of vicarious traumatization. For example, crisis counseling strategies could be addressed in course work, such as supervision, professional orientation, skills development, and practicum and internship. A specific course in crisis counseling, however, would be ideal.

Recommendations for Counselor Preparation

I have taught in CACREP-accredited counselor education programs for the past 5 years. I have incorporated information on crisis counseling and vicarious traumatization in various courses, especially master's-level practicum and internship. Doctoral supervision courses have provided an opportunity to share information about vicarious traumatization as students complete readings on this topic and are encouraged to consider any signs of vicarious traumatization in their supervisees. Practically any counseling course can provide some opportunity to discuss crisis counseling, especially if a crisis is unfolding on either a national or global level. Counselor educators can use this event to talk about counselor responses to clients who are traumatized as well as how to engage in self-care when caring for these clients. In today's media-oriented culture, major crises receive around-the-clock coverage. Students may be fatigued by simply watching this programming. Providing a forum for in-class discussion of the crisis and related student reactions can help stimulate thinking about crisis counseling and vicarious traumatization. Specific practices that have been used include topical presentations, breath work and guided imagery, and reflective reading.

Topical Presentations

In master's-level practicum and internship, students are often required to prepare a topical presentation to be offered in class. They are provided with a list of potential topics, such as current multicultural issues, contemporary ethical practices, treatments relevant to specific client populations, and mandated reporting of child abuse. In addition to these more standard topics, I always include self-care, vicarious traumatization, and crisis response. Each semester I attempt to limit the number of topics to closely match the number of students in class to guarantee that topics related to vicarious traumatization will be addressed. Student presentations include a 20-minute didactic component based on current scholarly literature and a 10-minute

segment for questions and answers. Topical presentations related to vicarious traumatization and self-care serve to stimulate active discussions and allow students to share their own feelings about and reactions to working with clients who are traumatized. These discussions often serve as a reference point for addressing this topic during the remainder of the course.

Breath Work and Guided Imagery

Early in practicum and internship, self-care is emphasized. I use a metaphor to introduce the topic, such as (a) a flight attendant explaining that in the case of an emergency, passengers are not able to assist others if they do not place their own oxygen mask on first and (b) not keeping one's personal car well maintained and with a full tank of gasoline may hinder its use for transportation. I stress that self-care is as important to the professional practice of counseling as theoretical orientations and technical applications. The use of a round-robin or a circle-around at the start of each week's class allows students to briefly share what is happening at their sites and how they are feeling about their work. On weeks when multiple students indicate high levels of stress, students are encouraged to practice in class self-care techniques such as breath work or guided imagery. I invite the entire class to participate, and after 5 years of practice, I have yet to have a student indicate that he or she did not wish to participate.

When using either breath work or guided imagery, classroom lighting is dimmed. I suggest that students get comfortable in their chairs and close their eyes. Using breath work is a relatively simple practice that can be challenging to perfect. I recommend that students pay attention to their breath as it enters and as it leaves the body by focusing either on their nostrils or on the rising and falling of their bellies. Students are encouraged to silently note to themselves "in" as they inhale or "out" as they exhale. I practice the breath work along with the students, although I periodically offer reminders about what we are doing by saying, "Remember to pay attention to the breath" or "If you find yourself thinking, just allow yourself to return to your breathing." After about 10 minutes of breath work, I suggest that students begin to bring their awareness back to the present. Readers not familiar with such practices can consult Suzuki (1987).

When using guided imagery in practicum or internship, begin with breath work and then move to progressive relaxation. For example, I lead students through an exercise (speaking softly and slowly) to have them focus first on their feet by giving their feet permission to relax. The exercise encourages students to slowly move their focus from their feet upward to other parts of their bodies. The purpose remains to permit various parts of the body to relax, especially areas prone to tension, such as the neck and shoulders. When the focus of the exercise transitions to the head, I suggest that students pay special attention to their facial and scalp muscles, allowing each of these tiny muscles to completely relax. At this time, students are encouraged to notice how completely relaxed they feel. They are asked to allow an

image to enter their minds, an image that represents this feeling of relaxation. I purposefully do not direct the imagery in any way so that students select images that are most meaningful to them. I provide them with a few minutes to concentrate on and experience the image selected, and then I suggest returning to this state of relaxation in the future by paying attention to their breathing and mentally focusing on their personal image for relaxation. The guided imagery exercise takes approximately 20 minutes.

After breath work or guided imagery, time is spent processing what the students have experienced. Student comments have included "I feel more peaceful" and "I feel much less stressed out." Over the course of the semester, we use these practices periodically but not during each class; however, I regularly ask if students are using either breath work or their personal relaxation symbol on their own. Many students indicate that these practices have become a regular part of their personal self-care programs.

Reflective Reading

When I teach practicum and internship courses, I assign readings that are thought provoking and geared toward self-reflection. One book that students have found particularly helpful is *Diary of a Country Therapist* by Marcia Hill (2004). This book details Hill's experiences over a number of years and is written in short, journal-like passages. There are no particular reading assignments; rather, students are encouraged to read at their own pace and keep track of passages they found particularly meaningful. Periodically, I will ask students to comment on their reading and to share their favorite passages. I also discuss entries relevant to issues being addressed in the class. Hill speaks poignantly and clearly about the challenges of the counseling profession and writes in a way that seems to resonate with most students. Her hardships and heartbreaks relating to clients often help students begin to discuss similar feelings of their own. This book has been well received, and in course evaluations, students have recommended the continued assignment of this book for future practicum and internship students.

Further Reflections

Two studies illustrate the disparity between what is deemed necessary training and what is actually practiced. Kitzrow's (2002) survey of master's and doctoral CACREP-accredited programs found that although 95% of respondents agreed that training in the area of sexual abuse was "very important" or "important," only 9% of the programs required any training in this area (p. 111). Sommer and Cox (2005) found that of nine sexual violence counselors interviewed, only one received any academic preparation related to vicarious traumatization. Counselor educators may therefore not incorporate material related to crisis intervention and vicarious traumatization until they are required to do so. The practices described in this article are intended to help

counselor educators address ACA ethical standards and CACREP-proposed standards that relate to vicarious traumatization.

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