McBride, Dawn (2008). Supervision issues in family violence cases. In S. Brooke (Ed.), The use of creative therapies with survivors of domestic violence (pp. 321-342). Springfield, IL: Charles C. Thomas.

Chapter 17

SUPERVISION ISSUES IN FAMILY VIOLENCE CASES

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Introduction

A counselor, somewhat new to the field of family violence work, debriefs her frustration to you, the agency supervisor, at her client's decision to return to an abusive partner. You sense the counselor is feeling disheartened the client did not listen to her advice to remain at the shelter for another week. You wonder if the counselor is personalizing the client's decision as a counter transference reaction given her unusual amount of frustration. Further, you wonder if a risk assessment was done before the client left the session to ensure the client's safety. All these thoughts, and more, are running through your mind as the counselor stands before you. You question the best way to approach this counselor as there are a host of options and each option is dependent on many variables such as the counselor's developmental competency stage, her personal background, and her personality style.

This is just one of the many scenarios supervisors have to contend with when supervising therapists who carry a caseload of clients with a family violence background. Supervisors need to adopt a new way of thinking when they become a supervisor (Pearson, 2006). They need to think and act like an educator/trainer, consultant, and counselor (Bernard, 1997; Stoltenberg & Delworth, 1987) with the mandate to always look after the best interests of the client but at the same time ensure the counselor is gaining therapeutic competence. It is a juggling act that can be taxing, particular if the supervisor has not received training in the art and science of supervision. The lack of training of supervisors is a significant concern, particularly since many universities still fail to offer graduate counselor courses in supervision (Nelson, Johnson, & Thorngren, 2000). Furthermore, it is not uncommon for

therapists (often those working for non-profit agencies such as shelters) to be promoted to the role of supervisor without receiving training in the understanding and application of the theoretical underpinnings associated with supervision (Lindblad-Goldberg, 1996; Nelson et al., 2000), especially as it relates to supervising family violence cases. Thus, this chapter is timely.

The context of this chapter is specific to supervising counselors with clients who were/are in a domestic relationship (e.g., dating, common-law, marriage) characterized by abuse. The guiding assumption is that both males and females can be perpetuators and/or victims of abuse and that abuse occurs in both same-sex and heterosexual relationships. Perhaps not surprisingly, the body of academic literature on supervision practices is limited as noted by Bradshaw, Butterworth, and Mairs (2007) and Edwards and associates (2005). Furthermore, the literature is even scarcer when it pertains to family violence and supervision issues. Consequently, much of the material in this chapter is drawn from my experiences as a clinical supervisor and educator on family violence.

To explore issues in family violence supervision, this chapter begins with an overview of the developmental stages of counselors. If the supervisor does not align with the needs of the supervisee, significant conflicts will likely occur. The next major section explores the value of knowing the supervisor's and supervisee's personality profiles as it relates to maximizing communication and learning practices. The last section in this chapter discusses the inherent risk of family violence therapists experiencing vicarious traumatic reactions and the role of the supervisor in helping the supervisee overcome the effects of listening to stories of trauma. The chapter concludes with an experiential activity family violence supervisors can use to promote discussion of self-care in their supervisees.

Developmental Stages of Supervisees

Intuitively, supervisees are in different stages of developing professional competence. As noted by Pearson (2001), knowledge of these stages allows supervisors to decide on the amount of structure needed in the supervision sessions including the balance between teaching, consulting, practicing the skills, and exploring supervisee's personal reactions and beliefs. Many writers have written about these developmental stages, notably Loganbill, Hardy, and Delworth (1982, a very comprehensive review) and Worthington (1987, an excellent review). Since these stages are described at length elsewhere, I will present three integrative stages, based on the work of Stoltenberg and Delworth (1987), using the same descriptive headings (levels) as Hawkins and Shohet (1989, p. 52) to reflect the main focus of the supervisee.

Level I: Self centered–Can I make it in this work?

If you are helping newcomers to the field of counseling and/or to the field of intervening in family violence cases, it is likely the counselors are grappling with anxiety, uncertainty, self-doubt, and confusion. These counselors (known forth as supervisees) will be dependent on the supervisor for guidance, reassurance, and support (Stoltenberg & Delworth, 1987). As noted by Costa (1994), supervisee anxiety needs to be addressed, for if it continues, supervisees may rely on unhealthy defense mechanisms to cope with the anxiety (e.g., submissive, blaming, projection, displacement, intellectualization). This reaction could interfere with the supervisees learning process and could put them at risk of developing poor working alliances with their clients (Ackerman & Hilsenroth, 2001). One strategy (among seven described by Costa) to reduce anxiety is to have the supervisees list their irrational fears and beliefs about supervision (and working with family violence clients). I would then follow this exercise with cognitive behavioral exercises to challenge their irrational beliefs. Throughout this normalizing and instructional phase, it is of crucial importance to create a trusting, caring, and nonjudgmental relationship with the supervisees. A strong working alliance between a supervisee and supervisor will promote safety for exploration and will act as a buffer when negative events occur in counseling (Ramos-Sanchez et al., 2002, a good empirical study on the value of good working in supervisory relationships; Worthington & Roehlke, 1979, a classic article on what supervisees find helpful from their supervisors).

Structured supervision sessions are highly valuable when working with supervisees at level I. The work of Bradley and Whiting (2001) and Powell (2004) provide ample resource material that can be used during structured supervision sessions (e.g., supervisee goal sheets, pre-post evaluations, case review forms, live observation forms, supervisory record, etc.). In addition, see Appendix A for an interview schedule to help build the relationship between the supervisee and supervisor as well as outline the expectations for supervision (McBride, 2007).

Supervisees in this stage need to learn about the dynamics of family violence and how counselors manage the intensity in these sessions. To meet this learning need, two required readings I assign family violence supervisees are Herman's (1997) book on the impact of trauma and the recovery from it and Dutton's (1995) narrative account of a group program for men who have abusive histories. I also encourage supervisees, before they start work with family violence clients, to observe a diverse range of family violence sessions (e.g., intake, group and individual sessions, crisis sessions, etc.) being facilitated by a number of different counselors. This exposure hopefully demonstrates there is more than one way to counsel family violence clients and that

there is "no perfect session," which can have the effect of reducing supervisee performance and evaluation anxiety. In debriefing their observations, I ensure there are no judgments or criticisms of fellow counselors as it preserves the cohesiveness of the agency and promotes a safe atmosphere for learning. This is an important piece to note, as it is a precaution against vicarious traumatization, which will be explained later in the chapter.

Once level I supervisees start to counsel family violence clients, it is critical the supervisor observes the sessions of the supervisees and/or reviews the content of the session (e.g., reviews the counseling tapes and/or written transcripts). This is because supervisees at this particular stage tend "to focus on specific aspects of the client's history, current situation, or personality assessment data to the exclusion of other relevant information. Grand conclusions may be based on rather discreet pieces of information" (Stoltenberg & Delworth, 1987, p. 56). I find this is a very common reaction when a therapist (at any skill level) feels overwhelmed with the volume and intensity of the multiple issues often associated with working with family violence cases (i.e., a common family violence client scenario: The client has numerous systems involved in the case, has active PTSD symptoms such as flashbacks, has an unending list of resolved family of origin issues, and is at risk for suicide). Guiding level I supervisees on how to prioritize clients concerns and manage the long list of issues is a process that requires active involvement from the supervisor. In fact, co-therapy or direct observations behind a mirror using a telephone are my preferred strategies when working with counselors new to family violence work. This format of supervision allows me to guide the counseling session if the supervisee(s) is uncertain what to say or do next or focuses on issues that do not require immediate attention. An excellent book on co-therapy by Roller and Nelson (1991) and the chapter by Goodyear and Nelson (1997) provides an informative review of the major supervision methods (e.g., bug in the ear, group supervision, reflecting teams, case presentations).

In addition to the narrow perspective level I supervisees are prone to have when processing client information, I find counselors new to trauma work tend to either block (or deny) their emotional and physical reactions during session work or become very overwhelmed with these sensations. Teaching counselors how to ground themselves when hearing stories of violence and despair is critical to prevent emotional burnout and vicarious traumatization. To this end, I assign Pearlman and Saakvitne's (1995) excellent chapter on specific strategies to manage the content when listening to client's stories of experiencing or inflicting abuse. I also actively invite supervisees to process with me what they felt in their body while working with a family violence client. For example, I might ask a supervisee: "what was happening in your body as you heard the husband describe? . . . , "I notice you grimaced at the

disclosure of . . . put words to your grimace," "were you aware of making this grimace?" and/or "what sensations or thoughts are you aware of that might give you a clue of a grimace starting to form?"

Overall, supervisees new to the field of counseling and/or working with family violence cases may be highly anxious but are often highly motivated to learn (level I; Stoltenberg & Delworth, 1987). Navigating through this level requires the supervisor to assume a nurturing role, combined with sharing family violence literature and indirectly exposing the supervisee to family violence cases to prepare them to move to level II. This is one of the most taxing levels for the supervisor because of the steady demand for assistance and the need for the supervisor to constantly monitor how much information and processing the supervisee can handle to avoid overwhelming the already insecure, anxious supervisee.

Level II: Client centered–Can I help this client?

By this point, supervisees have gained some confidence in working with family violence cases. There is also an overall reduction in expecting the supervisor to offer "cookbook" solutions (Powell, 2004). Likewise, experienced therapists new to family violence work, and who are in level II, will come to realize many of their counseling skills can be integrated to help clients with an abuse/abusive history. To the relief of their supervisors, supervisees at this stage are often able to remain somewhat grounded before, during and after a trauma session. As a result of their anxieties decreasing and their confidence building, they become more client focused (Stoltenberg & Delworth, 1987). However, there is more of a risk at this stage for supervisees to over identify, become enmeshed, or emotionally distant from their clients (Powell). This may be demonstrated by the supervisee accepting calls at home from clients who are wanting to leave their partners, if the counselor has a vested interest in making sure clients do leave their abusive spouses. Or, in facilitating groups for those who abuse, the supervisee may act reserved and decline to socialize with the group members during the coffee breaks.

Supervisees in level II are described by Haber (1996) as being like adolescents undergoing a rapid and turbulent growth process characterized by wanting to become autonomous but at the same time recognizing (hopefully) that they still need guidance and support. It is also common for level II supervisees to experience fluctuations in their confidence and motivation as they realize therapy is not easily learned or powerful enough as they start to encounter therapeutic failures (Stoltenberg & Delworth, 1987). Consequently, Hawkins and Shohet (1989) warn supervisees, at this point, may become

disillusioned with the supervision process and become frustrated with the supervisor. They wisely recommend these supervisee feelings need to be monitored, processed and/or contained as these feelings could leak into their counseling sessions, which may be one of the explanations why the therapist in the opening case was so frustrated at her client for returning to her abusive partner.

The supervisor's role, in this level, is to provide "a transparent safety net, giving counselors the courage to venture out with the knowledge that someone is there to catch them should they fall" (Powell, 2004, p. 89). This can be a very challenging stage to navigate as the supervisor is now seen as fallible so there is often more challenging of the supervisor's feedback (Hawkins & Shohet, 1998). In addition, even though there is significant value in allowing the supervisees to learn from their mistakes (much like parenting an adolescent; Hawkins & Shohet) supervisors still need to ensure the supervisee's clients are safe and receiving appropriate care.

One of the ways I manage this balance between respecting autonomy and ensuring client care is to outline clear, non-negotiable expectations as to when I must be consulted, particularly with family violence cases (see Appendix B, McBride 2006). I find this list serves as a face saving mechanism as the supervisee can start off the supervision session by saying "you told me I have to consult with you when. . . ." This encourages the supervisee to come forth with therapeutic problems rather than get caught in the shameful circle of "I should know what to do." An excellent article on the experience and behavior of shame in supervision sessions is by Hahn (2001). I highly recommend supervisees read this article and process it with their supervisors as a way to prevent shame from flourishing as the supervisee works through the "dependency-autonomy" conflicts.

Level III: Process oriented–How are we relating together?

Level III supervisees have a "mature awareness of their own strengths and limitations . . . they can empathize with a client while maintaining sufficient objectivity. . . . As a result, they can make therapeutic use of their own and client's reactions. . . . [Their] motivation is steady, consistent, realistic, and balanced" (Powell, 2004, pp. 92-93). This awareness and objectivity allows theme to refine what Hawkins and Shohet (1989) refer to as, "helicopter skills" (p. 51) where they have the skill to gain a holistic view of the situation. Consequently, their assessment and case conceptualization skills are sharp and thus, they can be trusted to seek supervision when needed as they will know when they are at an impasse (Stoltenberg & Delworth, 1987). Pearson (2001) notes supervision sessions "come alive . . . primarily in the form of

self-challenge, and a deeper exploration of personal reactions and relationship processes. At this level, the supervisor essentially follows the counselor's lead in determining the content of supervision" (p. 176). In other words, as the supervisee becomes more effective, Worthington (1987) advocates the supervisor can become more reactive.

There are two inherent dangers I have witnessed with level III supervisees, particularly those based in rural communities or in non-profit agencies. First, supervision sessions are not as regular and are frequently rescheduled or canceled as the supervisor may not see the value in regular supervision with a skilled clinician, particularly if the supervisor has a heavy case load of level I and II supervisees. In my opinion, this puts the counselor at great risk for burnout, vicarious traumatization, and/or counter transference issues. Second, I find level III supervisees are often promoted to supervisor status with little to no support or guidance, as it is assumed that if they can counsel family violence clients, they can supervise. This is most unfortunate as supervisors-in-training also navigate a very similar developmental process paralleling supervisees, indicating new supervisors would also need a considerable amount of support and guidance (see Stoltenberg & Delworth, 1987). Of relevance, the ethical guidelines of the Association for Counselor Education and Supervision clearly stipulate counselors should receive training in supervision before becoming supervisors (Nelson, Johnson, & Thorngren, 2000).

Regardless of the developmental level of the trainee (supervisee or the supervisor in training), there is an inherent need to "think and talk freely, reflectively, without censorship" in their supervision sessions (Mollon cited in Hahn, 2001, p. 281). The use of measures, such as the Manchester Clinical Supervision Scale (Edwards et al., 2005) can provide feedback on the success of creating this type of safe environment. Another measure I rely on to increase the quality of positive interactions with my family violence supervisees is the Myers Briggs Type Indicator personality test, which will be discussed next.

Using Personality Profiles in Supervision

In many cases, when I am asked to be a consultant for a problematic therapist-client relationship or supervisee-supervisor relationship, I usually find the problem originates in one or two areas: (i) lack of clarity and/or agreement on the goals for change as defined by the client, counselor, and/or supervisor, or (ii) personality differences in interpersonal communication, where one or more individuals do not feel understood or supported. Revisiting and re-writing the goals from all stakeholders' perspectives, and

achieving consensus of these goals, address the former problem. The work of Cormier and Nurius (2002) is a good resource on this topic. In terms of addressing the latter problem of interpersonal difficulties, I often rely on the Myers Briggs Type Indicator (MBTI: Myers, McCauley, Quenk, & Hammer, 1998).

The MBTI personality assessment tool, based on Jungian theory, has the potential to help uncover personality preferences as it relates how one prefers to structure interactions and learn new information and/or make decisions (Myers et al., 1998). This can be critical information for a supervisor to know about their supervisees. A good resource is the book "What type am I?" by Baron (1998). Hogan and Champagne (Personal Style Inventory, n.d.) have a non-copyrighted Inventory and follows the same theory and presentation style as the MBTI (a free copy is available at http://home.ica.net/~oyar/perstype.pdf)

Briefly, MBTI (which also applies to the Personal Style Inventory, n.d.) are composed of four sets of preferences, which forms a four-letter preference code. Each preference will be briefly explained, amplified with the use of supervisee-supervisor examples drawn from my family violence experiences.

Introversion (I) or Extroversion (E): How do you get energized?

Supervisees with strong preferences towards Introversion (I) type interactions tend to rejuvenate when they are by themselves, whereas supervisees with a strong orientation to Extroversion (E) are likely to be quite open and interactive with others as well as driven to connect with people to feel re-energized (Baron, 1998). Thus, it is common for those with a strong E preference to seek out the supervisor to debrief after intense family violence counseling sessions. A supervisee with strong Introversion preferences may be more inclined to spend time alone before debriefing with a supervisor or colleagues.

Both behavior preferences can be judged negatively: Supervisees with introversion tendencies are often being judged for not being more social with one's peers and/or for not seeking support earlier. And, those with a strong E preference for being needy, as they may want considerable connection time from their supervisor. To prevent this negative characterization, I find it useful to introduce the strengths and potential weaknesses of each preference to the supervisees, and how this information can enhance and distract the quality supervision. I also recognize that supervisees with a strong E preference may need to learn how to contain their need to debrief until the next scheduled supervision sessions and/or learn other ways to appropriately

debrief when the supervisor is not available. Further, both preference styles, but perhaps more so with I's, benefit from clear expectations as to when they must consult with their supervisor. This will minimize the I's tendency to be too reflective and independent when needing to make clinical decisions (see Appendix B for my expectations when supervisees need to seek consultation).

Sensing (S) or Intuition(N): How do you receive information?

Those with a strong preference for Sensing (S) tend to be very detail orientated, careful, practical, and are driven to learn the facts (Personal Style Inventory, n.d.). This is in sharp contrast to the preference of Intuition (N) individuals who are known for exploring possibilities and patterns, particularly with novel problems (Baron, 1998). Such people are typically drawn to supervisors who ask constructive based questions. When working with supervisees with a strong N preference, it is important to ensure they are explaining key concepts and techniques to clients in the amount of detail required (e.g., safety precautions, time out procedure, what to say to a lawyer when advocating for child visitation rights). It has been my experience that supervisees with a strong N profile tend to regard communicating details as rather tedious. On the other hand, supervisors could maximize the learning for supervisees with a strong preference for S by catering to their need to have extensive detailed explanations. Supervisors would be wise to observe the amount of detail S type supervisees share with their clients, as they may have a tendency to be overly specific and not leave enough time for the client to engage in self-discovery such as processing what the counselor is suggesting or practicing by using role plays.

Thinking (T) or Feeling (F): How do you make decisions?

Those with a strong Thinking (T) preference are often driven by principles of fairness and logic where as those with strong Feeling (F) preferences tend to place emphasis on the relationship factors as the main priority when making decisions (Baron, 1998). A supervisee (or supervisor) with a high T preference might argue that child welfare should remove the children from the home because the parents are physically abusive to each other and it is the law to protect children from witnessing such abuse, despite the parents clearly loving their children. In the same situation, a supervisee (or supervisor) coming from a strong F orientation may be more inclined to advocate the family needs to stay together, to keep the parents motivated to change their abusive ways. Neither approach is wrong in itself; however, both supervisors

and supervisees need to be aware of how their preferences in making decisions can color their ability to explore the relevant options.

Judging (J) or Perceiving (P): How do you interact with others?

Those with a strong Judging (J) preference are likely to be well organized, active note takers, not easily distracted, and seem prepared well in advance (Personal Style Inventory, n.d.). They indicate a strong preference for supervision sessions to be structured and to start/end on time. However, those supervisees (and supervisors) who have more of a Perceiving (P) preference are typically drawn to supervision styles that have more of a "go with the flow" style. They seem to prefer supervision sessions that are open-ended and process material in the moment, and may resist doing ample preparation work before supervisory sessions. They are often seen as being more flexible and open to change than those with a strong J preference (Baron, 1998). Both preferences have merit but at the same time can contribute to significant interpersonal clashes when they go unrecognized.

Of interest, Hammer (1993) reported counselors typically hold preferences toward INFJ, INFP or ENFP profiles. Thus, an INFJ type supervisee (or supervisor), for example, would be decisive in how things should be done, hold very firm values, drawn to seek connections, and be curious about why people do what they do. Supervisors would need to help INFJ supervisees do a thorough assessment before creating hypotheses. In addition, since an INFJ supervisee (or supervisor) may be inclined to lead very structured sessions, they also need to learn to allow the client open-ended time to process and raise whatever issues they want. On a similar note, pairing an INFJ with an ESFJ could be quite taxing, as both will see the need and format of supervision quite differently. To prevent an interpersonal clash, both would need to understand each other's personality profiles and then reach agreement in advance of their expectations for supervision (hence the need for the form found in Appendix A).

The connecting theme between the first two supervision issues (i.e., developmental stages of competency and personality profiles) is the need to have open communication where supervisors and supervisees can speak openly and directly about what they need from each other. There is often a perceived risk in asking for what you need and it is this fear of consequences that contributes to the profession's dark secret. This topic will be addressed next.

Addressing Vicarious Traumatization

Most people in the counseling field are aware of the profession's dark secret–vicarious traumatization (VT). McCann and Pearlman (1990), who

were influential in naming the secret, describe VT as a serious internal reaction in response to listening empathetically to descriptions of client's traumatic experiences. With repeated exposure, helping professionals may experience VT, which results in cognitive shifts in their core beliefs about safety, trust, esteem, intimacy, and control as it relates to themselves and others, regardless of the amount of clinical experience they have. Counselors may further be haunted by flashbacks, intrusive thoughts, and somatic responses after listening to a client's traumatic material. For a brief yet informative account of a supervisee experiencing VT and how the supervisor intervened, read Rothschild (2002).

Saakvitne, Gamble, Pearlman, and Lev (2000) believe that VT is no one's fault as it "is the natural consequence of being human, connecting to and caring about our clients as we hear about, and see, the effects of trauma on their lives" (p. 157). I sense there is still a considerable amount of shame in the counseling profession, particularly among family violence workers, of disclosing vicarious trauma. As Hahn (2001) notes, "supervisees experience a strong desire to be competent and autonomous along with fears of being found wanting in some respect . . . and supervisors also struggle identifying their own shame and may inadvertently allow their supervisee to carry a disproportionate burden of shame" (p. 272). There is a cultural norm, along with personal drivers (beliefs) of "be strong," "keep trying," "be perfect" (Toth, 2004) that provide extensive reinforcement to cover feelings of inadequacy.

When these norms and beliefs are not overtly challenged, it promotes "projecting an illusion of self-sufficiency" (Hahn, 2001, p. 277). This internal and external pressure to be perceived as competent makes it very difficult to admit to having a client's traumatic material surface in one's dreams, thoughts, or in the form of flashbacks (McCann & Pearlman, 1990) or experiencing cognitive shifts (e.g., becoming more pessimistic, losing hope that the world is a safe place, having intimacy difficulties, etc.). These haunting experiences deepen the risk for anyone in the counseling profession to develop emotional exhaustion, compassion fatigue, and/or VT. It is my firm belief, supported by Hahn, that supervisors need to take a preventive role in addressing the role of shame in their sessions. Likewise, supervisors must provide a climate where it is acceptable (and encouraged) to pursue personal therapy to gain control and inner peace. The remaining section of this chapter will highlight three main strategies which supervisors can utilize to create a place where being impacted by trauma work is contained in support, not shame.

Supervisees' Actions in the Counseling Room

Those who work with trauma material need to take extra precaution in how they privately process client disclosures to foster an empathetic connection with their client (Rothschild, 2002). Many counselors are taught to "step into the client's shoes" to deepen the understanding what the client may be thinking, feeling, and behaving. In most cases, this is an effective strategy. However, when listening to traumatic material, a firmer boundary is needed so the horrors are contained externally and not within the counselor's body or mind. If the horrors do surface in the supervisee's private domain, then this needs to be processed immediately. To this end, the supervisor must alert the supervisee of the need to set boundaries with the material heard in the session and to develop effective tools to develop and maintain this boundary.

Ample VT prevention resources are available including Saakvitne, Gamble, Pearlman, and Lev's (2000) excellent training curriculum manual for working with survivors. A host of ideas are also listed in Pearlman and Saakvitne (1995) such as reminding oneself that the client has survived the trauma–the trauma is over. Or, lighting a candle at the start of the session and blowing it out after the session along with saying a small affirmation that the client's story is to be put at rest until the next session. Some counselors put a picture of something that connects them to the present (e.g., family, a recent holiday) that they can glance at while listening to a heavy disclosure. The overall message is to give permission, followed by support, for supervisees to take action to protect themselves.

It is important to stress to supervisees that in very few cases does a counselor need to listen to the minute details of the trauma being disclosed. Rather, teach them to listen for connecting themes such as limiting beliefs (e.g., She deserved it! I am not allowed to show anger! It IS my fault!) that can be therapeutically challenged to foster a discharge of held emotions. For example, I will invite a supervisee to play a section of her counseling tape where her client describes the violence he inflicted on his partner. After listening to the tape, I will ask the supervisee what were the key pieces to listen to and validate for the client. I also share with the supervisee how I might process the material I was listening to, as a way to role model. This demonstration shows it is not only inexperienced therapists who have to make the effort to set boundaries in regard to the clients' stories and the extent to which they are heard.

Supervisor's Actions in Supervision Sessions

The supervisor offers the supervisee coaching on how to meet therapeutic goals, assisting with case conceptualization, and providing feedback on their

skill delivery. But, the work of trauma also requires the supervisor to be a container for the pain and despair the supervisee may be processing. This pain often stems from listening to client disclosures of how they were victimized or how they victimized others (Pearlman & Saakvitne, 1995). The supervisor needs to invite this level of processing and ensure it is held with utmost respect (e.g., supervisee is not later criticized on an evaluation form for not being able to stay grounded after a session). Family violence counselors need to know they have the freedom to turn to their supervisor who will offer them a safe place to have their own pain of helping others, witnessed, and validated (Pearlman & Saakvitne). This is an important role of a family violence supervisor because the supervisee will be violating confidentiality and/or not maintaining healthy boundaries if the supervisee turns to their family/friends for this level of emotional support.

Supervisees' Protective Behaviors

A comprehensive approach to protect and/or recover from VT involves three groups of activities, as described by Saakvitne and associates (2000). The first group involves engaging in activities that promote self-care, self-nurturing, and offer an escape from trauma exposure. Next are the activities that allow the negative elements of trauma work to be transformed into value and purpose, by finding meaning in the work we do and not losing hope. The last set of activities requires an acceptance of the reality of VT occurring in the helping profession. This entails a responsibility to address it by regularly monitoring and handling VT like reactions (e.g., periodically complete assessment tools on emotional fatigue, VT, etc.) and to address one's own unfinished issues in personal therapy.

To process many of these strategies with supervisees, I like to facilitate a modified version of the "Draw-a-Tree" task described in a workbook on VT (Saakvitne & Pearlman, 1996). I prefer to do this activity in a group setting to increase the range of ideas and to also normalize that reactions to client material is not something to be ashamed about but it does require taking action to minimize the impact this type of work has on one's private and professional life. The required supplies include blank paper and felts.

- Image what a healthy, well-grounded tree looks like. Draw this tree. This tree will be called your healthy tree.
- Recall how you feel after a very difficult session that didn't go very well for whatever reason. Draw another tree to represent how you are feeling after this type of session. What would your tree look like?

The group debriefing questions I use include:

1. What feelings and thoughts describe your two trees?
2. What are some differences between your two trees?
3. What type of protection does your healthy tree need to remain strong and in this state even if it exists in a taxing environment? (e.g., have extra water buckets, install a fence, add birds)
4. What does the second tree (i.e., the tree after a difficult session) need so it can return to a healthy state?
5. Transform your answers from question #3 and/or #4 into some concrete ideas as to what you can do (i.e., self care) to help the tree (you) stay strong.

Your answers	Transform	*A Concrete Self-Care Strategy*
EXAMPLE: Store more water	→	I need to make sure I drink enough fluids during my workday.

The message in this tree exercise is the responsibility we have to look after our inner healthy tree and to make it stronger and more resilient as time goes on. To do this, we need to acquire the skills and activities to keep our tree in good shape. When our trees become exhausted, we also need to have strategies in place to rejuvenate our tree. If you encounter difficulties in nursing your tree, then you need to have a plan in place to seek more support.

Conclusion

Saakvitne and associates (2000) captured the essence of this chapter when they wrote, "the most important factor in the success or failure of trauma work is the attention paid to the experience and needs of the helper" (p. 157). This chapter has provided over a dozen strategies on how to tune in to the needs of the supervisee working with family violence cases. These needs are critical issues in supervision and may often be overlooked if the supervisor is driven to put the client needs ahead of the supervisee. It was the premise of this chapter that the role of the supervisor is to address the supervisee's needs so the supervisee has the passion, energy, resources, and skill to help family violence clients.

APPENDIX A–SUPERVISION WITH DAWN MCBRIDE: GETTING TO KNOW EACH OTHER & OUTLINING SUPERVISION EXPECTATIONS (MCBRIDE, 2007)

This handout is a modified version of the Initial Supervision Session Checklist (ISSC) developed by Prest, Schindleer-Zimmerman, and Sporakowski (1992, pp. 130-133). The authors designed this handout to facilitate discussion between the supervisee and supervisor to help establish a clear contract for supervision, maximize the fit between supervisee and supervisor, and ensure the supervision sessions are purposeful.

Working through this handout will take approximately one or two hours as both supervisor and supervisee will share their answers to the questions. The use of prompts, paraphrasing, and seeking clarification, and/or examples will further enhance the relationship-building phase between the supervisee and supervisor. After the discussion, written copies of the relevant sections should be exchanged to allow for reflection and future reference. Relevant sections of this handout should be reviewed on a regular basis since expectations and counselor skill level will change overtime.

I. Interest in Counseling, Education, Training and Clinical Experiences

A. What factors lead to your decision to become a therapist?
B. What do you look forward to about your work (or future work) at this counseling centre?
C. Inquire about the following background characteristics of each other:

- Educational background (degrees, relevant courses, conferences attended, etc.)
- Training experiences.
- Work experience(s) and relevant volunteer experiences.
- Sense of mission/purpose/desire to work in the field of counseling.
- Educational plans as well as professional developmental plans and goals.

II. Theoretical Orientation

A. What models and specific schools of thought (e.g., feminist, systems, behavioral) have you trained in and also use on a regular basis? How do these models influence your beliefs on the nature of humans, problem development and maintenance, and personal growth?
B. What level of interest do you have in learning other new models, theories and styles?

C. In your opinion, what are some characteristics of a good therapist and a not so good therapist? Why might a poor functioning therapist be under-performing?

III. Philosophy of Supervision

A. Explore each other's perspectives and value of the supervision process, including the developmental competency stages of supervision and the experience of shame in supervision.

IV. Previous Supervision Experiences (Supervisee)

A. Describe your previous supervision experiences (e.g., which supervisor influenced you the most, liked/disliked about past supervision experiences, etc.).
B. What do you see as your strengths and areas of needed growth in terms of counseling (may be useful to assess developmental level)?
C. How would you rate your competence with:

- Facilitating the stages of therapy? The stages of change?
- Assessing for risk?
- Managing crisis sessions?
- Identifying & solving ethical dilemmas?
- Conducting assessment, informal & formal?
- Case planning, and preparing for case reviews?
- Advocating in the justice and child welfare systems?
- Working with trauma?
- Addictions and other DSM issues?
- Knowing community resources for basic needs and other social support services?
- Working with various age groups?
- Handling anger and other intense emotions in counseling sessions?
- Preventing emotional exhaustion and minimizing vicarious traumatization?

V. Supervision Goals

A. In order to establish and evaluate goals of supervision, the following topics need to be addressed:

- What are supervisee's goals that meet the definition of goal criteria (e.g., specific, measurable, observable, incremental, and realistic)?

- When will the goals be measured and how often?
- How does the supervisee plan to meet these goals (emphasize personal responsibility to ensure these goals are met)?

VI. Supervision Style and Techniques

A. In order to facilitate an optimum fit in terms of supervisory style, the following need to be addressed:

- A review of the various types/styles of supervision to facilitate clinical growth of the supervisee. Followed by a discussion on each other's preferred style & modality of supervision.

VII. Ethical and Legal Considerations

The legal and ethical parameters for the supervision process should be defined, discussed, and documented. At minimum, the topics should include:

A. The need to participate in an agency orientation. Furthermore, the supervisee is to take the initiative to be familiar with the organization's policies and procedures (e.g., refer to operating and policy manuals).
B. Emergency and back-up procedures available 24 hours a day. Furthermore, the supervisor's accessibility and who to consult with on the staff when the supervisor is not available.
C. Expectations of when the supervisee is to contact the supervisor for clinical consult.
D. Awareness and adherence to the organization's and professional codes of practice.
E. Confidentiality regarding the nature of ALL information pertaining to client data (e.g., client records, discussing client cases with non-staff or with inappropriate staff, not allowed to take any client material off site, etc.).
F. Specific issues to be dealt with in situations where dual roles exist (e.g., one is both a supervisee and staff member of supervisor).
G. Utilization of sense of self in supervision (e.g., genogram, life history, etc.) and differentiation between supervision vs. therapy. Majority of code of ethics states clearly that personal counseling is not to be part of the supervision process.
H. Process for dealing with issues that relate to supervisee's personal issues which may/are interfering with delivery of service to clients (e.g., family of origin issues, burn-out, transference issues with supervisor, and counter-transference issues with clients).

VIII. Practical Issues

Discuss and document the following:

A. Supervision schedule, location and duration of meetings.
B. Duration of supervision (e.g., first and last day of supervision).
C. Role of other supervisors and supervisees in the supervision sessions (e.g., spectator, co-supervisor, reflecting teams).
D. Process for handling conflictual issues between supervisee-supervisor.
E. Statistical record keeping for agency purposes.
F. File management and storage.
G. How to job shadow, observe other sessions, etc.
H. Number of cases for which the supervisee will be responsible for and clients are obtained.
I. Responsibility of the supervisee to maintain an accurate journal of supervision hours she/he has received, the supervisor's written comments (formal) and a brief summary of each formal supervision session including observation/job shadow experiences.
J. Consent forms to be signed by each client to discuss the case in supervision.
K. The responsibility of the supervisee to ensure **prior** to supervision meetings that:

- Proper forms (e.g., consent forms for supervision, case review worksheets) are completed ahead of time.
- For each case, a list of questions to ask supervisor, and/or identified areas of needed support has been prepared
- A supervisor room has been booked and is set up (e.g., chairs arranged, do not disturb sign posted).
- All necessary equipment is set up and in working order (e.g., TV/VCR and/or cassette player is ready to play).
- The tapes have been viewed by the supervisee and are cued in advance.
- All necessary materials (e.g., case review forms, video-tapes) are present.
- If live observation: Supervisee has confirmed his/her attendance and the supervisee has back-up plans for supervision if the client does not appear for live supervision (e.g., tape of a previous session, case presentation, audio clips, etc.).

Winding Down:

- What do we need to know about each other that we have not already discussed?

- What, if any, questions do you have?
- What was it like for you completing this form? What things would you want to keep in mind when having to ask clients a series of questions, much like the format on this form?
- When should selected questions from this form be reviewed to assess compliance and/or update information?

Appendix B–Indications When to Alert Your Supervisor for Therapeutic Support, Feedback and/or Direction (McBride, 2006)[1, 2]

1. Any sudden or unexpected change for the worse in the client's psychological or physical status.
2. Client's overt expression of suicidal ideation and/or threats of harm (real or perceived).
3. Children who appear to be suffering significant neglect and/or are in danger of being abused physically or sexually.
4. When there is a threat of/or actual removal of the children from the home.
5. Behavior change in the client that may suggest potentially destructive behavior toward others (e.g., collecting pills, buying a gun, etc.) even when intent is denied.
6. Significant deterioration in the client's mood with increased depression and/or anxiety.
7. Stagnation in the therapeutic process, i.e., after a series of two to three sessions at reasonable intervals. And/or, the therapist and/or client are at an irresolvable impasse.
8. The therapist is uncertain as to the treatment plan and/or the agenda for the next session.
9. The therapist feels a need to debrief the case after a heavy session.
10. Suspect psychotic symptomatology in client (i.e., delusions, hallucinations, bizarre actions).
11. Suspicion of organicity (i.e., persistent change in personality, alertness, and/or mood).
12. The client requests to see another agency counselor or speak to a supervisor.

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1. This list was created by initially drawing on the work of Wright, L., & Leahey, M. (1984). *Nurses and families: A guide to family assessment and intervention* (pp. 225-226). Philadelphia: F.A. Davis.

2. The events are not presented in any particular order. This list is not exhaustive. If you have encountered an event not listed on this handout that you believe justifies consulting a supervisor, then please contact your supervisor.

13. The client conveys dissatisfaction with the therapist or with the treatment offered.
14. The client refuses to continue attending sessions when further treatment appears desirable.
15. The client shows noticeable discomfort or expresses concern about videotaping and/or observation and as a result refuses to attend further sessions.
16. The client refuses to sign a release of information form and/or consent form for supervision.
17. When there appears a possibility of conflict within or outside the agency with regard to the client, personally, or with any political, medical, or social agency.
18. When there is a possibility of some legal encounter or you a request/order to participate in legal proceedings.
19. When the client is in therapy elsewhere and/or is accessing numerous therapists.
20. A case conference needs to be called and/or you have been invited to a case conference.
21. The client misses two consecutive individual sessions with or without notifying the therapist of the cancellations.
22. When the therapist anticipates and/or is in an ethical dilemma or conflict with the feedback received from another supervisor other than your own.
23. When you have received feedback from another supervisor that seems to be in conflict with that received from your own supervisor.
24. The file is ready to be closed (only about 2-3 sessions remaining)
25. The client requests to review their file and/or wants a copy of their file.
26. The file is ready to be closed.

References

Ackerman, S., & Hilsenroth, M. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy: Theory, Research, Practice, Training, 38*(2), 171-185.

Baron, R. (1998). *What type am I? Discover who you really are.* New York: Penguin Group.

Bernard, J. (1997). The discrimination model. In C. E. Watkins, Jr. (Ed.), *Handbook of psychotherapy supervision* (pp. 310-327). New York: Wiley.

Bradley, L., & Whiting, P. (2001). Supervision and training: A model. In L. J. Bradley & N. Ladany (Eds.), *Counselor supervision: Principles, process and practice* (3rd ed.), (pp. 361-387). Philadelphia: Brunner-Routledge.

Bradshaw, T., Butterworth, A., & Mairs, H. (2007). Does structured clinical supervision during psychosocial intervention education enhance outcome for mental health nurses and the service users they work with? *Journal of Psychiatric and Mental Health, 14*, 4-12.

Cormier, S., & Nurius, P. (2002). *Interviewing and change strategies for helpers: Fundamental skills and cognitive behavioral interventions* (5th ed.). Pacific Grove, CA: Brooks/Cole.

Costa, L. (1994). Reducing anxiety in supervision. *Counselor Education and Supervisor, 34*, 30-40.

Dutton, D. (1995). *The batterer: A psychological profile.* New York: Basic Books.

Edwards, D., Cooper, L., Burnard, P., Hanningan, B., Adams, J., Fothergill, A., & Coyle, D. (2005). Factors influencing the effectiveness of clinical supervision. *Journal of Psychiatric and Mental Health Nursing, 12*, 405-414.

Goodyear, R., & Nelson, M. (1997). The major formats of psychotherapy supervision. In C. Watkins (Ed.), *Handbook of psychotherapy supervision* (pp. 328-344). New York: John Wiley & Sons, Inc.

Haber, R. (1996). *Dimensions of psychotherapy supervision.* New York: W.W. Norton & Company.

Hahn, W. (2001). The experience of shame in psychotherapy supervision. *Psychotherapy: Theory, Research, Practice, Training, 38*(3), 272-282.

Hammer, A. (1993). *Introduction to type and careers.* Palo Alto, CA: Consulting Psychologists.

Hawkins, P., & Shohet, R. (1989). *Supervision in the helping professions.* Philadelphia: Open University Press.

Herman, J. (1997). *Trauma and recovery.* New York: Basic Books.

Lindblad-Goldberg, M. (1996). Forward. In R. Haber, *Dimensions of psychotherapy supervision: Maps and means* (pp. vii-viii). New York: W.W. Norton & Company.

Loganbill, C., Hardy, E., & Delworth, U. (1982). Supervision: A conceptual model. *The Counseling Psychologist, 10*(1), 3-42.

McCann, I., & Pearlman, L. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*, 131-149.

Myers, I., McCauley, M., Quenk, N., & Hammer, A. (1998). *MBTI manual: A guide to the development and the use of the Myers-Briggs Type Indicator* (3rd ed.). Palo Alto, CA: Consulting Psychologists.

McBride, D. (2006). *Indications when to alert your supervisor for therapeutic support, feedback and/or direction.* Unpublished paper, Zayed University, United Arab Emirates.

McBride, D. (2007). *Education 719: Counselling practicum 1998 guidebook, revisions 2007.* Terrace, Canada: University of Northern British Columbia, Department of Education.

Nelson, M., Johnson, P., & Thorngren, J. (2000). An integrated approach for supervising mental health counseling interns. *Journal of Mental Health Counseling, 22*(1), 1-9. Retrieved February 2, 2007, from the PsycINFO database.

Pearlman, L., & Saakvitne, K. (1995). *Trauma and the therapist.* New York: W.W. Norton & Company.

Pearson, Q. (2006). Psychotherapy-driven supervision: Integrating counseling theories into role-based supervision. *Journal of Mental Health Counseling, 28*(3), 241-252. Retrieved January 22, 2007, from the PsycINFO database.

Pearson, Q. (2001). A case in clinical supervision: A framework for putting theory into practice. *Journal of Mental Health Counseling, 23*(2), 174-183. Retrieved February 6, 2007, from the PsycINFO database.

Personal Style Inventory. (n.d.). Retrieved January 22, 2007 from http://home.ica.net/~oyar/perstype.pdf

Powell, D. (2004). *Clinical supervision in alcohol and drug abuse counseling: Principles, models, methods.* San Francisco, CA: Jossey-Bass.

Prest, L., Schindleer-Zimmerman, T., & Sporakowski, M. (1992). The initial supervision session checklist (ISSC): A guide for the MFT supervision process. *The Clinical Supervisor, 10*(2), 117-133.

Roller, B., & Nelson, V. (1991). *The art of co-therapy: How therapists work together.* New York: Guilford Press.

Ramos-Sanchez, L., Esnil, E., Goodwin, A., Riggs, S., Touster, L.O., Wright, L.K., Ratanasiripong, P., & Rodolfa, E. (2002). Negative supervisory events: Effects on supervision satisfaction, and supervisory alliance. *Professional Psychology: Research and Practice, 33,* 197-202.

Rothschild, B. (2002). The dangers of empathy: Understanding the keys to vicarious traumatization. *Psychotherapy Networker, July/August,* 61-65.

Saakvitne, K., Gamble, S., Pearlman, L., & Lev, B. T. (2000). *Risking connection: A training curriculum for working with survivors of childhood abuse.* Lutherville, MD: Sidran Foundation.

Saakvitne, K., & Pearlman, L. (1996). *Transforming the pain: A workbook on vicarious traumatization.* New York: W.W. Norton.

Stoltenberg, C., & Delworth, U. (1987). *Supervising counselors and therapists: A developmental approach.* San Francisco: Jossey-Bass.

Toth, M. (2004). Dealing with fear of failure: Working with script concepts in the classroom. *Transactional Analysis Journal, 34*(3), 209-215.

Worthington, E. (1987). Changes in supervision as counselors and supervisors gain experience: A review. *Professional Psychology: Research and Review, 18*(3), 189-208.

Worthington, E., & Roehlke, H. (1979). Effective supervision as perceived by beginning counselors-in-training. *Journal of Counseling Psychology, 26*(1), 64-73.

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Dawn Lorraine McBride, is a registered psychologist and an assistant professor in graduate counselor education at the University of Lethbridge, Canada. The prevention, assessment, and treatment of family violence is one of her main areas of research and clinical interest. For nearly ten years, Dawn worked at a large family violence treatment centre/emergency shelter that provided counseling to men, women, adolescents, and children who were the perpetrators, victims, or witnesses to abuse. At this centre, she held various positions including outreach coordinator, specialist therapist for difficult cases, clinical supervisor, and program manager. She designed and taught one of the first undergraduate and graduate level family violence assessment and treatment courses in Canada. Dawn has held teaching positions in the Middle East (Gulf Region) as well as presented at numerous international conferences. She has recently finished co-editing a book on learning and teaching across cultures in higher education. She also has a private practice specializing in mental health issues. You are welcome to contact the author at dawnm@apmcomp.com

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STEPHANIE L. BROOKE, PH.D.

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Edited by

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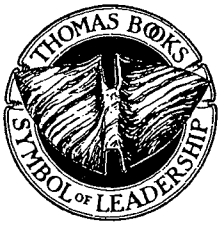

CHARLES C THOMAS • PUBLISHER, LTD.
Springfield • Illinois • U.S.A. (2008)