Trauma-informed practice and care: Implications for field instruction

In 2001, Harris and Fallot introduced the term "trauma-informed" to refer to social, behavioral, and mental health services that account for the possibility that clients may have experienced some form of past trauma. Since then, an ever-expanding body of conceptual and empirical literature has further delineated the trauma-informed perspective, the core characteristics of which are: trust, safety, choice, collaboration, and empowerment. A trauma-informed (TI) orientation conforms to the defining principles of social work. However, this orientation has yet to be routinely integrated into field and classroom curricula (Author, 2015; Berger & Quiros, 2014; Levenson, 2017). Further, field instructors often are unfamiliar with requisites of a trauma-informed orientation and their implications for practice and supervision. This problem is compounded by the lack of guidelines for trauma-informed supervision, generally (Author, 2018; Berger & Quiros, 2016; Mattar, 2011).

This article summarizes the evolution in thinking about trauma and its impact on survivors. The trauma-informed perspective and its implications for field instruction are then explained. The author argues that skills of field instruction that already have an evidence base lay the foundation for TI field instruction. Composite case examples drawn from the author's experiences as a field liaison, a practitioner who works with trauma survivors, and an instructor in the generalist practice curriculum illustrate methods and skills of field instruction.

The Nature of Trauma

Trauma and its aftereffects have received considerable attention from researchers and practitioners alike, beginning almost forty years ago, resulting in significant advancements in understanding of the nature of trauma and its impact on those who experience it.

Emphasis on Precipitating Event

The earliest investigations of trauma and its impact focused on two different lines of inquiry: the experiences of veterans returning from the Vietnam War and the impact of childhood abuse (Courtois & Gold, 2009). The focus expanded to natural and human-made disasters like the Oklahoma City bombing in 1995, the terrorist attacks in the United States in 2001, and Hurricane Katrina in 2005 (Scheeringa & Zeanah, 2008; van der Kolk, 2007). Sociopolitical events like civil wars, genocide, and human trafficking prompted further refinements in the understanding of trauma (Courtois & Gold, 2009; Haans & Balke, 2018).

Emphasis was placed on understanding the traumatic impact of a precipitating event. Traumatic exposure was found to be consistently associated with an array of social, psychiatric, psychological, behavioral, and physical problems. Researchers also sought to identify the relationship between trauma exposure and psychiatric problems (Brown, Schrag, & Trimble, 2005; Garno, Goldberg, Ramirez, & Ritzler, 2005; Mulvihill 2005; Randolph and Reddy 2006). In 1980, the American Psychiatric Association's third edition of the *Diagnostic and Statistical Manual* introduced a new diagnostic category, Post-Traumatic Stress Disorder (PTSD). The most recent, fifth, edition of the *DSM* (APA, 2013), replaced the PTSD diagnosis with a new, broader diagnostic category, Trauma and Stressor-Related and Dissociative Disorders.

A different line of theoretical and empirical inquiry focused on changes in cognition. Constructivist self-development (CSD) theory addressed distortions in thinking about the self- characterized by feelings of powerlessness and worthlessness, and of others- in the form of mistrust, experienced by survivors of childhood trauma (McCann & Pearlman, 2000). CSD theorists also noted how childhood victimization negatively impacted individuals' feelings of mastery- or self-capacities- regarding maintaining connections to others, establishing a stable sense of self and identity, and managing affect (Brock, McCann, and Varra, 2006). Distortions in

thinking about others were presumed to undermine the individual's ability to form secure attachments (Waldinger, Schulz, Barsky, & Ahern, 2006). CSD constructs were expanded from a focus on childhood victimization to address challenges faced by survivors of other forms of trauma. Research findings indicated that trauma exposure resulted in diminished feelings of power, control, and safety, and heightened feelings of fear (Cloitre, Miranda, & Stovall-McClough, 2005; Giesen-Bloo and Arntz 2005; Kolts, Robinson, & Tracy, 2004).

The Experience of Trauma is Unique to the Individual

Constructivist self-development theory and the research it prompted led to the realization that individuals exposed to a similar- or even the same- traumatic event experienced it in their own unique way based upon personal, social, and cultural variables (Elliott and Urquiza 2006; Ullman and Fillipas 2005). Traumatic exposure was seen as a *psychological* event as well as a physical experience. This realization led to efforts to identify factors that increased or mitigated the risk of being traumatized.

Risk and Protective Factors. Individual and community support has emerged as a powerful variable that may mitigate or increase the risk of traumatization in response to a stressful event (Feinauer, Hilton, & Callahan, 2003; Ruggiero, Smith, Hanson, Resnick, Saunders, Kilpatrick, & Best, 2004; Twaite & Rodriguez-Srednicki 2004; Whiffen and MacIntosh 2005). Social support is important both at the time of exposure to trauma and long-term, as individuals struggle with aftereffects (Sippel, Pietrzak, Charney, Mayes, & Southwick, 2015). This factor is multi-dimensional and includes validation and understanding, acceptance, affirmation, and availability of appropriate resources. The absence of support, which includes blame and/or accusation, continued exposure to the experience, and the lack of

acknowledgement of the impact of the event, places survivors at greater risk of experiencing the social, behavioral, emotional, and physical symptoms associated with traumatization.

Prior emotional functioning may either intensify or mitigate the impact of a traumatic event (Andres-Hyman, Cott, & Gold, 2004; Bradley, Schwartz, & Kaslow, 2005). Individuals with pre-existing mental health problems are at greater risk of being traumatized. Emotional, psychological, and psychiatric problems that are common responses to traumatic exposure may have *preceded* the exposure, or at least have been exacerbated by it (Breslau, 2002).

Adversarial and Post-Traumatic Growth. Researchers also examined how individuals who have been exposed to potentially traumatic events benefited from their experiences. Benefits have been found to include: reordering of priorities, an enhanced or new sense of spirituality, a deeper appreciation for life and for loved ones, and increased feelings of self-efficacy, empathy, and concern for others (Bonanno 2004; Linley and Joseph 2004; Tedeschi and Calhoun 2004). Research also indicates that when individuals can identify positive aspects of their traumatic experience, they are likely to experience fewer negative long-term consequences (Linley and Joseph 2004).

Trauma and Neurobiology

A recent advancement in the understanding of trauma is the recognition that trauma exposure results in neurobiological changes that interfere with the brain's ability to process trauma and affects the body's stress response systems (Nemeroff & Binder, 2014). Ongoing research substantiates the role that these maladaptive brain processes play in explaining symptoms that had been viewed as purely psychological, emotional, and/or psychiatric. Physiological changes-including increased heart rate, respiration, and blood flow- in response to stress serve an adaptive function by allowing the body to rapidly respond to threat (Sperry,

2016). However, continued traumatic exposure or to an event that overwhelms the body's stress response system ultimately compromises the body's regulating systems including memory and affect. Research also indicates trauma exposure in childhood- particularly when it is ongoing-affects brain development and can lead to permanent neurological damage in the same regulating systems (Neneroff & Binder, 2014; Sperry, 2016).

Indirect Exposure to Trauma

Studies of clinicians who work with survivors of trauma reveal that they are themselves at high risk of being indirectly traumatized. Three reactions have been discerned: secondary traumatic stress, vicarious trauma, and compassion fatigue. These terms often are used interchangeably, but each refers to a distinct manifestation. In this article, the term indirect trauma is employed to refer to the overall impact that working with trauma survivors has on clinicians.

The first two manifestations of indirect trauma mirror those of survivors. *Secondary traumatic stress* refers to symptoms clinicians working with trauma survivors experience that are with consistent with PTSD: persistent, intrusive thoughts and images of clients; hypervigilance; re-experiencing the client's trauma in recollections and dreams, and hyperarousal (Bride, 2004). In the most recent *DSM* (APA, 2013), the expanded stress disorders diagnosis includes secondary traumatic stress. The term *vicarious trauma* refers to changes in cognition that lead to clinicians adopting a worldview characterized by suspicion, pessimism, and powerlessness (Cunningham, 2003, 2004; Pearlman & Saakvitne, 1995; van Deusen & Way, 2006).These cognitive changes parallel those experienced by trauma survivors themselves and stem from practitioners experiencing indirectly clients' vulnerability and powerlessness in the face of horrific events and/or interpersonal victimization. *Compassion fatigue* can and does occur in

many practice contexts and reflects clinicians' inability to empathize with clients. It is particularly likely to occur among practitioners who work with trauma survivors due to the emotion toll that results from listening to survivors' narratives and witnessing their distress firsthand (Adams, Boscarino, & Figley, 2006; Berzoff & Kita, 2010; Figley, 1995).

Indirect trauma is seen as an inevitable consequence of working with trauma survivors (Cieslak, Shoji, Douglas, Melville, Luszcynska, & Benight, 2014). Therefore, emphasis is placed on practitioners being proactive in mitigating and managing its effects. Indirect trauma is different from burnout and countertransference, but it may lead to one or both phenomena (Berzoff & Kita, 2010; Salston & Figley, 2003).

Risk and Protective Factors

Indirect trauma appears to be higher among professionals who have less education, are newer to their jobs, and have the most and least experience working with trauma survivors (Harr & Moore, 2011; Molnar, Sprang, Killian, Gottfried, Emery, & Bride, 2017). In the author's study (2010) of social work students and their field instructors, virtually all participants evidenced signs of indirect trauma. For example, on a standardized measure of vicarious trauma, social work students scored higher than a sample of trauma therapists overall and on nine of ten subscales. This included measures of trust in self and others, personal safety, and control.

There is some evidence that clinicians who experienced childhood trauma are at higher risk of experiencing indirect trauma (Baird & Kracen, 2006; Nelson- Gardell & Harris, 2003). It is unclear whether previous exposure to other forms of trauma predisposes practitioners to indirect trauma, since empirical inquiry has narrowly focused on childhood victimization.

An organizational climate that validates and normalizes workers' reactions mitigates the risk, while one that is perceived as unsupportive increases it (Brockhouse, Msetfi, Cohen, &

Joseph, 2011; Dombo & Blome, 2016). Lower risk is associated with organizational and supervisory environments that promote self-care and convey to staff that ameliorating indirect trauma is an organizational responsibility as much as an individual one (Hensel, Ruiz, Finney, & Dewa, 2015; Layne, Ippen, Strand, Stuber, Abramovitz, Reyes, et al., 2011; Salloum, Kondrat, Johnco, & Olson, 2015; Sprang, et al, 2017).

Vicarious Resilience

Vicarious resilience- or vicarious posttraumatic growth- has been observed among clinicians working in varied practice contexts (Barrington & Shakespeare-Finch, 2013; Cosden, Sanford, Koch, & Lepore, 2016; Frey, Beesley, Abbott, & Kendrick, 2017; Molnar et al., 2017). Consistent with the research of adversarial growth in trauma survivors, researchers have attempted to identify ways in which clinicians benefit from working with trauma survivors. Positive outcomes include enhanced appreciation for one's advantages in life, a re-ordering of personal goals and priorities, increased sense of professional competence and resourcefulness, and heightened capacity for compassion and empathy. Affirmation of strength and resilience also has been found to exist among clinicians who are themselves survivors of trauma (Killian, Hernandez-Wolfe, Engstrom, & Gangsei, 2017).

Trauma-Informed Practice and Care

The trauma-informed conceptualization recognizes that "any person seeking services or support might be a trauma survivor… [Treatment must] recognize, understand, and counter the sequelae of trauma to facilitate recovery" (Goodman, Sullivan, Serrara, Perilla, Wilson, Fauci, & DiGiovanni, 2016, p. 748). Epidemiological studies have found that most adults have been exposed to at least one event that could be characterized as traumatic (Beristianos, Maguen, Neylan, & Byers, 2016; Gillikin, Habib, Evces, Bradley, Ressler, & Sanders, 2016). Further, a

history of trauma exposure, especially in childhood, is disproportionately high among clinical populations in mental health, substance abuse, forensic, domestic violence, child welfare, homeless, and sexual assault settings, among others (Alvarez, Roura, Oses, Foguet, Sola, & Arrufat, 2011; Glad, Hafstad, Jensen, & Dyb, 2017; Helpman, Besser, & Neria, 2015; Rossiter, Byrne, Wota, Nisar, Ofuafor, Murray, & Hallahan, 2015).

While TI "practice" and "care" often are used interchangeably, *practice* is more accurately applied to clinical intervention, while *care* refers to the organizational context within which services are provided to clients. TI practice requires an organizational climate that supports it through the assignment of caseloads, availability of TI supervision, and support for self-care (Bassuk, Unick, Paquette, & Richard, 2017; Conover, Sharp, Salerno, 2015).

Core Principles

Trauma-informed practice is based upon five principles that reflect the research findings summarized previously (Berger & Quiros, 2016; Conover et al, 2015; Goodman et al, 2016). The principles reflect "the direct opposite conditions of persons who have experienced traumatic events" (Hales, Kusmaul, & Nochaski, 2017, p. 318).

Since trauma survivors often experience the world - and, in many cases, other people - as unsafe, *safety* is an essential feature of TI practice. This includes physical and emotional safety. Physical safety considerations include the location and nature of office furnishings, comfort of agency public spaces, and assurances of privacy. Emotional safety depends upon a working relationship in which clients experience validation, understanding, and support. Safety is interdependent with *trust,* the second principle, which requires clinicians to establish and uphold clear and consistent boundaries, protect confidentiality to the extent that is possible (and explain ahead of time when confidentiality may need to be violated), and maintain open and honest

communication (Author, 2015; Becker-Blease, 2017). Trustworthiness requires cultural awareness, since cultural identity influences individuals' experience of trauma exposure (Berger & Quiros, 2014; Mattar, 2011). Trust also includes helping clients trust themselves and develop the self-capacities needed to manage feelings and successfully address problems in living.

A third characteristic of TI practice is *empowerment.* The working relationship, itself, should be empowering, allowing clients as much control as possible over their goals and the means to achieve them. Regardless of the specific focus of intervention, emphasis is placed upon helping clients achieve greater mastery over their lives. Client empowerment depends upon clients having *choices*, the fourth characteristic of TIP. This requires that the worker adhere to core social work ethics: informed consent, clients are the experts of their lives, and respect for cultural identity. Finally, *collaboration* between worker and client reinforces client choice and empowerment.

Implications of Trauma-Informed Principles for Social Work Practice

Social work practitioners, educators, and researchers acknowledge the importance and necessity of integrating trauma-informed principles into the delivery of social work services. However, insufficient resources and continued misunderstanding of and confusion surrounding the application of a trauma-informed perspective have undermined implementation efforts**.** Therefore, research indicates that trauma-informed practice and care remain ideals rather than reality in most social work practice settings (Bassuk et al, 2017; Becker-Blease, 2017; Branson et al., 2017; Conover et al., 2015).

In settings that provide services to clients in the immediate aftermath of trauma exposure, TI practice helps clients make meaning of their experience and develop ways of coping with associated behavioral, emotional, social, and psychological problems. Emphasis is placed upon

promoting resilience and mitigating long-term negative effects (Burton, Cooper, Feeny, &
Zoellner, 2015; Kirst, Aery, Matheson, & Stergiopoulos, 2017). These settings are best viewed
as trauma *specific, focused,* or *centered*.

Most survivors of trauma are seen in practice settings that are neither trauma-focused nor
specific (Jones & Cureton, 2014; Author, 2009). These settings- child welfare, forensics, health,
school, mental health, homeless services, family services, addictions, and the like- are the ones in
which social workers are most likely to be employed and social work students to be placed. In
these settings, trauma survivors' concerns are likely to be associated with current problems in
living rather than the past trauma that may explain and be associated with them (Becker-Blease,
2017; Berthelot et al., 2014; Branson et al., 2017; Gillikin et al., 2016). TI practice in these
settings requires that social workers adhere to the five core principles and understand "the ways
in which current [client] problems can be understood in the context of past [trauma exposure]"
(Author, 2015, p. 26). Social workers are likely to struggle with how to address past trauma
when their practice is focused on, for example, addiction, child protection, or homelessness. If
underlying trauma is dismissed, not recognized, or is responded to in a way that is uninformed,
this increases the risk of re-traumatization and invalidates clients' experiences.

Integrating Trauma-Informed Principles into Field Instruction

Trauma-informed field instruction requires that field instructors be well-versed in trauma
theory and research, as well as the principles of TI practice. In settings that are not trauma-
specific, which are common for generalist and foundation year social work students, field
instructors must learn how they and their students can work within their agency-defined role and
still adhere to the five TI principles. Without this understanding, social work students and their

field instructors are likely to overlook the role that trauma plays in the present-day challenges faced by their clients as the following scenario demonstrates:

> Mark was placed in the public defenders office. He was tasked with collecting relevant history from clients awaiting sentencing that would be presented to the court in advance of their sentencing hearing. He meets with each of his clients once, usually in a detention facility. When Mark met with Travis, who had been charged with assault with a deadly weapon, the client disclosed that his mother's boyfriends "did sex stuff" with him. In his meeting with his field instructor, Mark said that he wanted to pursue what Travis meant by this but didn't think he should since he was "just supposed" to collect information that might help the client in court. His field instructor agreed that he made the right choice. Mark, however, believed that he let his client down.

Mark's assessment is correct. While it was beyond the scope of his role and purpose to encourage Travis to elaborate upon his comment, Mark's avoidance of the disclosure invalidated the client's experiences. Mark's field instructor failed to appreciate how Travis's possible sexual abuse as a child might factor into his current problems with the law *and* how this might affect the outcome of his trial.

> Contrast the previous example with the following:

> Sandy is placed in a housing and rehabilitation program for homeless veterans. She has been working as a case manager with Tim, a 45-year-old Army veteran who has been homeless for more than two years. Tim also has an addiction to opiates and alcohol. Tim has been in the program for one month and is likely to remain a resident for another three to four months. She meets with him weekly to see how he is progressing on the goals that he and the clinical team have established. During these meetings, Tim has begun to

disclose his memories of combat in the Mideast, which included seeing friends blown-up from improvised explosive devices and women and children killed by allied forces. When Sandy meets with her field instructor, Matthew, she tells him she does not know how to help Tim: "I'm not a therapist just a case manager". Sandy also becomes teary-eyed as she relates to Matthew some of the experiences that Tim shared with her. Matthew assures Sandy that she does have the skills needed to help Tim with what he has disclosed, and he also validates how difficult it is to hear stories such as Tim's:

Matthew: A lot of our clients have seen and done terrible things. That's why a lot of them end up homeless and addicted. And it's really hard to hear their stories. Over the years, I've learned ways to deal with my feelings. I'm thinking we could take some time to help you do the same. No matter where you work or who you work with, your feelings can get the best of you. But, how about we first talk about how you can be- really how you are – being helpful to Tim.

Sandy: Great, because I feel like I'm not qualified to help him!

Matthew: You're not giving yourself enough credit! First off, you listened to his recollections and expressed your concern for him and sadness for what he experienced, right? That means you validated his experience and what it meant for him. By letting him talk about this, you are helping him manage his feelings.

Sandy: But he needs so much more than I can provide.

Matthew: Well, I agree, that your role doesn't allow you to provide him with in-depth counseling, but as his case manager, you do have the ability to validate his concerns, identify resources that can help him deal with his war experiences, and support the positive changes he has been making. Those are all incredibly important for Tim.

Matthew had not been trained in trauma-informed practice or supervision. However, his work with Sandy is consistent with TI principles. Trauma-informed supervision simultaneously addresses supervisees' potential for indirect trauma and assists them in responding appropriately and in non-traumatizing ways to clients with histories of trauma. The *content* of field instruction exists within a climate that reflects safety, trust, empowerment, choice, and collaboration.

Safety and trust seemed to already exist in this field instruction relationship, as evidenced by Sandy's willingness to disclose her feelings about her work. Matthew uses his own experiences with indirect trauma to normalize Sandy's reactions and suggests they spend time identifying ways to manage them, which is empowering and reinforces safety and trust. He does not intend to tell her *what* to do to manage her feelings; he will help her decide this for herself, consistent with collaboration, empowerment, and choice. Finally, Matthew helps Sandy see how she can practice within her role as a case manager and still address in a meaningful way Tim's underlying experience with trauma.

Trauma-informed field instruction builds upon three basic responsibilities that are required for effective field instruction. These functions are interdependent and include educating the student, creating a learning environment that is conducive to learning, and attending to students' personal and affective reactions to their work and the supervisory relationship.

Education: Convey Knowledge of Trauma and Trauma-Informed Practice

Since social work education continues to lag in its teaching about trauma and trauma-informed practice, it may fall to field instructors to assume this responsibility. Research indicates that instructors' educational responsibilities must be tailored to their students' unique learning needs (Bogo, 2005). Findings further substantiate that field instructors' educational tasks are most effective when they occur in a climate of mutuality, in which students are active

participants in their learning (Miehls, Everett, Segal, & DuBois, 2013). Consistent with TI principles, the field instructor and student should engage in a *collaborative* learning endeavor.

Knowledge of the following topics is critical to students' ability to work with survivors of trauma:

1. The meaning of trauma in clients' lives;

2. The short- and long-term effects of trauma exposure;

3. The relationship between trauma exposure and challenges that clients currently experience;

4. The impact that trauma exposure has on clients' beliefs about self and others;

5. The impact that these beliefs have on clients' willingness and ability to engage in a working relationship with students; and

6. Intervention techniques that promote the five principles of TI practice consistent with students' roles within the agency.

The following example comes from an outpatient drug treatment program. The agency has made concerted efforts to adhere to TI principles in service delivery, paying particular attention to a history of sexual abuse, since this is common among many of its clients. Erin has been assigned to conduct an intake for a new client, Sylvia, who is self-referred for an addiction to cocaine. This is the first time that Erin will be conducting an intake on her own, though she has observed and participated in several intake interviews with her field instructor, Susan, and other agency social workers. The intake includes several questions designed to elicit clients' experiences with trauma generally, and sexual abuse in particular. Erin and Susan meet in advance of the intake to prepare Erin for this client encounter.

Susan: So, you're seeing Sylvia this afternoon. I'm wondering how you are feeling?

Erin: Nervous! But also excited. I'm glad I've gotten to see how you do this. It makes me feel more like I won't mess up.

Susan: Good to hear! I'm wondering what your thoughts are about asking Sylvia about any possible abuse history? I've been conducting these interviews for a lot of years, but I still find it hard to ask about this stuff. I hate to bring up a topic that might be painful for the client. I find myself holding my breath- hoping that when I ask, the client will say no!

Erin: I'm kind of feeling the same way. I know that if our clients have been abused, it's important we know about it as soon as possible to make it part of our treatment plan. But, I'm scared that if she tells me something did happen, I won't know what to say.

Susan: Okay, suppose Sylvia does disclose she was abused in some way? Where do you go from there? Remember we've talked about how important it is to validate our clients' experiences and feelings? That's a place to start. How might you go about doing that?

At this point, Erin and Susan discuss ways that Erin could respond to her client potential disclosures.

Susan's actions reflect a solid evidence base and are consistent with TI field instruction. First, she paved the way for Erin to be more independent by allowing her to sit in on and participate in sessions with clients. Encouraging students to observe professionals and debrief afterwards assists them in understanding the "nuanced" aspects of practice (Bogo, 2015, p. 319). Second, Susan helps Erin prepare for her interview using a variant of role playing, fostering Erin's ability to integrate theory and research with practice and enhancing her confidence (Bennett & Deal, 2012; Bogo, 2015; Miehls et al., 2013).

Third, Susan refines Erin's understanding of the needs of trauma survivors as well as how to approach the topic in a sensitive way in the intake interview. Rather than lecturing Erin, Susan

engages in a "mutual reflective dialogue" (Bogo, 2015, p. 320). Fourth, Susan encourages Erin to play an active role in her learning and asks her to identify her learning needs- what she believes she needs to know before she meets with Sylvia for the first time.

Supervisory Environment: Creating a Climate that Promotes Learning

Framing the field instructor- student relationship as a reciprocal one reflects the TI principles of safety and trust. Evidence underscores the importance of attending to the relational aspects of the field instruction relationship (Bennett et al, 2012; Ornstein & Moses, 2010). A supervisory relationship characterized by a secure attachment promotes learning as well as self-reflection and independent thought and action. Bennet and Sak's (2006) description of the "ideal" student scenario is consistent with trauma-informed supervision:

> [Students] are willing to ask for assistance and…they accept feedback and instructions…in a flexible manner, shifting from dependence to exploration…Self-reflective about their interventions and their own professional development, their presentations about their work are organized and coherent. They are able to discuss tough issues and examine their personal roles in their clinical relationships…(p. 674).

A supervisory environment that promotes safety and trust allows for exploration of students' experiences with indirect trauma. This environment also is one that empowers students. A collaborative relationship between student and field instructor enhances feelings of mastery and self-efficacy (Bennett & Saks, 2006; Bogo, 2015). This also encourages the student to be self-directive in identifying learning needs, a reflection of the TI principle of choice. The previous supervisory session between Susan and Erin continued, with Susan asking:

> Before we wrap up our session, how do you think you'd *feel* if Sylvia tells you she was abused? Have you thought about that?

Erin: I think I'd feel sad, sorry for her, angry for her.

Susan: All normal and understandable feelings, right? (*Erin nods*) And you and I are

going to keep talking about how our work affects us, because it sure does, as you can tell

from what I've told you before about my reactions.

Erin: I'm finding that out! *(Smiles)*

Susan's disclosures about her struggles with indirect trauma normalize and validate

Erin's reactions, indicating she attends to the relational aspects of her supervisory relationship

with Erin (Ornstein & Moses, 2010). Erin's willingness to discuss her anxieties about her

upcoming meeting with her client suggests that Susan has created an environment that Erin

experiences as supportive and one in which she can openly discuss her concerns (Strozier,

Barnett-Queen, & Bennett, 2000).

In a previous example, the field instructor, Matthew, also revealed to his supervisee,

Sandy, his experiences with indirect trauma. Consistent with considerations associated with self-

disclosure in social work practice, Susan's and Matthew's disclosures in supervision are limited

and intentional; they validate and normalize their supervisee's reactions. In both instances, the

supervisors' self-disclosures fostered their students' willingness to acknowledge and discuss

their affective reactions to their work. This is consistent with research findings that reveal that

supervisor self-disclosure is associated with supervisee comfort and willingness to disclose and

discuss sensitive and difficult topics (Bennett et al, 2012; Mehr, Ladany, & Caskie, 2010; 2015).

(Bennett et al., 2012).

While not obviously apparent from the two excerpts, Susan and Matthew maintain

appropriate boundaries, having clarified from the beginning of the placement how they and their

students would work together (Ganzer & Ornstein, 2004). Their disclosures about their reactions

to their work with survivors pave the way for their students to do the same. The field instruction

relationship is not a therapeutic one, but the "interpersonal worlds" of student and field instructor

(Ornstein & Moses, 2010, p. 108) are important considerations when discussing work with

trauma survivors (Berger & Quiros, 2016; Bride & Jones, 2006).

Working with trauma supervisors will inevitably generate strong affective reactions for

both field instructors and their students. Therefore, a notable aspect of trauma-informed

supervision is understanding and making use of parallel process. It has long been accepted that

interactions between supervisors and their supervisees will mirror reactions to and interactions

with clients. Contemporary conceptualizations of parallel process recognize its inevitability and

bidirectionality (Bennett, Mohr, Deal, & Hwang, 2012; Miehls, 2010). This dynamic is no longer

viewed solely or even mostly as a manifestation of transference or countertransference. Authors

observe that parallel process reflects the subtle interplay of the personalities of the supervisor and

supervisee as they genuinely engage with one another and with clients (Miehls, 2010). Further, it

need not be a disruptive force in the supervisory alliance. When this is the case, however, the

field instructor must address its manifestations directly. This is especially important when it is

the field instructor's reactions that are at play.

Whether disruptive or not, parallel process provides the field instructor with unique

teaching and learning opportunities (Strozier et al., 2000). As this dynamic is examined in

supervision, both student and field instructor deepen their understanding of themselves and one

another. The field instructor's actions in this regard model for students how to handle similar

situations when they surface in their work with clients (Miehls et al, 2013; Schamess, 2012).

They also are consistent with the trauma informed principles of collaboration and empowerment.

"Supervision relationships [in trauma work] are most meaningful, when co-created, and where

supervisor and supervisee anticipate a reciprocal process that may reflect enactments of treatment scenarios that surface in the supervisory relationship" (Miehls, 2010, p. 377).

In this last example, the setting is an inpatient psychiatric facility. The field instructor, Ricardo, addresses tension that has surfaced in his relationship with his student, Tanya. The student has been working with Marcus, a patient on the forensic unit, preparing a report for his court appearance on charges of assault with a deadly weapon. In previous supervisory sessions, Tanya emotionally described what she has learned about Marcus's childhood: he witnessed the murder of an older brother; was physically abused by his father; and was placed in numerous foster homes in which he was physically and sexually abused. In their current meeting- which occurred three weeks before Tanya's placement was ending- she reported that she had promised Marcus she would accompany him to his court hearing, which was to occur after the placement ended.

Ricardo: Whoa, Tanya, we need to talk about this. I understand you want to be there for Marcus for his trial, but once you leave us, you're no longer his social worker.

Silence

Ricardo: Tanya…..so…what are you thinking? You look pissed.

Tanya: Marcus has nobody! Not one person! He's told me that I'm the first person who has been nice to him, been there for him. I have to go! It's not fair to not let me go!

Ricardo: I'm not keeping you from going. I *am* reminding you that, when you terminate, your work with your clients is over, and I'm afraid that includes Marcus.

Silence

Ricardo: Tanya, I know this is tough. I know you care about him. And, yes, I know that Marcus has had no one, and you have been there for him. You seem angry with me? Maybe for reminding you of boundaries?

Tanya: I just don't think boundaries should matter in this case. I have been his social worker for four months. You don't understand how hard it's been on him! I don't think you're being fair to him or me.

Ricardo: I get that you're upset, and I'm glad you can tell me. I hope you'll consider the possibility that it's not really me you're angry at. Maybe you're angry at the situation- that you can't be there for him when he needs you to be. Angry at all those people that weren't there for him when he needed them. Maybe you're even feeling a little guilty? That you are 'abandoning' him when he needs you the most?

Silence

Tanya: I'm sorry. I'm being disrespectful.

Ricardo: Nothing to apologize for! You care about Marcus, and you have to terminate with him at a critical juncture in his life.

Tanya's willingness to reveal her anger to Ricardo suggests that their supervisory alliance promoted honest and open discussion. Ricardo does not respond defensively or in an accusatory manner to Tanya's reactions, consistent with research that indicates that negative reactions or no reaction at all undermine students' learning and the supervisory alliance (Bennett, et al, 2012; Ornstein & Moses, 2010). Instead, he normalizes Tanya's reactions and validates the understandable feelings of sadness, anger, and guilt that accompany ending her work with Marcus. As their discussion proceeded, Tanya was able to see how her personal feelings for Marcus- which were reasonable under the circumstances- led to a blurring of boundaries.

Ricardo also helped Tanya see how she could terminate with Marcus in a way that would minimize feelings of abandonment and empower him to continue with his goals. Traditional conceptualizations of parallel process would frame Tanya's reactions to her client as countertransference and her field instructor as countertransference. As noted, contemporary notions view them as normal and expected components of practice and supervision.

Attend to Students' Reactions: Managing Indirect Trauma

The field instructor must be proactive in addressing manifestations of indirect trauma. This begins with normalizing and validating students' reactions. It can include making an "affective check-in" (Etherington, 2009) a routine aspect of supervision. The field instructor queries students about their emotional responses to their work, and, as needed, offers students an opportunity to discuss reactions that are problematic and may interfere with their work and/or impact their personal lives.

Appropriate use of this strategy requires that students and field instructors have a clear understanding of boundaries as well as a shared understanding of why the check-in and the conversation that may follow are necessary for students' professional development. In an earlier example, the field instructor, Matthew, normalizes his student's reactions by disclosing the challenges he has faced working with traumatized clients. In another case scenario, the field instructor explores her student's possible feelings *in advance* of the student's meeting with the client, and in the final example, Ricardo directly addresses manifestations of transference. In each instance, students' reactions are normalized, lessening their negative impact.

Conclusion

Trauma-informed field instruction builds upon supervisory skills that already have a strong evidence-base and are widely acknowledged to further students' learning in the field

practicum. School and programs of social work have a responsibility to educate field instructors about trauma, its impact on clients and workers, and the nature of trauma informed practice. TI field instruction can only be effective if supervisors understand the nature of their and their students' practice. Field instructors also must understand how they can integrate the five trauma informed principles into their supervision. Emphasis should be placed on helping field instructors understand how supervisory skills they *are already using* and that have a strong evidence base fit within a trauma informed context. A straightforward way to foster field instructors' education is to offer continuing education workshops on trauma that meet licensure requirements.

Trauma-informed field instruction cannot exist without organizational support and a climate that is itself trauma-informed (which is often referred to as trauma-informed care) and adheres to and promotes the five TI principles with respect to organizational climate and culture, the treatment of clients and staff, and physical plant. (Bassuk, et al, 2017; Conover, Sharp, Salerno, 2015). This includes reinforcing the need and providing opportunities for self-care as well as other avenues for support for clinicians, administrative staff, and supervisors.

Unfortunately, organizations in which students are most likely to be placed have been slow to embrace trauma informed principles. Therefore, when field instructors engage in trauma-informed supervision, they and their students are likely to be challenged by an organizational environment that does not recognize the unique aspects of working with trauma survivors. Therefore, future efforts must not only be directed at helping field instructors adopt a trauma-informed orientation, but also at advocating that their employing organizations do the same. Most fundamentally, social work education, itself, must become more trauma informed. As

social workers become more trauma informed, the agencies and organizations that employ must be encouraged to follow suit.

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