Approved and recommended for acceptance as a dissertation in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

Special committee directing the dissertation of Madeleine Ann Dupre

4/11/12
Lennis G. Echterling, Ph.D. Date

4/11/12
Anne Stewart, Ph.D. Date

4/11/12
Cara Meixner, Ph.D. Date

4-12-12
Robin Anderson, Psy.D. Date

Received by The Graduate School
JER 4/13/12
Date

المنارة للاستشارات
www.manaraa.com

Crisis Supervision: A Qualitative Study of the Needs and Experiences of Licensed Professional Counselors

Madeleine Ann Dupré

A dissertation submitted to the Graduate Faculty of

JAMES MADISON UNIVERSITY

In

Partial Fulfillment of the Requirements

for the degree of

Doctor of Philosophy

Department of Graduate Psychology

May 2012

المنارة للاستشارات

www.manaraa.com

UMI Number: 3506491

All rights reserved

INFORMATION TO ALL USERS
The quality of this reproduction is dependent on the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript
and there are missing pages, these will be noted. Also, if material had to be removed,
a note will indicate the deletion.

UMI
Dissertation Publishing

UMI 3506491

Copyright 2012 by ProQuest LLC.

All rights reserved. This edition of the work is protected against
unauthorized copying under Title 17, United States Code.

ProQuest

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 - 1346

المنارة للاستشارات

www.manaraa.com

Dedication

I dedicate this dissertation to Pam. She is a constant source of encouragement, inspiration, and love.

المنارة للاستشارات
www.manaraa.com

Acknowledgements

It is a great pleasure to acknowledge and thank everyone who helped me with my dissertation. I am truly indebted to my advisor, Dr. Lennie Echterling, who worked tirelessly to establish the new Ph.D. in Counseling and Supervision at James Madison University. He has provided invaluable guidance and support throughout this project.

My dissertation committee members offered thoughtful feedback, encouraging words, and camaraderie. Dr. Anne Stewart challenged me to wonder about the deeper meanings behind what we see, and to delight in the journey. Dr. Cara Meixner expertly guided me through the qualitative research process.

I am grateful to my peer reviewers, Dr. Robin Anderson and Dr. Michele Kielty-Briggs who generously gave of their time and expertise to ensure the trustworthiness of the data. My thanks also go to many friends, colleagues, and supervisees who assisted and advised my research and writing efforts. I could not have completed my dissertation without the endless support of Dr. Don Roe, W. Joseph Tuell, and my co-workers at the Commonwealth Center for Children and Adolescents. I am grateful too, for the help that my dear colleague, Dr. Teresa Haase, provided. She was a wonderful editor and cheerleader.

I offer my sincerest thanks and appreciation to the thirteen Licensed Professional Counselors who participated in this study. Throughout the interviews, I was deeply touched by their candor, compassion, and humility.

Finally, I wish to honor the friendship and memory of Michelle Lynch. She was a fellow doctoral student who loved life and all things connected with JMU.

المنارة للاستشارات
www.manaraa.com

Table of Contents

Dedication ii

Acknowledgements iii

Table of Contents iv

List of Tables ix

Abstract x

I. Introduction and Overview of the Study 1

Statement of the Problem 3

Purpose of the Study 5

Research Question 6

Overview of Procedures 6

Significance of the Study 6

Limitations 7

Definition of Terms 7

Overview of the Dissertation 9

II. Review of the Literature 11

Introduction 11

Licensed Professional Counselors 11

Trends in Counseling and Supervision 14

Ethical Guidelines and Professional Practice Standards 15

The Concept of Crisis 17

Crisis and Trauma 20

A Broader Conceptualization of Crisis 21

المنارة للاستشارات

www.manaraa.com

Counseling Clients in Crisis 25

Need for Counseling 26

Within-Session Crisis.....27

Capital "C" Crisis Counseling Settings 28

Emergency Services Clinicians.....29

Home-based Counselors 30

Other Crisis Settings 31

Impact on the Counselor 31

Counter-Transference Reactions.....32

Professional Quality of Life.....34

Negative Effects of Crisis Work Burnout.....35

Compassion Fatigue.....36

Vicarious Traumatization.....36

Positive Outcomes 37

Vicarious Resilience and Post-Traumatic Growth.....37

Crisis Intervention.....39

Counselor Supervision 41

Supervision Models 44

Psychotherapy-Based Models.....44

Developmental Models 46

Social Role Models 47

Attachment Theory and Supervision 48

Crisis Supervision 51

المنارة للاستشارات
www.manaraa.com

Chapter Summary 58

III. Methodology 59

Introduction 59

Purpose of the Study 60

Research Question 61

Qualitative Inquiry 61

Procedures 64

Purposive Sampling 64

Participant Selection 66

Participant Characteristics 68

Researcher Qualifications and Involvement 69

Data Collection Protocol 71

Interview Format 72

Round I Interview Protocol 72

Round II Interview Protocol 74

Trustworthiness Procedures 74

Process Notes 75

Member Checking 75

Peer Review 76

Research Journal 77

Memo Writing 78

Data Analysis 79

Chapter Summary 82

المنارة للاستشارات
www.manaraa.com

IV. Results 84

Introduction 84

Category I: Counselors' Understanding and Experience of Client Crisis 85

Theme 1a: Counselors Confront a Wide Range of Crisis Situations 87

Ongoing Personal Struggles 87

Behavioral Emergencies 89

Tragic Events 92

Theme 1b: Crises are Complex 93

Clinical Complexity 93

Systemic Complexity 96

Cultural Complexity 100

Category 2: Impact of Crisis Response on the Counselor 103

Theme 2: Counselors Experience Positive and Negative Outcomes from Crisis Counseling 103

Positive and Negative Emotions 103

Resilience 106

Posttraumatic Growth 108

Negative Outcomes 110

Category 3: Crisis Supervision 114

Theme 3: Crisis Supervision is Essential, Generally Helpful, but Potentially Harmful 114

المنارة للاستشارات
www.manaraa.com

Essentiality 114

Helpfulness 121

Harmfulness 129

Category 4: Clinical Supervision 131

Theme 4: Clinical Supervision is the Heart of Professional Development throughout the Counselor's Career 131

Chapter Summary 134

V. Summary, Discussion, and Recommendations 136

Methodological Considerations, Limitations, and Challenges 136

Summary of the Findings 139

Discussion of the Themes 140

Recommendations for Future Research 157

Chapter Summary 159

Appendices 162

Appendix A: Demographic Questionnaire 162

Appendix B: IRB Approval 163

Appendix C: Participant Recruitment Announcement 164

Appendix D: Informed Consent Form 165

Appendix E: E-Mail Consent Form 169

Appendix F: Round I Interview Guide 172

Appendix G: Round II Interview Guide 174

List of References 176

المنارة للاستشارات

www.manaraa.com

List of Tables

Table 1: Frequency of Work Settings 69

Table 2: Categories, Themes, and Data Clusters 86

Table 3: Process Components of Helpful Supervision 122

Table 4: Qualities of a Helpful Supervisor 127

المنارة للاستشارات

www.manaraa.com

Abstract

This qualitative study explored the supervision needs and experiences of licensed professional counselors working with clients in crisis. The primary purpose of the inquiry was to understand crisis supervision from the perspective of counselors in the field. The rationale for the study rested on three fundamental assumptions. First, counselors routinely encounter crises in their work with clients. Second, crisis response exposes counselors to hazardous situations and increases the risk for developing burnout, compassion fatigue, and vicarious traumatization. Finally, good supervision protects counselors from the risks associated with crisis work and enhances counselor self-efficacy. However, crisis supervision is frequently not provided and has not been adequately addressed in the literature, CACREP standards, or professional practice guidelines. Data were collected during two rounds of semi-structured interviews with 13 licensed professional counselors. Inclusion criteria included: hold an active license to practice as a Licensed Professional Counselor (LPC) in Virginia, be employed full-time in a counseling position, and spend a minimum of 50% work time providing counseling services to clients. Numerous procedures enhanced trustworthiness, including peer reviewers, member checking, and memo-writing. Data were analyzed using constant comparison procedures. Five themes within four major categories were reflected in the data. Themes reflect participants' understanding of crisis, crisis counseling, crisis supervision, and clinical supervision. The results provided a cogent framework for crisis supervision and a compelling argument for post-licensure clinical supervision. Implications for counselors, supervisors, and counselor educators are presented. Contributions to the literature and future research recommendations are also explored.

المنارة للاستشارات
www.manaraa.com

CHAPTER I

Introduction and Overview of the Study

Fundamental to the human condition, crisis occurs throughout the lifecycle. Crisis is a state of emotional disequilibrium, a time when events overwhelm a person's problem-solving capabilities (Roberts, 2005). Typical crisis events include the death of a loved one, a serious accident or illness, the sudden loss of a job, and developmental transitions, such as starting school or leaving home. These experiences may disrupt the flow of one's life, triggering powerful emotions that are not easily resolved (Echterling, Presbury, & McKee, 2005).

The pervasive nature of crisis is well documented. In the United States, 48% of adults experience at least one significant mental health disorder, including serious depression, anxiety, and substance abuse (National Institute of Mental Health, 2011). These conditions both significantly increase the risk of crises, and impair one's ability to cope with adversity. In times of great despair, many people consider suicide. Over eight million adults have serious thoughts of suicide; more than one million adults attempt suicide each year (SAMHSA, 2009). Among adolescents, suicide is the third leading cause of death (Hipple & Beamish, 2007). According to the National Youth Risk Behavior Survey, 6.3% of students in grades nine through twelve attempted suicide one or more times (Centers for Disease Control and Prevention, 2010).

Crisis-inducing events have been studied extensively, particularly in the area of interpersonal violence (Roberts, 2005). Domestic violence—intimidation, physical assault, battery, sexual assault, and other abusive behavior—is an epidemic (National Coalition against Domestic Violence, 2012). One in six women and one in 33 men have

المنارة للاستشارات
www.manaraa.com

experienced an attempted or completed rape (National Institute of Justice, 2000). School violence is also on the rise. Results from the National Youth Risk Behavior Survey indicated that 5% of high school students in the United States did not go to school because they felt unsafe there or on their way home from school (Center for Disease Control, 2010). The broad spectrum of crisis issues also includes divorce, bankruptcy, and bias-motivated crime.

When crises occur, they pose significant risks for two reasons. First, during episodes of crisis there is the potential for serious physical and psychological harm. Second, maladaptive attempts to resolve the crisis can have catastrophic consequences. In either case, immediate intervention is required to stabilize the situation.

In response to crisis, the counseling field has developed specialized intervention models and strategies for managing a variety of emergency situations. These efforts have gained tremendous momentum in the last decade. Suicide prevention programs, crisis hotlines, crisis stabilization programs, and emergency response teams provide valuable assistance to people in crisis. Furthermore, there is a growing body of literature on emergency response, crisis intervention, and disaster mental health. As a result of these initiatives, counselors are more aware of the impact of crisis—on individuals, families, and communities—and better prepared to respond.

Today, there is also greater recognition of the challenges that crises present to the helping professional. In the midst of a mental health emergency, the counselor must manage multiple tasks—rapidly assess an unstable and potentially dangerous situation, respond in a clinically sound and ethical manner, and ensure the safety of everyone involved (Corey, Haynes, Moulton, & Muratori, 2010). Attempting to carry out these

المنارة للاستشارات
www.manaraa.com

services can also provoke a crisis for the helper, triggering fears of making a mistake and provoking feelings of helplessness and uncertainty (Echterling, Presbury, & McKee, 2005). Counselors working with clients in crisis report common physical and psychological stress reactions, ranging from anger, shock, confusion, and insomnia to burnout, demoralization, and vicarious traumatization (Trippany, Whitekress, & Wilcoxon, 2004). Clinical supervision may mitigate the risks associated with providing crisis services. By offering emotional support and guidance, supervisors can help counselors to safely manage a hazardous situation, resolve the situation positively, and solidify their professional identity (Corey, Haynes, Moulton, & Muratori, 2010; Dupré, 2011).

Statement of the Problem

Counselors routinely encounter clients in crisis. No matter where they work—in community clinics, psychiatric hospitals, or schools—mental health professionals intervene in situations where a person's ability to cope has been seriously comprised. According to McAdams and Keener (2008), "The frequency of serious client crises confronting human service professionals has escalated to such proportions that crises have been referred to as an 'occupational hazard' in the professional literature" (p. 388).

In Virginia alone, during fiscal year 2010, more than 57,000 adults received crisis and emergency services at community mental health centers. A large percentage of the workforce in community mental health centers, agencies, and managed care organizations consists of licensed professional counselors (LPCs). LPCs provide mental health and substance abuse counseling to millions of Americans each year. More than 120,000 professional counselors are licensed in the United States (ACA, 2011). Approximately

المنارة للاستشارات
www.manaraa.com

3,190 of these licensed professionals currently practice in Virginia (Virginia Department of Health Professions, 2011).

There is a growing awareness of the impact of crisis work on the counselor (Lindy, 1989; McCann & Pearlman, 1992). Exposure to client crises can shift the way counselors see themselves, others, and the world. Crisis counseling can shatter a counselor's identity, undermining the practitioner's confidence and competence (Pearlman & Saakvitne, 1995). Despite the risks and possible negative outcomes associated with crisis work, counselors can also experience positive outcomes, such as vicarious resilience (Hernandez, Gangsei, & Engstrom, 2007) and posttraumatic growth (Echterling, Presbury, & McKee, 2005).

Crisis Supervision

Good supervision can protect counselors from the deleterious effects of crisis work, reduce the incidence of secondary trauma, and enhance the counselor's resolve and self-efficacy (Dupré, 2011; Pearlman & Saakvitne, 1995; Salston & Figley, 2003). However, crisis supervision is frequently not provided and has not been adequately addressed in the literature. Traditional models of supervision do not meet the specific needs of counselors working with clients in crisis. The standard practice of providing one hour of scheduled weekly supervision following a client and counselor interaction is both inappropriate and insufficient during crisis events. Nevertheless, virtually all of the supervision literature is based on that assumption (Hipple & Beamish, 2007).

Moreover, very little published supervision research has been conducted that focuses exclusively on the crises that professional counselors encounter working in the field. Studies are typically conducted by university-based counselor educators, utilizing

المنارة للاستشارات
www.manaraa.com

graduate students as research participants (Crockett, Byrd, Erford, & Hayes, 2010). Finally, although accreditation boards, such as the Council for Accreditation of Counseling and Relate Educational Programs, require training in crisis services and supervision, they offer no clear guidelines about supervisory responsibilities or protocols during mental health emergencies.

The lack of a conceptual framework for field-based crisis supervision is ethically unsound and exposes clients, counselors, and supervisors to a number of hazards. First, without clear guidelines for supervising crisis counseling, there is no assurance that counselors are adequately prepared to manage these complex clinical situations. Second, the lack of supervisory support and oversight may negatively impact the counselor's personal and professional development. Finally, the absence of a clear framework for crisis supervision increases the risk of litigation for supervisors who are legally responsible for the clinical work of their supervisees (Corey, Haynes, Moulton, & Muratori, 2010).

The current investigation explored the phenomenon of crisis supervision from the perspective of professional counselors working in field-based settings. This investigation has important implications for counselors, supervisors, and counselor educators. Since there is no research that examines specifically the crisis supervision experience of licensed professionals, the findings will fill a significant gap in the literature.

Purpose of the Study

This qualitative study explored the supervision needs and experiences of licensed professional counselors working with clients in crisis. The primary purpose of the inquiry was to understand crisis supervision from the perspective of counselors working in the

المنارة للاستشارات
www.manaraa.com

field. There were two secondary goals: to discover and understand how counselors experience client crises, and to explore the supervision experiences of counselors in real world practice settings.

Research Question

The primary question guiding the inquiry was: What are the supervision needs and experiences of licensed professional counselors when working with clients in the midst of a crisis or mental health emergency?

Overview of Procedures

This study utilized a basic qualitative research design. Data were collected during two rounds of semi-structured interviews. The goal of the sixty minute interviews was to give voice to the counselors' experience of client crisis, crisis counseling and counselor supervision. Purposive sampling strategies were used to select 13 licensed professional counselors in Virginia. Interviews with twelve participants were conducted in person. One participant was interviewed using Skype, a video-conferencing option. Interviews were audio-recorded and transcribed. Numerous procedures enhanced trustworthiness, including peer reviewers, member checking, process notes, and memo-writing. Data were analyzed using constant comparison procedures. NVivo 9 ®, a software program, facilitated the coding process.

Significance of the Study

This study is highly significant for several reasons. First, there is very little published research on crisis supervision. Second, the literature on counselor supervision offers virtually no guidance about supervisory practices during times of client crisis. Third, a framework for crisis supervision is not found in professional practice standards

المنارة للاستشارات
www.manaraa.com

or ethical guidelines for counseling supervisors. Fourth, there is no published research that focuses specifically on the crisis counseling or supervision experiences of licensed professional counselors.

This investigation will broaden the knowledge in all four of these key areas. It will uncover the elements of supervision that help counselors manage crisis situations and will identify specific practices that promote counselor growth and effectiveness. Results from this study will aid in the development of a framework for crisis supervision that is based on the lived experience of counselors in the field. Furthermore, knowledge gained from this study will broaden our knowledge about crisis by promoting an understanding of how professional counselors understand and experience these events.

Limitations

Participants in this study are licensed professional counselors in Virginia. Since they come from a particular geographical area and from within a specific professional discipline, the generalizability/transferability of the findings may be limited. Moreover, participants are counselors currently working in the counseling field. Practitioners no longer providing counseling because of burnout or disillusionment with the field are not represented.

Definition of Terms

It is important to define the key terms that are used throughout this study. Three of these terms refer to the circumstances, dynamics, and potential consequences of crisis situations (crisis, resilience, and posttraumatic growth). Six terms are related to the counseling profession (client, crisis counseling, Licensed Professional Counselor, supervisee, supervision, and supervisor).

المنارة للاستشارات
www.manaraa.com

A *crisis* is a state of intense emotion when a great deal is at stake. A crisis is not necessarily a time when a client is actively homicidal or suicidal; but rather, a time when a client is experiencing much distress and there is the potential for serious negative consequences. *Resilience* refers to the ability to 'bounce back' after significant adversity and risk (Echterling, Presbury, & McKee, 2005, p. 10). Although the research on crisis has typically focused on negative consequences, there is a growing awareness that people can thrive under difficult conditions. The term *posttraumatic growth (PTG)* signifies positive changes that people experience as a result of encountering crisis. Benefits include enhanced relationships, increased confidence, and deepened sense of spirituality (Tedeschi, Park, & Calhoun, 1998).

A c*lient* is an "individual seeking or referred to the professional services of a counselor for help with problem resolution or decision-making" (ACA, 2005, p. 20). *Crisis counseling* involves providing guidance and support to an individual, family, group, or community during a crisis. The goals of crisis counseling include stabilizing a highly charged and potentially volatile situation, defusing heightened emotional states, ensuring public safety, and linking persons in crisis to community resources. A *Licensed Professional Counselor* (*LPC*) is a Masters-degreed mental health professional who has completed a residency in counseling, passed a qualifying examination, and successfully fulfilled all requirements to practice in this legally prescribed role. Services provided by licensed professional counselors include: assessment, diagnosis, treatment, prevention, consultation, and research of mental health and addictive disorders, along with promotion of growth and well-being (ACA, 2011). A s*upervisee* is a professional counselor,

المنارة للاستشارات
www.manaraa.com

resident-in-counseling, or counselor-in-training who is receiving supervision from a qualified trained professional while providing counseling services (ACA, 2005).

In this study, the terms *supervisee* and *participant* are used interchangeably.

Supervision is an intervention provided by a senior member of a profession to a junior member of the same profession. The supervisory relationship extends over time, enhances the professional functioning of the supervisee, monitors quality of services provided, and serves as a gatekeeper to people entering the profession (Bernard & Goodyear, 2009). In the present study, the term "supervision" refers to clinical supervision rather than administrative supervision, unless otherwise noted. A *supervisor* is a professional counselor who provides supervision to a practicing counselor or counselor-in-training for the purposes of promoting the development of clinical skills in the trainee and ensuring client welfare (ACA, 2011).

Overview of the Dissertation

This introductory chapter provided a broad overview of the current study. The chapter began with a brief description of crisis. Next, this chapter explored the rationale for the study and identified three underlying assumptions. First, counselors frequently encounter client crises. Second, responding to crisis increases risk of a negative impact on counselors, including compassion fatigue and vicarious traumatization. Finally, crisis supervision can reduce the risk of negative outcomes for the counselor by promoting resilience and posttraumatic growth.

The chapter also outlined the purpose of the study, introduced the primary research question, and provided a brief description of the methodology. Finally, the significance of the study and consideration of study limitations were addressed. Definitions of key terms

المنارة للاستشارات
www.manaraa.com

were included in this chapter.

Chapter II begins with an in-depth look at licensed professional counselors—the population from which the sample was drawn. Next, recent trends and changes in training and credentialing of professional counselors and supervisors are discussed. The remainder of the chapter provides a review of the literature across a broad range of topics pertinent to the study: crisis theory, crisis intervention, trauma counseling, counselor supervision, and crisis supervision.

Chapter III includes a brief review of qualitative research and describes the research methods employed in the study. The participant selection process, data collection protocols, procedures for analyzing data, and tools to enhance trustworthiness are also explained.

The results of the data analysis appear in Chapter IV. Five major themes within four broad categories are reflected in the data. These themes represent participants' understanding of crisis, crisis counseling, crisis supervision, and counselor supervision.

Finally, in Chapter V, the results of the study are discussed. The chapter examines the findings in light of the extant literature. Methodological considerations and study limitations are addressed. Implications of the findings for counselors, supervisors, and counselor educators are also explored. The chapter concludes with recommendations for future research.

المنارة للاستشارات
www.manaraa.com

CHAPTER II

Review of the Literature

Introduction

Chapter I provided a broad overview of the current study. The chapter began with a description of crisis situations—unexpected events that create uncertainty and pose considerable risks for individuals and families. The chapter also explored the rationale behind the study and briefly described the research design. As noted, three key ideas guided the inquiry.

First, counselors routinely encounter crises in their work with clients. Second, crisis response exposes counselors to hazardous situations and increases the risk for developing burnout, compassion fatigue, and vicarious traumatization. Finally, effective supervision mitigates the dangers associated with crisis counseling and enhances counselor resilience.

This chapter provides a review of the literature and establishes the theoretical context for the enquiry. The chapter begins with important background information about licensed professional counselors, the population from which the sample was drawn. Next, the chapter examines recent trends in counseling and supervision which are relevant to the investigation. The remainder of the chapter reviews the counseling and supervision literature across a broad range of topics pertinent to the study—crisis theory, crisis intervention, trauma counseling, counselor supervision, and crisis supervision.

Licensed Professional Counselors

Licensed professional counselors (the exact title varies by state, and includes other terms, such as licensed mental health counselors and licensed clinical professional

المنارة للاستشارات
www.manaraa.com

counselors) provide a wide range of mental health and substance abuse services to millions of Americans. More than 120,000 professional counselors are licensed in the United States, working in a variety of settings, including community mental health centers, hospitals, schools, colleges and universities, jails, prisons, and private practices (American Counseling Association, 2011). Services provided by licensed professional counselors include: assessment, diagnosis, treatment, prevention, consultation, and research of mental health and addictive disorders, along with promotion of growth and well-being. Licensure occurs at the state level and typically requires graduating with a master's degree in counseling from a national or regionally accredited program, completing post-master's supervised clinical experience, and passing a state-recognized licensure examination.

In 1976, Virginia became the first state to pass legislation to license professional counselors. Professional counseling is regulated by the Commonwealth of Virginia's Department of Health Professions, Board of Counseling. There are approximately 3,190 professionals in Virginia with an active license to practice mental health counseling (Virginia Department of Health Professions, 2011). The Virginia Board of Counseling (2011) recently clarified requirements for the post-internship experience and mandated supervisory training for persons supervising residents. In a guidance document issued this year, the Board stated that

> An individual who proposes to obtain supervised experience in Virginia, in any setting, shall submit a <u>supervisory contract</u> stating the proposed plans for the resident to provide clinical services using recognized counseling and counseling interventions while under the supervision of a qualified licensed practitioner

المنارة للاستشارات
www.manaraa.com

> (para. 1). The supervisor … must verify and document the resident's experience in the delivery of 2000 hours of face to face clinical counseling services utilizing counseling treatment interventions as defined in the **Code of Virginia** (para. 2).

These actions have far reaching consequences for both counselors seeking licensure in Virginia and supervisors guiding their work. The Board insisted that counseling residents provide "counseling treatment interventions" under the supervision of a qualified licensed practitioner trained in counselor supervision; furthermore, the supervised experience must occur within the framework of a written contract that must be approved by the Board prior to the beginning of the supervised experience (Virginia Board of Counseling, 2011).

Informed consent requires that CACREP and CORE accredited counselor education programs alert students and supervisors about expectations, procedures, and polices for practicum and internship placements. The programs typically make the required supervision experience consistent with state licensure requirements for those students wishing to pursue licensure (CACREP, 2009; CORE, 2010). In effect, the recent actions by the Virginia Board of Counseling ensure that post-internship supervised clinical experience adopts similar standards.

However, despite these improved standards for supervision of counseling residents, little attention has been given to post-licensure clinical supervision. As all other states, Virginia does not require supervision of counselors beyond licensure. Licensed professional counselors must complete a minimum of twenty hours of "competency activities" each year for license renewal to increase knowledge or skills in one or more areas; clinical supervision and consultation received may count for a maximum of ten

المنارة للاستشارات
www.manaraa.com

hours (Virginia Board of Counseling, 2011). There is great variation in the frequency and quality of supervision provided to LPCs in Virginia. It is not uncommon for counselors to receive virtually no clinical supervision beyond the residency.

Trends in Counseling and Supervision

The counseling profession has undergone tremendous change in the past decade. In part, this transformation can be traced to the terrorist attacks of September 11, 2001 and the powerful lessons that emerged from the tragedy. In an interview for *Counseling Today*, J. Eric Gentry recently commented that the profession has become more "trauma-aware" and is moving toward "trauma-competent" (Shallcross, 2011). The 2009 CACREP Standards infused core competencies in disaster response, trauma counseling, and crisis intervention and program specific training requirements for mental health, school, and addictions counselors. The new standards have far reaching implications for students and counselor educators and make one thing perfectly clear: graduates of CACREP accredited programs need specific knowledge, skills and attitudes to practice ethically and effectively in response to crises, disasters and traumas (CACREP, 2009).

Consequently, newly trained counselors should be more aware of the prevalence and impact of crisis and trauma on individuals, families, and communities, including the potential for post-traumatic growth. Furthermore, they have new resources and skills at their disposal to assist in crisis intervention and trauma recovery efforts. Counselors are becoming more cognizant of the need for effective crisis intervention and the importance of practicing self-care strategies.

Recent changes in the credentialing process for counselors, counseling

المنارة للاستشارات
www.manaraa.com

supervisors, and counselor education programs have resulted in greater accountability and standardization of training. As mentioned earlier, counselors applying for residency status in Virginia are required to submit a supervisory contract that outlines the specific counseling interventions that will be provided while under supervision and proof that the supervisor meets the standards established by the licensing board (Virginia Board of Counseling, 2011). These professional developments reflect broad-based support for supervisory training programs; furthermore, they reinforce three key ideas that appear throughout the literature: supervision is an intervention in its own right, ethical supervision practice requires a core body of knowledge and distinct competencies, and supervision is a skill that is acquired through a sequence of training and experience (ACA, 1990; Bernard & Goodyear, 2009; Powell, 1993).

Ethical Guidelines and Professional Practice Standards

In summary, there is a growing consensus among counselors and counselor educators about the need for specific education and training in two key areas: crisis response and clinical supervision. However, the models, research and practices in these areas seems to be progressing along parallel lines. There is no single framework that outlines best practices in counseling and supervision when clients are in the midst of a crisis. McAdams and Keener (2008) asserted, “There is a curious absence in counselor preparation, certification, supervision, and ethical practice standards of a consistent or comprehensive guideline for crisis prevention, intervention, and post-crisis recovery” (p. 388).

Ethical guidelines and professional practice standards stipulate only that counselors practice within the limits of their professional and personal competence and

المنارة للاستشارات
www.manaraa.com

practice in specialty areas only after adequate education, training, and supervised experience (ACA, 2011). At present, there is no systemic way to assess, enhance, or monitor counselor and supervisor efficacy in crisis situations.

Although many governing bodies, for example the American Counseling Association (1990), long ago developed specific criteria for supervision practice they did not address crisis supervision. Moreover, training requirements for counseling supervisors are notoriously vague and provide no guidance into the qualities that are most salient in times of client crisis. State and national counseling and supervision credentialing bodies fail to mention specialized training in crisis and emergency response (Center for Credentialing & Education, 2011; National Board of Certified Counselors, 2005). The American Counseling Association (ACA) Code of Ethics stipulated only that: "Supervisors establish and communicate to supervisees procedures for contacting them, or in their absence, alternative on-call supervisors to assist in handling crises" (ACA, 2005, F.4.b.).

There is an urgent need in the counseling field for a conceptual framework for crisis supervision that prepares and supports counselors who work with clients in crisis. Counselors routinely see clients with a history of suicidality, aggression, and trauma (McAdams & Keener, 2008). Clients in crisis present in states of heightened arousal, fear, helplessness, severe anxiety, and at times even horror. Trauma and crisis counseling incorporate "the most profound psychological experiences that people can endure, from grief to terror, from abuse to self-loathing, from sexual assault to divorce and warfare over custody" (Everstine & Everstine, 2006, p. xi). The research on crisis counseling has focused on the client experience, but these intense emotions can also overwhelm,

المنارة للاستشارات
www.manaraa.com

confuse, and discourage the professional counselor. Furthermore, highly emotionally charged and chaotic counseling situations present complex ethical and legal challenges for the counseling supervisor who is liable for the actions of supervisees. Before focusing specifically on supervision, the following sections explore the concept of crisis, crisis intervention, and the impact of crisis counseling on the helping professional.

The Concept of Crisis

In the mental health field, the word "crisis" has become an umbrella term for a wide range of experiences. For example, the term is used to describe personal tragedies, developmental transitions, behavioral emergencies, and chronic psychiatric conditions (Callahan, 2009). Crises also refer to natural disasters, community-wide catastrophes, and economic downturns. Callahan (2009b) discussed the need for definitional clarity.

A crisis is frequently portrayed as a situation that has reached a critical point, an event in which a person's thoughts and emotions become destabilized (Caplan, 1964; Echterling, Presbury, & McKee, 2005; Roberts, 2005). Everstine and Everstine (2006) stated, "Everyone reaches points of crisis in life, when one's modus vivendi cannot accommodate another source of stress" (p. xi).

As mentioned in the first chapter, crisis events can include suicide or attempted suicide, life threatening illness or accidents, sexual assault and other forms of physical violence, witnessing or experiencing natural or human caused disasters, and loss of a loved one. The majority of stressful situations do not trigger a crisis for most people. In fact, most people negotiate crises successfully (Callahan, 2009; Corey, Haynes, Moulton, & Muratori, 2010; Echterling, Presbury, & McKee, 2005; Roberts, 2005).

المنارة للاستشارات
www.manaraa.com

Callahan (2009) differentiated between behavioral emergencies, situations that require immediate intervention (suicidal behavior, violent behavior, and interpersonal victimization) from crisis events (a wide variety of situations that are highly stressful and deeply troubling, but do not require immediate intervention to prevent harm or loss of life). He pointed out that a consensus is forming to define the term "crisis" in ways consistent with the views espoused by Caplan in the 1960s.

Caplan (1964) defined crisis as a time-limited period of intense distress, a state of emotional instability that has the potential for radically positive or negative outcomes. The "crisis" is the state of disequilibrium that may follow a distressful event when a person's normal coping mechanisms are insufficient to meet the demands of the situation. Callahan (2009) referred to the crisis itself as "functional impairment," an "individual's inability to function at his or her usual level" (p. 15). In times of crisis, a person may be more willing to try new coping strategies or accept help from others. An individual's ability to cope with a distressful event depends upon the appraisal of the event, perception of his or her ability to manage it, and access to a social support system (Aguilera, 1998; Callahan, 2009; Echterling, Presbury, & McKee, 2005).

Numerous scholars pointed out that the Chinese symbol for crisis is a juxtaposition of two other symbols, "danger" and "opportunity" (Echterling, Presbury, & McKee, 2005; Everstine & Everstine, 2006,). However, Echterling recently stated (personal communication, June 25, 2011) that the two symbols are more accurately described as "danger" and "decisive moment." He emphasized that a crisis, which involves both risk and possibility, can promote post-traumatic growth. His remarks are

المنارة للاستشارات
www.manaraa.com

consistent with the views of crisis espoused by Caplan (1964) and contemporary crisis theorists.

A number of systems for categorizing crises have been suggested; two cited most frequently are developmental or maturational (emerging from normal developmental stages) and situational (arising from unpredictable stressful situations). A detailed discussion of these systems can be found in Erickson (1963) and Caplan (1964). Additional types of crises appear in the literature: existential crisis, which involves questioning the meaning of one's life (Brammer, 1985), behavioral emergency (Callahan, 2009), and psychological emergencies (Thomas & Woodall, 2006). Roberts (2005) described sixty different types of crisis events.

Everstine and Everstine (2006) referred to crisis as a "slow boiling stew," a situation that reaches a critical point and eventually comes to a head. Callahan (2009) divided crises into two categories according to the precipitant: normative stress (illness of a family member, dissolution of an important relationship, or job loss) and traumatic stress (life and death situations). Traumatic stress events are fairly common; it is likely that everyone will experience a traumatic event in their lifetime (Dubi & Sanabria, 2010).

As Callahan (2009) explained, crises triggered by normative or traumatic stress are quite similar. In both cases, people may be thrown into a state of disequilibrium and exhibit symptoms of depression and anxiety. Crises triggered by traumatic stress may lead to acute stress disorder (ASD) characterized by numbing, depersonalization, and dissociative amnesia. Acute stress disorder can develop within two days of a traumatic event, lasts up to one month, and often becomes posttraumatic stress disorder (PTSD) (Dubi & Sanabria, 2010). PTSD affects 7.7 million Americans in any given year.

المنارة للاستشارات
www.manaraa.com

Symptoms include strong and unwanted memories of the traumatic event, disturbing dreams, angry outbursts, emotional numbness, and avoidance of thoughts and situations that are reminders of the event (National Institute of Health, 2011).

Crisis and Trauma

Crisis and trauma are two different and related terms that appear throughout the literature and are often used interchangeably. Trauma is defined as a normal response to extraordinary events, a "serious physical or psychological injury that has resulted from a threatening, terrifying, or horrifying experience" (Echterling, Presbury, & McKee, 2005, p. 7). Trauma is a state of mind caused by a traumatic event that may be instantaneous and irrevocable, or prolonged over time as in the case of repeated physical or sexual abuse. Individuals can experience trauma by witnessing a traumatic event, for example seeing someone being shot at close range.

Callahan (2009b) distinguished between Type I and Type II trauma. Type I trauma is a single event (rape, assault, and a natural disaster such as Hurricane Katrina), whereas Type II trauma consists of a series of traumatic events over time that are "perpetuated on victims who are in a situation of physical or psychological captivity" (p. 17). Examples of Type II trauma include being a prisoner of war, domestic violence, and child abuse and neglect.

Crisis does not always have its roots in trauma. A crisis may be precipitated by a time-limited event that temporarily diminishes a person's problem-solving capabilities. However, an unresolved trauma may lead to a crisis later in life (Everstine & Everstine, 2006). The distinction between crisis and trauma is especially important in crisis counseling. There is compelling evidence of the widespread prevalence of trauma and its

المنارة للاستشارات
www.manaraa.com

impact on individuals, families, and communities. The majority of people who seek mental health and substance abuse treatment have survived traumatic events, including childhood sexual abuse and interpersonal violence. The trauma experience, which may provoke symptoms of acute stress disorder or posttraumatic stress disorder, is not necessarily a crisis. A person with a trauma history may experience a crisis related to the trauma, or not. For example, a woman who is rejected by her mother for "making up stories about what her step-father did" may become overwhelmed by intense emotions that are triggered by her mother's reaction. However, she may also have inner resources (strength, self-esteem, and coping skills) and social supports (friends, family members, and helping professionals) to manage the situation effectively.

A Broader Conceptualization of Crisis

Attempting to grasp what the word "crisis" means in clinical practice is a quagmire: it is used to denote both a specific event associated with adverse outcomes (Callahan, 2009; Corey, Haynes, Moulton, & Muratori, 2010), and a state of disequilibrium precipitated by an event (Echterling, Presbury, & McKee, 2005; Caplan, 1964). Neither explanation captures the essence of "crisis" as it occurs in the counseling context. According to Dupré (2011b), crisis is an unfolding, multi-layered systemic process that affects clients, counselors, and supervisors in a variety of ways. The definition of crisis is highly individualized—something that is overwhelming for one counselor is familiar and routine to another. A full understanding of "crisis" requires a close look at the lived experiences of counselors in diverse settings and hearing first-hand accounts of what is destabilizing for them.

المنارة للاستشارات
www.manaraa.com

Dupré (2011c) reported findings from a focus group on crisis supervision. She asked four residents-in-counseling to recall a time in their counseling career when they worked with a client in crisis and to describe the supervision received during that time. One participant presented the following scenario: a young adolescent female reported that she was being physically abused by her mother. According to his narrative,

> An 11-year-old female client of mine, and it was the second time we met, and she was reporting to me that she was being abused at home by her mother. And, very, just very overwhelmed with telling, with telling me about this, this situation at home, was in tears, was, was almost like it was the first time that she had ever, ever told anybody about this, so it just felt like it was just spilling out. . . . Towards the end there was some relief, noticed there was some relief in her eyes, something that seemed cathartic (p. 2).

In this encounter, the client appeared distressed and reached out to the counselor for support. Continuing the story, the resident said,

> For me, I think there was a lot going on. I think first it was, was my experience empathizing with, with this is little girl and with her situation and seeing, seeing the pain in her eyes, the hurt, and also the relief of, of talking with somebody about it. And feeling that along with these feelings that were also present, of, of what do I do? What are my ethical responsibilities? What are my counselor responsibilities, what here do I say? How can I help? And I almost wanted to somehow fix it (p. 3).

The resident described a counseling interlude that had clearly become a crisis for him,

المنارة للاستشارات
www.manaraa.com

> That was the feeling inside me to do something to help her, and um, I just went over all of those things, experiencing all those things at once. Just kind of a big question mark. . . . What am I going to do when I leave this room and what's the first step that I am going to take? Can I let this, can this little girl leave this room, worrying that somehow her parents were going to find out that she told what was going on at home (p. 3).

According to Dupré (2011c), the situation was extraordinarily complicated for a number of reasons. First, Children's Protective Services (CPS) had to be notified. Second, this was the resident's first experience with mandated reporting. Third, the site supervisor made the report, which led to a break in the supervisory relationship. Fourth, since the client disclosed the alleged abuse at school, the school administrators became involved. The crisis therefore occurred on multiple levels, involved several people, and evolved over time.

The narrative implies that a crisis is not only an external event that a counselor witnesses from a distance or an internal psychological state. Crisis may be a more complicated, unfolding, and collective process. As the events unfold, they may take on different meaning for everyone involved.

These same themes are evidenced in the narrative of a second focus group participant who described a crisis involving an adolescent girl in a psychiatric hospital (Dupré, 2011c). During a brief conversation, the client reportedly said that she was experiencing a flashback of a traumatic rape. The resident-in-counseling described the event in this way, "One client was experiencing, I guess, was having a flashback of being raped and in that moment she was very overwhelmed and she also had this intense

المنارة للاستشارات
www.manaraa.com

emotion where she was like she could never overcome this experience" (p. 1). She went on to explain what the experience was like for her, the counselor:

> There was so much going on in my mind, I'm thinking, what are some things I can do to help her in the cause in the moment; she felt like she was having this anxiety and she was just very emotional. And part of me was thinking, okay so what can I do to help her in this moment, um, so I don't do any harm to her? being in the moment was kind of tough. . . . I was thinking, Oh, my goodness, I hope I'm able to help her (p. 3).

Dupré reported that the client in this scenario was an adolescent in a psychiatric hospital having flashbacks of sexual assault. The counselor, a resident at the time, had no prior experience with post-traumatic stress disorder, and said "There was a lot going on, going through my mind" (p. 3). She described her own reaction in much the same way as she depicted the client's presentation, and briefly talked about her experience in supervision which served to ground and protect her. She said, "It was helpful to have a reflective piece, understanding who I am, but also understanding what I was experiencing in the moment with my client, that was really helpful, and acknowledging what I was feeling in that moment and being appreciated" (p. 9).

This account reinforces the idea that crisis is not something that a counselor responds to as a concerned observer, but rather that crisis is a process that the counselor and counseling supervisor are drawn into and powerfully affected by; it is a shared experience that presents danger and decisive moments for everyone involved. It also suggests that the supervisory relationship may play an integral part in crisis response. McAdams and Keener (2008) provided a framework for counselor preparation and

المنارة للاستشارات
www.manaraa.com

response (PAR) which supports these ideas. They argued that crisis is not a spontaneous or isolated event, but rather a progressive sequence of events—precipitant events, events defining the crisis, and the aftermath, that can have potentially damaging impact on counselors.

In summary, crisis is not sufficiently defined in the literature. There is evidence to suggest that it is an unfolding, profoundly personal and collective experience. A broader conceptualization is needed. Perhaps, as Rainer and Brown (2007) asserted,

> In contemporary practice, crisis is best defined by examining the nature of the crisis state. Simplistically, the definition could be left wholly phenomenological and subjective, that is, "I'm in a crisis when I say that I am". For the practitioner, understanding crisis is a more in-depth and interesting journey adding objective elements and requiring a stance of participant-observer with the client in his or her psychological, sociological, and spiritual functioning. The practitioner is obligated to extend the work from a diagnostic frame in order to determine the depth and nature of the crisis and its impact on the individual and the surrounding system (pp. 3-4).

Counseling Clients in Crisis

Virtually every counselor will work with a client in crisis (Corey, Haynes, Moulton, & Muratori, 2010; McAdams & Keener, 2008). Dupré (2011c) found that counselors had no difficulty identifying times in their counseling career when they worked with clients in the midst of a crisis. Presbury, Echterling, and McKee (2008) stated, "Life itself is a nonequilibrium and is always handing us new challenges for which

المنارة للاستشارات
www.manaraa.com

we must muster our resources, and many of these challenges can knock us off course" (p. 100).

People seek counseling when events build up to a critical point; they look for solutions to problems they are encountering—painful family dynamics, concerns about children, probation officers breathing down their neck, or troubling anxiety about the possible meaninglessness of life. All of these experiences are potentially destabilizing. Moreover, therapy itself can precipitate a crisis for clients grappling with difficult personal issues. Some scholars view counseling as a "perturbation of the client's current cognitions" intended to interrupt the homeostatic balance and stir people to think about things in new ways (Presbury, Echterling, & McKee, 2008). In this sense, crisis is at the very heart of good counseling. It is not something to manage or avoid, but rather an experience to acknowledge, embrace, and occasionally provoke.

Echterling (personal communication, July 20, 2011) discussed common crisis situations and differentiated between "crisis with a lower-case c" (times of distress and heightened emotional states, including normal developmental and unpredictable situational events) and "crisis with a capital C (violence, sexual assault, suicide, life-threatening disease, for example). The probability that counselors will encounter specific crisis situations depends upon a number of variables, including the counseling setting, client population, role of the counselor, and amount of work experience.

Need for counseling. The National Comorbidity Survey (1990-1992) was the first large field survey of mental health in the United States. The survey was replicated during a two-year period (2001-2003) with 9,282 adults. Results from the National Comorbidity Survey Replication (NCS-R) indicated that 48% of the sample met criteria

المنارة للاستشارات
www.manaraa.com

for at least one mental health disorder (Diagnostic and Statistical Manual of Mental Disorders, or DSM IV-TR) in their lifetime. Of the people who experienced mental illness in their lifetime, 27% experienced more than one illness. Lifetime prevalence of common disorders was: anxiety disorder, 31.2%; major depressive disorder, 16.9%; substance use disorder, 35.3% (National Institute of Mental Health, 2011).

In Virginia, forty publically-funded Community Services Boards (CSBs) provide mental health and substance abuse services to persons living within their catchment areas. In fiscal year 2010, more than 194,000 individuals received counseling services from the CSBs; almost 77,000 adults and 30,000 children receiving these services met criteria for serious mental illness (Virginia Department of Behavioral Health and Developmental Services, 2010). The actual number of people in receiving counseling services is considerably higher; however statistics about utilization from private agencies and independent practitioners are not available.

Results from the Youth Risk Behavior Survey, a national school-based survey of students in grades nine through twelve, indicated that, during the 12 months preceding the survey, 26.1% of students felt so sad or hopeless almost daily for two or more weeks in a row, that they stopped doing usual activities; 9.8% experienced dating violence (slapped, hit, or physically hurt); and 7.4% reported that were forced to have sex. During the 30 days before the survey, 24.2% consumed five or more drinks in a row within a couple of hours one or more times, 31.5% were involved in a physical fight, 7.7% had been threatened or injured with a weapon on school property, and 5% did not go to school because they felt unsafe at school or on their way home from school.

Within-session crisis. Counselors routinely face situations that demand

المنارة للاستشارات
www.manaraa.com

immediate response, a client who is actively suicidal, potentially violent, or at risk for being victimized (Kleespies (2009). These are the situations that Callahan (2009) described as behavioral emergencies. Psychotherapists report that these are the most stressful client behaviors they encounter (Hipple & Beamish, 2007; Echterling, Presbury, & McKee, 2005; Rodolfo, Kraft, & Reilly, 1988).

Professional counselors can expect that at times in their careers they will work with clients who are actively suicidal. Roughly 875,000 people attempt suicide each year (American Association of Suicidology, 2010). In a study involving 241 counselors, 71% of the participants reported that they had worked with a client who attempted suicide (Rogers, Guelette, Abbey-Hines, Carney, & Werth, 2001). McAdams and Foster (2000) surveyed professional counselors and almost one fourth of the respondents experienced the suicide of a client they were treating.

Results from the Youth Risk Behavior Survey indicated that in 2009, 13.8% of students seriously considered suicide, 10.9% made a suicide plan, and 6.3 % attempted suicide (Centers for Disease Control and Prevention, 2010). In a study of adolescents and adults hospitalized for a suicide attempt, 37% - 52% of the patients received outpatient counseling prior to the attempt (Barnes, Ikeda, & Kresnow, 2001).

The impact of client suicide on counselors can result in severe and long-term consequences. From a review of the literature, Foster and McAdams (1999) concluded that client suicide could induce acute reactions in therapists (depression, intrusive thoughts and memories, shock, self-blame, and guilt), anniversary stress reactions to the event and pathological grief reactions.

Capital "C" crisis counseling settings. Overall, it is clear that every counselor

المنارة للاستشارات
www.manaraa.com

will work with people in crisis. However, some counseling roles and work settings place counselors in circumstances where exposure to crisis is on-going and customary. Counselors may be working in volatile environments, such as psychiatric hospitals, or with clients in extreme distress.

Emergency services clinicians. Counselors in emergency services departments provide psychiatric evaluations, crisis intervention, and telephone assistance to clients who are experiencing acute distress. Over 57,000 people received emergency services in Virginia during fiscal year 2010 (Virginia Department of Behavioral Health and Developmental Services, 2010).

In Virginia, certified pre-screeners (professional counselors, social workers and nurses) conduct diagnostic interviews to assess the need for involuntary commitment. Involuntary commitment is a process whereby individuals with a mental illness, and who are actively suicidal, homicidal, or unable to care for themselves, may be temporarily detained (emergency custody order, or ECO) or committed to a hospital following a commitment hearing (temporary detaining order, or TDO). Involuntary civil commitments are governed by state law and are predicated on the perceived need to protect the individual from one's self, and the public from people whose mental status makes them dangerous to others.

In the Commonwealth of Virginia alone, over 12,000 adults were committed to psychiatric hospitals between July 1, 2009 and March 30, 2010 (Martinez, 2010). During fiscal year 2010, more than 800 patients were committed to Virginia's only public acute psychiatric hospital for children and adolescents (W. J. Tuell, personal communication, December 12, 2011).

المنارة للاستشارات
www.manaraa.com

Emergency services clinicians serve all ages of clients who present in a state of extreme upset and disorganization: children, adolescents, adults and geriatric patients. Co-morbid conditions (such as chronic mental illness, intellectual and developmental disabilities, substance abuse, and infectious disease) and homelessness are also common. Furthermore, emergency response typically requires intensive collaboration between counselors and police officers, paramedics, and fire fighters, family members, attorneys, and magistrates (Everstine & Everstine (2006).

The demands placed on the counselor evaluating the need for involuntary commitment are enormous. Successful crisis intervention in these situations requires strong assessment and intervention skills, the ability to remain calm and focused under duress, encyclopedic knowledge of the DSM IV-TR (American Psychiatric Association, 2000), familiarity with the intricacies of state laws governing civil commitment, and detailed awareness of community resources.

Home-based counselors. Professional counselors work in other settings that increase the likelihood that they will encounter clients who are experiencing acute distress. Intensive in-home clinicians, for example, routinely meet with clients in their home environment. Home-based counseling programs serve families with children at risk for placement in foster homes, residential treatment centers, or the juvenile justice system. Services provided by professionals in the home include individual and family counseling, 24-hour emergency response, parent training and education, and care coordination with schools and other community agencies. Families are typically referred for intensive in-home services when a child is demonstrating such behaviors as aggression, truancy, and self-injury. These behaviors increase the risk of out-of-home

المنارة للاستشارات
www.manaraa.com

placement. Consequently, most home-based counseling programs have the primary goal of preventing such placements.

From a family systems perspective, the behavior of the child is seen as an expression of the struggles that the family is experiencing (Berg, 1994). When counselors work with families in the home, they typically encounter multigenerational family struggles, stressors that may overwhelm them including family violence, substance abuse, poverty, and social injustice; moreover, the home environment may not be a safe place for counseling.

Other crisis settings. Professional counselors also work in other "crisis with a capital C" environments, such as psychiatric hospitals and forensic psychiatric centers where clients are actively suicidal, homicidal, psychotic, and aggressive. In these settings, crisis intervention is the counselor's modus operandi. Finally, counselors may be in positions within jails and prisons, where the rate of suicide far exceeds the national average. Between 2000 and 2002, suicide was the cause of death for 32.3% of adults jailed in the United States (Center for Substance Abuse Treatment, 2009b).

In conclusion, crises are ubiquitous. Whatever the cause of a crisis—precipitating event, condition, or disorder—there is an extensive need for counseling services and practitioners skilled in crisis response.

Impact on the Counselor

The focus in the crisis literature has been on the client. More recently, investigators are studying the impact of crisis counseling on the mental health practitioner. Counselors working with clients in crisis manage a multitude of stressors, including complex clinical issues, exposure to extreme suffering, long work hours, large

المنارة للاستشارات
www.manaraa.com

caseloads, high stakes situations, and minimal support. These factors, in combination with fantasies of rescuing the client in crisis, can become the perfect storm that leaves counselors feeling overwhelmed and exhausted.

Responding to crisis situations puts counselors at risk for difficult counter-transference reactions, compassion fatigue, and vicarious traumatization (Berthold, 2011; Figley, 2002; Wilson & Lindy, 1994). Wilson and Lindy (1994) provided a detailed description of the transference and counter-transference reactions that frequently arise in the treatment of trauma. People with trauma histories may react to the counselor in ways that reflect difficult past experiences that have not been fully resolved. In other words, they may act as if the counselor is a perpetrator, collaborator, fellow survivor, or rescuer. When this dynamic happens, it can evoke powerful emotions in the counselor – fear, anger, hurt, or self-loathing. As a result, counselors may become drawn into the trauma narrative and alternate between trying to save the "victim" and avoid trauma issues in the therapy.

Counter-transference reactions. Powerful and unresolved counter-transference reactions can induce empathic strain in counselors (Wilson & Lindy, 1994; Wilson & Thomas, 2004). Empathy, the capacity to understand and validate the experience of another person, is widely recognized as a core condition for a successful therapeutic relationship. Presbury, Echterling, and McKee (2008) described a triad of behaviors that enable the counselor to maintain the emphatic stance, which include listening, understanding, and validating. They coined the term "LUV triangle" to capture the essence of empathic engagement and emphasized that the primary task of the counselor is to sustain empathy by attending to and acknowledging the client's story. Some

المنارة للاستشارات
www.manaraa.com

researchers now have documented that mirror neurons are involved in the experience of empathy (Preston & deWaal, 2002; Ramachandran, 2005). Based on these findings, exposure to the experiences of others, either through direct observation or by listening to first-hand accounts, stimulates similar brain activity in the observer. Ramachandran (2009) stated that not only do these mirror neurons stimulate other people's behavior, but they may be the neural basis of introspection and self-other awareness.

Although empathic engagement is the foundation of successful counseling, the counselor's capacity to maintain this emphatic stance may be diminished when the client is in the midst of a crisis or mental health emergency. Ironically, counselors with the greatest capacity for empathy are at the highest risk of developing compassion fatigue (Figley, 1995). Counter-transference reactions—attempts to rescue the client or withdraw—can sabotage well-honed clinical skills. Wilson and Lindy (1994) provided a detailed explanation of the common counter-transference reactions that counselors have when working with trauma survivors. They described two types of empathic strain: objective, predictable cognitive and affective reactions to the client's narrative; and subjective reactions precipitated by the counselor's own conflicts and unresolved issues. Empathic strain, both objective and subjective, interferes with the counselor's ability to stay present and engaged.

Counter-transference reactions may be particularly intense in counselors who have not resolved their own trauma experiences or who lack training and experience in trauma counseling. Wilson and Lindy (1994) identified two types of counter-transference reactions—avoidance and over-identification, and four distinct ways modes of empathic strain—withdrawal, repression, enmeshment, and disequilibrium.

المنارة للاستشارات
www.manaraa.com

Not all counter-transference reactions are problematic; in fact, the counselor's response is a wellspring of information about the client and the quality of the therapeutic relationship. Furthermore, counselors and clients may experience empathic growth, an enhanced ability to understand and connect (Wilson, Lindy, & Raphael, B., 1994). According to Berthold (2011), it is imperative that counselors identify and address their counter-transference reactions. The thoughts, feelings, and behaviors evoked in the counselor during times of client crisis can be catalysts that move the healing process forward or precipitants of emotional reactivity, sleep disturbances, and somatic complaints.

Professional quality of life. Professional quality of life is defined as "the quality one feels in relation to their work as helper" (Stamm, 2010, p. 8); it is influenced by both the positive and negative aspects of doing one's job. As Stamm pointed out, people from diverse professional backgrounds respond to individual, community, national and international crises. Helpers include paid employees, such as health care workers, police officers, fire fighters, clergy, disaster site clean-up crews; and volunteers, including Red Cross disaster responders and Green Cross volunteers. The impact of crisis response will vary considerably given the personal characteristics, cultural differences, and trauma history of the individuals on the scene. Professional quality of life integrates two aspects of the helping process: compassion satisfaction (positive) and compassion fatigue (negative). Compassion satisfaction is defined as the pleasure and enjoyment people feel when they perform their job well (Stamm, 2010). Counselors who experience compassion satisfaction feel happy and energized by their work; they are confident and motivated to help people tackle life's challenges.

المنارة للاستشارات
www.manaraa.com

Negative effects of crisis work. Extensive research has been conducted to explore the negative impact of crisis response on the helper. Various terms appear throughout the literature: compassion fatigue, secondary traumatic stress, vicarious trauma, and vicarious traumatization. Stamm (2010) noted that the terminology is a "taxonomical conundrum," and, in reality, there is no delineation between them (p. 9). Figley (1995) described compassion fatigue as the confluence of traumatic stress, secondary traumatic stress, and cumulative stress in the lives of helping professionals and other care providers. He called this phenomenon the "cost of caring" and said that no one is immune to its effects.

Burnout. Maslach (1982) provided the most widely used definition of burnout, "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do people-work of some kind …" (p. 3). Burnout is caused by the long-term involvement in emotionally demanding situations (Pines & Aronson, 1988). Burnout develops gradually and is exacerbated by ongoing, intensive contact with clients and an unsupportive work environment.

Five types of symptoms associated with burnout are described by Kahill (1988): physical (exhaustion, sleep disturbances, somatic complaints, emotional (depression, anxiety, guilt), behavioral (aggression, defensiveness, substance abuse), work-related (diminished performance, tardiness, absenteeism), and interpersonal (withdrawal, impaired ability to communicate). Counselors experiencing these symptoms may find it difficult to maintain rapport with clients, and may "go through the motions" of counseling with little affect or interest.

المنارة للاستشارات
www.manaraa.com

Compassion Fatigue. Figley (1983; 1995) viewed compassion fatigue as a combination of burnout and secondary traumatic stress. When helping professionals are exposed to the pain and suffering of others (vicarious or secondary trauma), they run the risk of developing symptoms similar to the people they help. Symptoms of compassion fatigue include depression, diminished confidence, social withdrawal, and substance abuse. Additionally, counselors exposed to secondary trauma may develop symptoms identical to posttraumatic stress disorder – nightmares, intrusive images and thoughts, and heightened arousal (Pearlman & Mac Ian, 1995; Stamm, 2010).

Vicarious Traumatization. McCann and Pearlman (1992) used the term "vicarious traumatization" to describe the impact of empathic engagement with the client's trauma material on the counselor. Vicarious traumatization, a cognitive phenomenon, is a normal response to trauma material that can result in decreased motivation, efficacy, and empathy. The cumulative effect of secondary trauma exposure transforms the counselor's inner experience and disrupts the counselor's self-experience in five primary areas: frame of reference (diminished counselor empathy), self-capacities (loss of identity and difficulty managing negative emotions), ego resources (demoralization and burnout), and psychological needs and cognitive schemas (diminished capacity for trust and intimacy). The effects of vicarious trauma are pervasive, cumulative, and potentially permanent (Trippany, White-Kress, & Wilcoxen, 2004; Saakvitne & Pearlman, 1996).

Counselors, because of their capacity for empathy, are especially vulnerable to the deleterious effects of bearing witness to the pain of others. Factors that increase the counselor's susceptibility to vicarious traumatization include personal history of trauma,

المنارة للاستشارات
www.manaraa.com

prolonged trauma exposure, professional isolation, long work hours, a non-supportive work environment, and absent or unsupportive supervision (Pearlman & Saakvitne, 1996).

Positive Outcomes. In spite of these negative consequences and risks, counselors can experience outcomes from crisis counseling that keep them energized and excited about their work. Stamm (2010) coined the term "compassion satisfaction" to capture the positive aspects of helping: altruism, confidence, and happy thoughts about work. Compassion satisfaction reduces the risk of compassion fatigue. Counselors are changed in positive and powerful ways from their work with clients in crisis. In the midst of a mental health emergency—when emotions are intense and the danger is palpable—counselors can intervene effectively, and emerge feeling stronger and more fully alive.

Vicarious resilience and posttraumatic growth. There is a growing literature about the power of witnessing how clients cope with adversity. Hernández, Gangsei, and Engstrom (2007) proposed the concept "vicarious resilience" to highlight the process whereby therapists are empowered by stories about their clients' resilience. Resilience is commonly defined as the ability to bounce back and flourish under fire; it reflects the belief that people are inherently strong and face their challenges with courage and optimism (Echterling & Stewart, 2008).Wolin and Wolin (1993) identified seven resiliencies that emerge as survivors overcome adversity: insight, independence, relationships, initiative, creativity, humor, and morality. Echterling, Presbury, and McKee (2005) described a resolution process, highlighting four pathways to resilience—social support, making meaning, managing emotions, and successful coping.

المنارة للاستشارات
www.manaraa.com

Tedeschi, Park, and Calhoun (1995) described positive changes and personal growth people can experience as a result of encountering crisis. They proposed the term "posttraumatic growth" (PTG) to describe these possible benefits, which include feeling more confident, becoming more self-disclosing, deepening the connection with others, being more willing to accept help, and strengthening religious or spiritual beliefs. Echterling, Presbury, and McKee (2005) talked about the possibility of thriving, achieving a higher level of personal well-being after a devastating event. They identified the "rainbow" of positive emotions that people experience in the process of resolving a crisis including courage, hope, inspiration, and joy. O'Hanlon (1999) coined the term "posttraumatic success" and described three sources of resilience rooted in spirituality: connection, compassion, and contribution.

Vicarious resilience is a specific resilience process that occurs when helping professionals counselors bear witness to the strength and resolve of people overcoming hardship and suffering. The term emerged from a study of psychotherapists working with survivors of kidnapping and torture in Bogota, Columbia (Hernández, Gangsei, & Engstrom, 2007). The participants in the study described the ways that clients' resilience changed their own attitudes and emotions and enhanced their psychotherapy practice. Specifically, it increased their ability to reframe negative events (put them in perspective), enhanced their coping skills, and reinforced the important role of spirituality in the healing process. These findings were replicated in subsequent studies (Engstrom, Hernández, & Gangsei, 2008; Hernández, Engstrom, & Gangsei, 2010). Crisis events need not be debilitating; they are full of new possibilities for the survivor and everyone

المنارة للاستشارات
www.manaraa.com

who witnesses their journey—connection to others, heightened appreciation for life, and enhanced spirituality.

Previous sections of this chapter provided a conceptual framework for understanding crisis, prevalence data relative to crisis situations, and a synopsis of the literature relative to the impact of crisis work on the helper. The following section reviews widely accepted models of crisis intervention. This information is critical for understanding the urgent need for a model of crisis supervision. In general, counselors must develop specific knowledge, attitudes, and skills to intervene effectively in times of crisis.

Crisis Intervention

In the past fifty years, a number of crisis intervention models have been proposed (Cavaiola & Colford, 2006; Slaikeu, 1990; Roberts, 1995). The majority of models are based on the main features of crisis theory espoused by Caplan (1964). As noted earlier, Caplan emphasized the emotional upset and disequilibrium which characterizes crisis, as well as the accompanying breakdown in problem-solving and coping abilities. Two underlying assumptions, previously discussed, appear to be at the heart of contemporary crisis intervention. First, crises have identifiable beginnings and precipitating events. Second, the crisis is a time-limited phenomenon. Furthermore, there seems to be almost unanimous agreement among crisis theorists that crisis intervention protocols should be "crisis specific" whereby standardized procedures are applied to similar events.

Roberts (1995) identified two phases of crisis response: initial phase (immediate response to defuse the event), and crisis counseling (time-limited intervention to promote resolution). He proposed a seven-stage model of crisis intervention which he applied to

المنارة للاستشارات
www.manaraa.com

events such as school violence, stalking, and divorce. Cavaiola and Colford (2006) viewed crisis intervention as a short-term encounter aimed at restoring "victims in crisis" to a state of equilibrium. They outlined the LAPC model of intervention (listen, assess, plan, and commit), highlighting simple techniques to use in situations involving intimate partner violence, child abuse, bereavement, and other crisis situations. Both of these intervention models are useful in the sense that they define concrete steps for managing a crisis (conducting a lethality assessment, for example); however, they reinforce the idea that crisis is an external event that can be successfully managed by objective helpers. They suggest that there is a way to "do crisis intervention" and at times their approaches appear overly simplistic and reductionist.

Echterling, Presbury, and McKee (2005) offered a broader perspective for understanding crisis intervention, emphasizing that it is a way to be with survivors—not merely not a technique to use. Their relationally-based approach celebrates the crisis survivor in everyone. Crisis intervention tools and strategies are abundant in their book, embedded within a conceptual framework that emphasizes resilience, and post-traumatic growth. Counselors are encouraged to see themselves not as crisis managers, but rather as survivors' assistants, co-facilitating the natural process of resolution. Echterling and Stewart (2008) expanded this framework—integrating elements drawn from the attachment literature, family systems theory, and the field of play therapy—to develop a model of creative crisis intervention. They described creative techniques for engaging children and families in experiences that promote crisis resolution. Speaking to practitioners in the field of crisis intervention, Echterling and Stewart offered that no

المنارة للاستشارات
www.manaraa.com

matter what form of creative expression is used (play, dancing, drawing, or making music), “The most important tool is you” (p. 202).

Counselor educators have stressed the need to develop a conceptual framework for preparing professional counselors to respond to client crisis. MacAdams and Keener (2008) asserted that counselors are ill equipped to deal with client violence and suicide—two situations that they will undoubtedly encounter. They proposed the Preparation, Action, Recovery (PAR) model for responding to client crisis. The PAR approach is based on the premise that mental health crises progress through a series of phases: onset, occurrence, and aftermath. MacAdams and Keener identified “mandatory counselor responsibilities for pre-crisis preparation, in-crisis action, and postcrisis recovery” (p. 390).

From a review of the literature on crisis intervention, two conclusions become clear. First, most intervention models are protocol driven. The primary focus of crisis response is seen as taking action rather than “being with” survivors. Few scholars emphasize the relational aspects of the work. Second, there is virtually no discussion in the crisis intervention literature about the supervision experiences or needs of counselors working with clients in crisis. This point will be explored in detail in the following two sections of Chapter II.

Counselor Supervision

Supervision, one of the most common activities in which counselors engage for their professional development, is the crucible in which counselors acquire knowledge and skills for the profession (CSAT, 2009). There is a consensus in the field that practice alone is insufficient for achieving proficiency as a counselor; it must be accompanied by

المنارة للاستشارات
www.manaraa.com

systematic feedback and guided reflection in the context of an ongoing supervisory relationship. Bernard and Goodyear (2009) described supervision as a distinct intervention with theories, competencies, and techniques unique to it. They provided the most frequently cited definition of supervision that appears in the counseling literature and is taught in counselor education programs:

> Supervision is an intervention provided by a senior member of a profession to a more junior member or members of the same profession. This relationship is evaluative and hierarchical, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitoring the quality of services offered to the clients that he, she, or they see; and serving as a gatekeeper to those who are to enter the particular profession. (p.7)

A panel of experts from the Center for Substance Abuse Treatment (CSAT) described best practice guidelines and central principles for counselor supervision in community settings. According to them, supervision is an essential component in all treatment programs; every counselor, regardless of level of skill and experience, has the right to supervision; clinical supervision requires balancing administrative and clinical supervision; and direct observation is the most effective way of monitoring counselor performance (CSAT, 2009). Furthermore, the consensus panel expanded the definition of supervision and said that "effective supervisors … build teams, create cohesion, resolve conflict, and shape agency culture, while attending to ethical and diversity issues in all aspects of the process. Such supervision is key to … implementation of … evidence-based practices" (CSAT, 2007, p. 3). Powell (1993) defined supervision as "a disciplined

المنارة للاستشارات
www.manaraa.com

tutorial process wherein principles are transformed to practical skills, with four overlapping foci: administrative, evaluative, supportive, and clinical" (p. 9).

Taken together, these views provide evidence of five facets of contemporary supervision practice. First, supervisors in field-based settings must balance multiple and competing roles. They work to foster the supervisee's professional development, ensure client welfare, advance the agency's mission and goals, and build culturally competent, and cohesive treatment teams. Second, as a result of the competing demands and pressures they face, supervisors working in the field are frequently in untenable positions. They must juggle administrative demands while attending to the needs of supervisees for support and direction. Third, supervision in real world settings looks very different from the supervision provided to students in university-based clinics where the primary focus is on education and training. Fourth, when supervisees emerge from counseling programs, they may be ill-prepared for the changes in the supervision environment that they encounter.

Furthermore, it is important to recognize that the literature does not adequately represent the supervision of experienced practitioners working in the field. University-employed authors have written the bulk of the supervision literature, focusing on students as research participants. Over a twenty-five year period, only 4% of the authors of articles appearing in *Counselor Education and Supervision*, the flagship journal of the Association for Counselor Educators and Supervisors, were from non-academic settings. By far, the most frequent participants during the same period were counseling students; only 10% were counselors in the field, and 3% were counseling supervisors (Crockett, Byrd, Erford, & Hayes, 2010). This point will be addressed in greater detail as a major

المنارة للاستشارات
www.manaraa.com

gap in the literature.

Supervision models. Invariably, discussions about supervision include detailed descriptions of the more commonly accepted models for conceptualizing this process. Models are organized in a variety of ways. Bernard and Goodyear (2009) highlighted three broad categories of supervision models: psychotherapy-based models (psychodynamic, person-centered, cognitive-behavioral, systemic, constructivist, and narrative) developmental approaches (stage, process, and life-span models), and social role models. Additional categories have been proposed including competency-based and treatment-based models (CSAT, 2009), and integrated or blended models (Powell, 1993). A detailed discussion of individual supervision models is beyond the scope of this literature review. However, a brief synopsis of several key points provides an important backdrop for the section that follows on crisis supervision.

Psychotherapy-based models. Psychodynamic models of supervision focus on the intrapersonal and interpersonal dynamics in the counselor's relationship with clients and supervisors. Major concepts embedded in this approach include transference, counter-transference, parallel process, and the working alliance (Bernard & Goodyear, 2009). The goal of supervision, from a psychodynamic perspective, is to increase the supervisee's awareness of how personal issues impact the course of therapy. As discussed previously, counselors working with clients experience a host of counter-transference reactions which can cause disequilibrium in the counselor and provoke defensive reactions to the client. In psychodynamic supervision, these reactions are seen as central to the counseling process.

Parallel process is a phenomenon in which "supervisees unconsciously present

المنارة للاستشارات
www.manaraa.com

themselves to their supervisors as their clients presented to them. The process reverses when the supervisee adopts attitudes and behaviors of the supervisor in relating to the client" (Friedlander, Siegel, & Brenock, 1989, p. 149). Parallel processes are bi-directional. Frawley-O'Dea and Sarnat (2001) described "symmetrical parallel processes" in which "both the treatment and the supervisory dyads play out similar relational constellations" (p. 182).

Parallel process is closely related to the construct of "isomorphism" that appears throughout the systemic supervision literature. Isomorphism involves the replication of similar patterns at all levels of a system. Cook (1997) described how dynamics of families in treatment can be replicated throughout the client-therapist-supervisor-agency-community system. Supervision is considered an isomorph of counseling (Bernard & Goodyear, 2009). Many of the same rules apply to both, including the importance of establishing rapport and setting clear and mutual goals.

The "recursive replication" that occurs between therapy and supervision (Liddle, Breunlin, Schwartz, & Constantine, 1984) is evident in the ways that supervisors conceptualize their work. According to Bernard and Goodyear (2009), it is inevitable that supervisors rely on their own particular models of therapy during supervision. Counselor educators tend to rely heavily on person-centered, solution-focused, constructivist, and narrative approaches to counseling. As a result, they are likely to approach supervision of practicum students and interns with empathy, warmth, and curiosity.

While the experience of being "prized" by the supervisor can facilitate growth in the trainee, it may be problematic for the emerging professional. First, it might set up the trainee to be disappointed and perplexed with supervision that follows graduation. Given

المنارة للاستشارات
www.manaraa.com

the multiple hats that agency supervisors wear, is unlikely that they will be provide the same amount and quality of supervision that the trainee received in school. Second, the developmental approach that suggests the need to be validated diminishes with experience. In times of crisis, for example, experienced counselors may feel conflicted—wanting structure and support in dealing with volatile situations on one hand, and feeling that they should not need it on the other. Counselors may worry that their need for help will be seen as a sign of personal weakness or professional incompetence.

Developmental models. Developmental approaches to supervision have become "the Zeitgeist of supervision thinking and research" (Holloway, 1987). These approaches view counselor/supervisor development as stage-specific evolutionary processes. Each stage of development is defined by specific personal attributes, professional skill level, and learning needs. A number of developmental models appear in the literature. Perhaps the most well known developmental model is the Integrated Developmental Model (IDM) formulated by Stoltenberg, McNeill, and Delworth (1998).

According to the Integrated Developmental Model, counselors move through four discrete levels of development, from beginner to master. Each stage is characterized by changes in three overriding structures: self-other awareness, motivation, and autonomy. Novice counselors are highly anxious, motivated, and dependent on the supervisor; they become more skilled, less apprehensive, and more independent with supervised experience. The IDM proscribes supervisory interventions based on two key assumptions. First, as supervisees gain experience, they need less structure and direction in supervision. Second, progression through the stages of counselor development signals an increase in counselor confidence and a diminished need for supervisory approval and

المنارة للاستشارات
www.manaraa.com

support.

It is important to note that the IDM, like most models of counselor development, was based on the experiences of counselors- in-training working at practicum and internship sites. There is no evidence to suggest that the IDM is a useful framework for understanding counselor development or supervision needs beyond graduation. Furthermore, developmental models do not take into account contextual variables that impact the supervisees need for structure and support. In the midst of a crisis for example, even counselors with years of clinical experience may need affirmation.

Social role models. Supervision models have also been characterized according to the role of the supervisor. The Discrimination Model (Bernard, 1997) is based on the premise that supervision should be tailored meet the particular needs of supervisees. This approach outlines three possible foci for supervision (intervention, conceptualization, and personalization skills) and three supervisor roles (teacher, counselor, and consultant). According to Bernard, effective supervisors assume all roles and address all foci with supervisees at all stages of development.

The Systems Approach to Supervision (SAS) is a model developed by Holloway (1995). It has a model seven components—five supervisor functions (roles), five tasks (foci), four contextual factors (supervisor, supervisee, client, and the counseling setting), and the supervisory relationship. The supervisory relationship is the core factor upon which the other components rested. Holloway described three elements in the relationship: the supervision contract, the phase of the relationship, and the structure of the relationship (levels of interpersonal power and involvement). Given the emphasis

المنارة للاستشارات
www.manaraa.com

placed on the relationship and contextual variables that impact supervision, the SAS model may have greater potential for application in field-based counseling practice. Although the Systems Approach to Supervision (SAS) incorporated contextual variables, including the setting in which counseling occurs, it did not address supervision during crisis/non-crisis events.

Hawkins and Shohet (2000) described the "good enough" supervisor, supportive and reassuring, who contains the affective responses the supervisee has. They depicted the "Seven-Eyed Model of Supervision" which highlighted seven possible areas that the supervisor can focus on. The model recognizes multiple systems in supervision—the therapy system, the supervisory system, and the environment within which both occur.

A number of scholars see the supervisory relationship as the key to good training Bernard & Goodyear, 2009; Borders & Brown, 2005). Holloway (1995) viewed the relationship as the container and anchor of supervision, while Rønnestad and Skovholt (1993) called it supervision's heart and soul. Borders (2005) said that it is essential for supervisors to create a challenging, safe, and trusting environment. Bordin (1983) proposed the working alliance model, characterized by supervisor-counselor bonding and mutual agreement on learning tasks and goals. Efstation, Patton, and Kardash (1990) developed the widely-utilized Working Alliance Inventory, which was based on Bordin's earlier work.

Attachment theory and supervision. More recently, scholars have focused on the relevance of attachment theory in counselor supervision (Stewart & Echterling, 2008). Bowlby (1977) stated, "Briefly put, attachment behavior is conceived as any form of behavior that results in a person attaining or retaining proximity to some other

المنارة للاستشارات
www.manaraa.com

differentiated and preferred individual, who is usually conceived as stronger and/or wiser" (p. 203). Pistole and Watkins (1995) applied attachment constructs to the supervisory process and stated that the primary goal of supervision is to facilitate counselor development. This process, conceptualized as a "developmental unfolding," is promoted by a secure supervisory base. The supervisor-supervisee relationship (secure base) holds the supervisee, promotes exploratory behavior, and facilitates counselor identity formation and consolidation. The secure base also provides a stimulating function—promoting a sense of wonder, awe, and curiosity about the counseling experience. Stewart and Echterling (2008) applied an attachment theory and research driven intervention called the Circle of Security (Marvin, Cooper Hoffman, & Powell, 2002) to the supervisor-supervisee relationship. In their view, the supervisor should be "bigger, stronger, wiser, and kind; whenever possible, follow the supervisee's need; whenever necessary, take charge" (p. 286).

Essential supervisory characteristics (availability, constancy, sensitivity, and flexibility) and supervisory behaviors (judicious intervention, consistency, appropriate structuring, and setting of goals) contribute to the formation of a secure base (Pistole & Fitch, 2008). Fitch, Pistole, and Gunn (2010) introduced the Attachment-Caregiving Model of Supervision (ACMS) to conceptualize the supervisory relationship. They described the model in this way:

> The supervisor guides learning through caregiving that complements the trainee's attachment bond. The process . . . cycles from the trainee's experience of threat/anxiety and attachment system activation, to the supervisory safe haven function, to deactivation of the trainee's attachment system, to activation of the

المنارة للاستشارات
www.manaraa.com

trainee's exploratory system, to the supervisory secure base function, and to the trainee's achieving exploratory system (e.g. learning) outcomes (p. 24).

According to the ACMS, the counselor's anxiety during supervision activates the attachment system. The anxiety may arise from counseling session stressors such as challenging clinical issues and intense emotions, or from the counselor's own feelings of inadequacy and vulnerability. When the attachment system is activated, the counselor seeks proximity to the supervisor. The supervisor provides the safe haven function by exhibiting sensitivity, flexibility, and accessibility; the attachment system is deactivated and the exploratory system is re-prioritized. The supervisor then shifts to providing a secure base that supports learning.

The ACMS may be relevant to the current study. As the model suggests, crisis situations, characterized by chaos and uncertainty, may activate the supervisee's attachment system. During these times, the supervisor's response is critical for enhancing counselor well-being and self-efficacy. While this is an intriguing idea, it remains largely theoretical at this time and is not supported in the literature. Furthermore, the model has several limitations. First, to be effective, supervisors must be able determine what constitutes effective response in providing both the safe haven and secure base functions. It may be difficult for supervisors to determine how much structure, support, and didactic feedback is required at different points in the supervision process. Second, pressures on the supervisor, such as time constraints, could result in attachment cues being dismissed or devalued. Finally, too much guidance can promote dependency on the supervisor (Fitch, Pistole, & Gunn, 2010).

In general, the supervision literature does not address the major concern of

المنارة للاستشارات
www.manaraa.com

the current investigation—supervision of professional counselors during times of client crisis. This issue will be explored in great detail in the next section on crisis supervision.

Crisis Supervision

Supervision of counselors who work with clients in crisis is of critical importance, but it has not been systemically investigated. A close inspection of the professional literature has uncovered remarkably few studies. In fact, a search for relevant journal articles, book chapters, and research investigations turned up very little nothing on this topic. Corey, Haynes, Moulton, and Muratori (2010) recently published a supervision textbook that included a chapter on managing crisis events.

They defined a crisis situation for a counselor as, "any unusual event involving the supervisee that might have an adverse impact on the supervisee's ability to function in the role for which he or she is being supervised" (p. 198). The authors identified crisis events that counselors commonly encounter—suicide, and suicide attempts, personal threats by clients, school violence, and witnessing disasters—and highlighted problem-solving supervision strategies.

Counselors who are overwhelmed by crisis events may react too quickly, assuming inordinate amounts of responsibility for managing the situation. In response, supervisors may overact by immediately telling the counselor what to do. While these reactions are common and understandable, neither leads to successful resolution of the crisis. The supervisor must encourage the counselor to problem solve independently and to act in accordance with ethical and legal guidelines. To be effective, crisis supervisors must possess a wealth of technical skills, strong theoretical understanding of counseling and crisis response, poise, creativity, flexibility, resiliency, and strong communication

المنارة للاستشارات
www.manaraa.com

skills. Corey, Haynes, Moulton, and Muratori (2010) presented a number of valuable insights about crisis supervision and provided specific tools that counselors and supervisors can use in the field.

However, their framework has several limitations. First, they define crisis as an unusual event that occurs, and suggest that the counselor's job is to manage the event. The inherent weaknesses in these arguments were discussed earlier. Suffice it to say, the idea that crisis is a singular event which can be managed successfully may not capture the essence of the experience. Second, crisis supervision strategies are seen as merely ways to approach problems that may arise in supervision, rather than important vehicles for promoting counselor resilience and enhancing relationships. Finally, the supervision strategies themselves rely heavily on the PAR (preparation, action, and recovery) approach developed by MacAdams and Keener (2008). The PAR model, endorsed more recently in the literature, does not adequately address complex and multifaceted supervisory dynamics.

Hipple and Beamish (2007) reviewed the supervision literature from the perspective of counselor educators working in university-based clinics. They described several common difficulties encountered in providing crisis supervision to counselors-in-training. Supervisors rarely have direct contact with crisis clients and obtain information from supervisee self-report and written case notes, which are notoriously inaccurate. Additionally, the traditional model for the supervision session is one scheduled hour per week following a counselor-client interaction. In a crisis situation, delayed supervision is neither appropriate nor ethical. They highlighted a number of critical ingredients for crisis response including formalized procedures and risk assessment protocols that are

المنارة للاستشارات
www.manaraa.com

similar to the strategies suggested by MacAdams & Keener (2008). They also offered concrete suggestions to supervisors for facilitating crisis supervision inside and outside of the office setting, including performance monitoring strategies (live supervision, three-way counseling sessions), backup supervision, and supervisory debriefing of the crisis event.

Dupré (2011) described a prototype of resilience-based crisis supervision. They emphasized the protective functions supervision serves when counselors work with clients in crisis—mitigating the risk of compassion fatigue and enhancing post-traumatic growth. Echterling, Presbury, and McKee, (2005) provided the scaffolding for this preliminary design. Dupré (2011b) used data collected from qualitative interviews to develop a theoretical and conceptual framework for a resilience-based crisis supervision model (RBCS). The model emphasizes immediacy, empathy, and the development of crisis counseling competencies. The conceptual framework "focuses on three critical tasks of the crisis supervisor: building and managing rapport in high stress situations; providing concise, direct, and immediate feedback; and promoting supervisee self-care" (p. 6). Dupré, Stewart, and Echterling (2011) expanded this model even further to include elements of attachment theory and play therapy.

To date, research projects on crisis supervision that illuminate the experiences of professional counselors do not appear in the literature. A comprehensive search of research databases uncovered three published research articles (two of which appeared more than twenty years ago), and two unpublished doctoral dissertations that provide potentially relevant information.

One study explored the impact of crisis supervision on volunteer crisis workers

المنارة للاستشارات
www.manaraa.com

and found that learning to be emphatic requires ongoing and immediate supervision (Doyle, Foreman, & Wales, 1977). Since timing of supervision has not been studied in a systemic way (Bernard & Goodyear, 2009), this finding is especially important.

A second investigation, which involved counselors-in-training, generated interesting data about preference for structure in supervision (Tracey, Ellickson, & Sherry, 1989). Results suggested that preference for structure may be moderated by the personality characteristics of trainees and the content of supervision—either crisis or non-crisis material. These are intriguing findings in light of widespread acceptance of developmental models of supervision such as the IDM (Stoltenberg, McNeil, & Delworth, 1998). As mentioned earlier, developmental models assume that as counselors gain more experience, the need and desire for structure in supervision decreases. However, a counselor's stage of development may be only factor that impacts preference for supervision that is more structured and directive.

More recently, researchers explored the impact of client suicide on therapists-in-training and implications for supervision (Knox, Burkard, Jackson, Schaack, & Hess, 2006). Participants offered advice to supervisors for effectively working with supervisees whose client commits suicide. Suggestions included providing a safe place for supervisees to process their emotions, self-disclose about personal experience with client suicide, and normalize reactions to suicide.

Of the two unpublished doctoral dissertations on crisis supervision, only one included professional counselors as research subjects. Cherry (2001) utilized quantitative methodology to identify sources of stress and burnout as well as the supervisory needs of emergency services clinicians in Massachusetts. He administered a battery of survey

المنارة للاستشارات
www.manaraa.com

instruments to 340 study participants and obtained a response rate of 36% (123 participants). Participants came from a variety of mental health professions, including psychology, social work, and psychiatric nursing. Of the emergency services clinicians participating in the study, twenty-eight were licensed mental health clinicians (LMHC). Aggregate results were reported for the participants as a whole, so it is impossible to know how professional counselors responded. Sixty-one percent of study participants reported that they received no clinical supervision. The supervisory needs most commonly cited were: skills training (help developing and refining crisis intervention skills), emotional consultation (opportunities to process emotions), respectful confrontation, and mutuality (the degree to the supervisor discloses self-doubts and positively reinforces the counselor's competency). Dissatisfaction with supervision was positively associated with the intensity of emotional exhaustion and depersonalization, and was negatively related to a sense of personal accomplishment.

The supervisory needs of emergency services clinicians may be related to sources of stress. Cherry (2001) found that stress related to client populations (children and families, patients with both psychological and medical needs, and geriatric patients) was positively correlated to the need for the supervisor to provide emotional consultation, while stress from self-doubt was positively correlated to mutuality. Although his sample size was reasonable, the results may not generalize to emergency service clinicians outside of Massachusetts or clinicians in other practice settings. Despite these limitations, the study provided information about crisis supervision and highlighted a troubling aspect of emergency services work—many clinicians working with clients in crisis receive no supervision.

المنارة للاستشارات
www.manaraa.com

Hoffman (2009) explored the process of supervision of counselor trainees working with suicidal clients from the perspective of five practicum supervisors at CACREP-accredited counseling programs. The objective of this study was to elicit the perspectives of the participants regarding several aspects of their job as supervisors—securing client safety, facilitating client growth, and promoting trainee maturation. The participants, directors of on-campus counseling clinics, held doctorates in counselor education and were licensed as professional counselors

Four key categories or themes emerged during data analysis: the role of the supervisor is complex and multi-layered, working with suicidal clients is a formative experience, client suicidal experience affects the supervisory relationship, and the process of supervision differs when a client is suicidal. Hoffman (2009) described ten subcategories in the data. Three categories are consistent with the Cherry (2001) findings: training considerations, supervisee needs after working with a suicidal client, and collaboration (mutuality). The results are also consistent with the Hipple and Beamish (2007) recommendation that supervisors and counselors work together to provide quality counseling during a crisis episode.

An unpublished qualitative semi-structured interview with a counselor trainee working at an acute inpatient hospital for children and adolescents was conducted by Dupré (2009). The purpose of the pilot interview was to highlight the crisis supervision experience of the counselor trainee working with youth at imminent risk of self-injury and aggression, laying the groundwork for crisis supervision research. The supervisee identified six key elements that contributed to the success of the supervision: accessibility of the supervisor, immediate and constant feedback, non-directive approach, permission

المنارة للاستشارات
www.manaraa.com

to express emotion, and an atmosphere of acceptance. She described lessons learned from the supervision received: clients and counselors are resilient, teamwork is essential, and assumptions about clients in crisis can impede the recovery process. Her comments echo the opinions and experiences of the participants in the studies by Cherry (2001) and Hoffman (2009), reinforcing the idea that effective crisis supervision integrates specific attitudes and practices that promote resilience in both clients and counselors.

Dupré (2011) conducted an unpublished pilot study to determine the effectiveness of utilizing a qualitative interviewing process and focus group to understand the experience of counselors receiving crisis supervision. The study utilized a standardized open-ended interview format. A number of common themes emerged in the pilot study as a whole: the volatility of the crisis situation, the intensity of emotion (expressed by clients and counselors), common problematic counselor responses (such as over identification with the client), and qualities of effective crisis supervisors (available, non-authoritarian). The data suggested that a parallel process occurs in crisis counseling and crisis supervision. In the midst of the crisis, the counselors in the pilot study felt an urge to rescue the client. In turn, the supervisors conveyed a wish to rescue them by taking a highly proscriptive approach. The pilot study participants expressed a collective understanding that neither strategy is helpful in managing crisis events.

Overall, the research to date on crisis supervision has raised a number of fascinating questions that remain unanswered. The proposed study will illuminate the supervision needs and experiences of counselors working with clients in the midst of a crisis or mental health emergency. It will advance our understanding of supervisory attitudes and practices that may promote resilience and self-efficacy in counselors

المنارة للاستشارات
www.manaraa.com

responding to client crisis.

Chapter Summary

Chapter II reviewed the relevant literature and established the context for the current study. It began with background information about licensed professional counselors and trends in counseling relative to crisis intervention. Building upon this framework, the chapter synthesized literature across a number of related topics—crisis counseling, counselor supervision, and crisis supervision. It is clear from this review that there is a significant gap in the literature relative to crisis supervision. Furthermore, professional counselors are frequently ignored in supervision research.

The present study utilized a basic qualitative design to give voice to professional counselors working with clients when the stakes are high. Chapter III provides an introduction to qualitative inquiry and outlines the procedures used for participant selection, data collection, ensuring trustworthiness, and data analysis.

المنارة للاستشارات
www.manaraa.com

CHAPTER III

Methodology

Introduction

In the previous chapter, the literature review led to several major conclusions. First, counselors routinely work with clients in crisis. They are confronted with situations that are highly complex, volatile, and disturbing. Crises may occur during the initial contact with a client or during a routine counseling session. They may be infrequent, or in some cases, woven into the fabric of a typical workday. Whenever they are encountered, crises pose a number of challenges for even the most seasoned clinician. No matter what the crisis involves—attempted suicide, threats of violence, disturbing psychological states—counselors face a myriad of ethical, legal, and personal dilemmas which may overwhelm and destabilize them. Counselors do not just witness crisis events; they are drawn into an unfolding process of change that has the potential for negative and positive outcomes for everyone involved.

A second conclusion is that crisis supervision can help counselors to safely manage a hazardous situation, resolve the crisis positively, solidify their professional identity, and enhance their resilience and optimism. Despite the critical importance of crisis supervision, it is frequently not provided and has not been adequately addressed in the literature. Additionally, there are no clear guidelines about supervisory responsibilities or protocols during mental health emergencies in the professional counseling practice standards.

Finally, traditional models of supervision do not adequately address the specific supervision needs of counselors working with clients in crisis. The practice of providing

المنارة للاستشارات
www.manaraa.com

one hour of regularly scheduled weekly supervision, conducted at a leisurely pace following a client and counselor interaction is not appropriate or sufficient during crisis events. Virtually all of the supervision literature is written from that perspective (Hipple & Beamish, 2007). Also, it focuses almost exclusively on the experience of counselor educators and graduate students in university-based clinics. The voices of professional counselors are not easily found in the literature. The only recent research projects on crisis supervision that involved licensed clinicians are two unpublished doctoral dissertations. One of these studies solicited the views of supervisors, not counselors, at five CACREP accredited training sites. The second utilized quantitative methodology to examine the supervision needs and experiences of emergency services clinicians across a range of disciplines (social work, nursing, and psychology). Although licensed mental health clinicians were included in the sample, results were reported for the sample as a whole. The investigator did not focus on the views of professional counselors (Cherry, 2001).

The absence of a conceptual framework for crisis supervision, grounded in field-based counseling practice, is unsound and places counselors, supervisors, and clients in jeopardy. The current enquiry was designed to explore and conceptualize crisis supervision through the accounts of professional counselors working in a variety of settings. Since little is known about crisis supervision, qualitative inquiry was the best-suited approach for understanding this phenomenon.

Purpose of the Study

The primary purpose of this qualitative study was to highlight the supervision needs and experiences of professional counselors working with clients in crisis. The

المنارة للاستشارات
www.manaraa.com

investigation relied on intensive interviewing techniques to elucidate the counselor's experience of supervision when the stakes were high. There were two secondary goals of the research project: to understand how counselors define and experience "crisis" in the context of counseling, and to illuminate counselors' supervision experience in real world practice settings. Results from the investigation have important implications for counselor supervision.

Research Question

The primary question guiding the inquiry was: *What are the supervision needs and experiences of licensed professional counselors when working with clients in the midst of a crisis or mental health emergency?*

Qualitative Inquiry

The current investigation utilized a basic qualitative research design (Merriam, 2009). Recently, there has been a significant increase in the number of published studies that use qualitative methodologies. Between 2005 and 2009, 34% of the research articles that appeared in Counselor Education and Supervision were qualitative (Crockett, Byrd, & Hayes, 2010). "Qualitative research has become a powerful research methodology used to answer important 'how' questions, build theory, and apply inductive models to scientific inquiry" (Erford, Miller, Schein, McDonald, Ludwig, & Leishear, 2011, p. 79).

There are several important variables to consider when choosing a research design—the question guiding the inquiry, the information required to answer the question, and the best strategy for gathering sufficient data (Merriam, 2009). The purpose of the present study was to capture the lived supervision experience of professional counselors in the midst of client crisis. My ultimate research goal was to provide a rich,

المنارة للاستشارات
www.manaraa.com

thick description of this phenomenon from the perspective of the study participants. In order to capture and give voice to this experience, an interpretive, naturalistic approach was required.

I chose a qualitative design to understand and articulate the experience of crisis supervision from the counselor's frame of reference. This approach enabled me to explore the phenomenon under investigation in context, as suggested by Richards (2005). As mentioned previously, no current published research has examined crisis supervision specifically from the counselor's perspective. Qualitative research is recommended when partial or inadequate theories exist (Creswell, 2007).

Merriam (2009) described the characteristics of qualitative research: "The overall purposes of qualitative research are to achieve an *understanding* of how people make sense out of their lives, delineate the process (rather than the outcome or product) of meaning-making, and describe how people interpret what they experience" (p. 14). The primary objective is to understand the insider's or "emic" position. In qualitative research, the researcher is the vehicle for data collection and analysis. As such, she may have a number of advantages in the research endeavor, including the ability to respond immediately to participant input.

The qualitative approach to scientific inquiry reflects the philosophy of constructivism and assumes that, as people reflect on their experiences, they construct the realities in which they participate. There is no single observable reality, but rather a myriad of understandings about reality based on individual experiences and ideas. Proponents of the constructivist position assert that it is impossible to know a person's reality by taking an objective stance. Charmaz (2006) stated, "Constructivist inquiry

المنارة للاستشارات
www.manaraa.com

starts with the experience and asks how members construct it. To the best of their ability, constructivists enter the phenomenon, gain multiple views of it, and locate it in its web of connections and constraints" (p. 187). The interpretation of the studied phenomenon is itself constructed.

Basic qualitative studies look at recurring patterns in the data to understand how people make sense of their lives. Qualitative data is conveyed through words, obtained in interviews, recorded in observations, or extracted from documents. When we are curious about events in the past or how people interpret their world, interviewing is the best technique to use (Merriam, 2009). Patton (2002) explained the main purpose of an interview:

> We interview people to find out from them those things we cannot directly observe…. We cannot observe feelings, thoughts, and intentions. We cannot observe behaviors that took place at some previous point in time…. We cannot observe how people have organized the world and the meanings they attach to what goes on in the world. We have to ask people questions about those things. (pp. 340-341)

Since qualitative methods are typically chosen when it is unclear what specific information is required, person-to-person interviews may be the ideal strategy for gathering data about lived experience. They allow the investigator to obtain certain kinds of information—for example, subjective reactions to supervisors—and provide flexibility during the research process. The interview format can be designed to maximize the flow of ideas, providing opportunities to follow-up on key points as they emerge. For these

المنارة للاستشارات
www.manaraa.com

reasons, qualitative interviewing was the most appropriate methodological approach for the current investigation.

Procedures

Purposive sampling. Purposive, or purposeful, sampling is a technique for identifying study participants who have experienced the phenomenon under investigation (Berg, 2001; Patton, 2002). Participants are selected because they can "provide substantial contributions to filling out the structure and character of the experience" (Polkinghorne, 2005).

In this study, it was critical that the participants were professional counselors working with clients in crisis. A key assumption, gleaned from the literature and my extensive counseling experience, was that every counselor encounters crisis during routine counseling practice. Sampling techniques were chosen to identify "information-rich cases" (Merriam, 2009; Patton, 2002). Specific inclusion criteria were determined to identify and select counselors to participate in the research who could contribute to the researcher's understanding of counselor supervision. I followed the recommendations of LeCompte and Preissle (1993) to create a list of essential participant attributes that reflect the purpose of the study.

The inclusion criteria were:

1. Hold a current and active license to practice as a Licensed Professional Counselor in Virginia;
2. Be employed full-time as a professional counselor (in a variety of settings including outpatient, inpatient, and residential programs, court and/or jail-based services, schools, colleges and/or universities, private practice settings, hospitals);

المنارة للاستشارات
www.manaraa.com

3. Spend at least 50% of work hours providing direct counseling services to clients;
4. Desire and ability to participate in two qualitative in-person interviews scheduled one to three months apart.

I selected these criteria for several reasons. First, as explained earlier, my overall intent in the current study was to give voice to the supervision experience of professional counselors. There is great variation in the type of training received and credentials earned within the counseling profession. Therefore, to ensure homogeneity in the sample, prospective participants had to be professional counselors licensed by the same regulatory body—the Virginia Board of Counseling. Second, as discussed in the previous chapter, professional counselors work in a variety of settings. The inclusion criteria were developed to capture varying instances of crisis supervision. Third, I was interested in understanding the phenomenon from a counselor's vantage point. In addition to their work with clients, clinicians in the field may have administrative and supervisory responsibilities. If their job is more heavily weighted with these duties, however, it may be more difficult for them to identify as "counselors in supervision." Hence, I established standards to ensure that study participants worked full-time and spent at least half of the time at work providing direct face-to-face counseling services. Finally, specific criteria were chosen to address limitations inherent in convenience sampling, a strategy employed in this study.

Convenience sampling is a common approach for participant selection in qualitative research. The sample is selected based on some dimension of convenience for the researcher, such as visibility, location, or availability. Participant selection based solely on convenience sampling may not be credible and may not produce information-

المنارة للاستشارات
www.manaraa.com

rich cases (Merriam, 2009). The danger in utilizing convenience sampling to identify participants is that the sample selected may not represent the population of interest (Mitchell & Jolley, 1988). Therefore, I used homogenous sampling of individuals within the subgroup of licensed professional counselors in Virginia to ensure the collection of relevant data. I also developed a demographic questionnaire (See Appendix A) to verify that potential participants met the inclusion criteria.

In qualitative inquiry, the investigator is encouraged to include an adequate number of participants to answer the research question. The literature does not provide clear guidance about sample size. Participants are selected until the point of saturation is reached, when no new information is forthcoming (Lincoln & Guba, 1985). In many cases, the size of samples in qualitative research is selected arbitrarily (Onwuegbuzie & Leech, 2007). A number of scholars provided sample size guidelines for qualitative interviewing that ranged from six to twenty participants (Creswell, 2002; Kuzel, 1992; Morse, 1994). For the present study, I approximated that between ten and twenty-five participants would be sufficient. This projection was based on three primary considerations—guidelines in the literature, flexibility of the research design, and the fact that this was my first qualitative research study. Understanding that interviews would continue until data saturation was attained, I selected a sample size that would ensure adequate data collection.

Participant selection. I obtained approval for this study from the James Madison University Institutional Review Board (See Appendix B).[1] To recruit participants, I sent an announcement via e-mail to 107 licensed professional counselors and to department heads at counselor education programs in Virginia (See Appendix C). I asked e-mail

[1] A request to change the protocol title was approved by the Institutional Review Board.

المنارة للاستشارات
www.manaraa.com

recipients to forward the message to colleagues and graduate program alumni who might be interested in participating. As an incentive, I offered a free two-hour ethics training, contingent upon completion of the study. Forty-two licensed professional counselors responded to the announcement. I sent a follow-up e-mail to these counselors, reiterating the inclusion criteria. The demographic information form and two versions of the informed consent form were attached to the e-mail (See Appendix D and Appendix E). Thirteen licensed professional counselors met the inclusion criteria and agreed to be interviewed.

The study protocol included two rounds of qualitative interviews lasting approximately sixty minutes each. The decision to conduct two rounds of interviews was based on three considerations. First, as Onwuegbuzie and Leech (2007) pointed out, words that are spoken in interviews are sample units of data that represent the total number of words from that individual. To capture the voice of participants, a sufficient number of words must be collected. Although many qualitative inquirers typically conduct only one interview (sixty minutes or less), there is no evidence in the literature that this is sufficient for understanding the phenomenon of interest. Second, as previously mentioned, I am a doctoral candidate without prior experience conducting qualitative research. Third, the topic of interest—crisis supervision—has not been investigated in a systematic way. For these reasons, I theorized that two rounds of interviews would be needed to generate enough data to reach saturation. Furthermore, this strategy is consistent with the objectives of prolonged engagement and persistent observations (Lincoln & Guba, 1985; Onwuegbuzie & Leech, 2007).

المنارة للاستشارات
www.manaraa.com

I scheduled the first interview upon receipt of the completed demographic data form. Participant selection, and scheduling/completion of interviews occurred on a continuous basis. Five participants returned the informed consent document via e-mail prior to the first interview, while eight participants brought the completed form with them. All participants received a copy of the signed consent form before the first interview commenced.

Participant characteristics. All participants met the inclusion criteria outlined previously. They possessed an active license to practice as a professional counselor in Virginia, worked full-time in a counseling role, and spent at least half of their work time counseling clients (face-to-face encounters). To protect anonymity and confidentiality, individual characteristics of each participant are not described in detail. Rather, information about the sample as a whole is provided.

Participants ranged in age from 26 to 63 years, with a mean age of 48 and a median of 55 years. There were three males and ten females in the sample. Participants were asked to identify their racial/ethnic background. Eleven identified themselves as Caucasian, one as African American, and one as Caucasian and Native American. The year of initial licensure as a professional counselor in Virginia spanned from 1990 to 2011. Of the thirteen participants, three were licensed between 1990 and 1999, five between 2001 and 2008, and five between 2009 and 2011.

Participants worked full-time as professional counselors in a variety of settings as shown in Table 1. The participant who worked full-time in a private-for-profit counseling agency also worked part-time in a private practice setting.

المنارة للاستشارات
www.manaraa.com

Table 1 Frequency of Work Setting

Setting	No. Participants
Private practice	3
Community Services Board (Outpatient)	1
Community Services Board (Emergency Services)	2
Community Services Board (Outpatient/Emergency Services)	1
Public Alcohol and Drug Treatment Center	1
Vocational Rehabilitation Program	1
College Counseling Center	1
Correctional Center	1
Public High School	1
Private For-Profit Agency (Intensive in-home counseling)	1

Researcher qualifications and involvement. In qualitative research, it is assumed that the investigator can learn the most about a situation by participating or immersing oneself in it. According to Patton (2002) the participant observer can simultaneously witness events and experience what it is like to be a part of the setting. This stance is described as the insider's or emic position. From the outset, it is important for the researcher to position herself in relation to the study participants and to identify any past experiences, prejudices, or views that may impact the study or interpretation of

المنارة للاستشارات
www.manaraa.com

the findings (Creswell, 2007). Lincoln and Guba (1985) described the process of reflexivity—reflecting critically on the self as the primary data collection instrument—as a key element of the research design. It will be considered in greater detail when trustworthiness procedures are outlined.

In the present study, I conducted all of the participant interviews. I am a Caucasian female, fifty-six years of age, residing in Harrisonburg, Virginia. I am currently a Ph.D. candidate in Counseling and Supervision at James Madison University. I am licensed to practice as a professional counselor and substance abuse treatment practitioner in Virginia (Virginia Board of Counseling), and am also an Approved Clinical Supervisor (Center for Credentialing and Education). My interest in this topic stems from my work as a counselor, clinical supervisor, and adjunct graduate instructor in a CACREP-accredited counselor education program. I received my Master's degree in Counseling Psychology almost thirty years ago, and have worked in various settings since that time—outpatient clinics, a medium-security prison, county jail, women's centers, and college/university counseling clinics. I am currently a program director at an acute-care public psychiatric hospital for children and adolescents in Virginia, providing counseling services and clinical supervision to professional counselors, residents-in-counseling, practicum students and graduate interns in counseling, and doctoral students in psychology.

Throughout my career, I have worked in places that can be characterized as "crisis with a capital C" environments—situations that are unpredictable and volatile. In supervising counselors and counselor trainees, I became cognizant of the unique challenges and opportunities of crisis counseling and the critical importance of crisis

المنارة للاستشارات
www.manaraa.com

supervision. Furthermore, I became increasingly more aware of the limits of current knowledge in this area. My passion for supervision and desire to contribute to the literature provided the impetus for the study.

Data collection protocol. Two rounds of semi-structured interviews, approximately sixty minutes in length, were conducted. Thirteen licensed professional counselors were identified as participants during the selection process. All study participants completed both interviews. The time frames for the interviews were: Round I, October 11- November 2, 2011; Round II, November 11-December 2, 2011.

I gave participants the choice of meeting with me in person or conducting the interview via Skype—a video-conferencing option, stressing the importance of finding a location for the interviews that was confidential, safe and convenient for the counselors. Twelve participants asked to meet me in person. Of these twelve, eight asked me to come to their office. For the remaining four participants in this group, interviews were conducted at a neutral location in the community. One participant requested that the interview be conducted via Skype.

I used an electronic digital recorder to record all interviews. Following each interview, the audio file was transferred to my personal computer, which is password protected and in a secure location. Once the transfer was completed, the original recording was erased. To ensure safety of the data, the copy on the hard drive was routinely backed up on a password protected external hard drive.

I wrote process notes during each interview, using a form developed for this purpose. Within one hour of the interview, I reviewed these notes and added additional

المنارة للاستشارات
www.manaraa.com

comments and procedural observations. Moreover, I listened to the audio recording within twenty-four hours and continued the reflection process.

Paid transcriptionists transcribed the interviews verbatim. For member checking purposes, participants were given the entire transcript from the first interview seven calendar days before the second interview. They were given an opportunity to clarify, question, or amend the document. Following the second interview, participants were given seven calendar days to review and amend the second transcript as appropriate.

Interview format. The current investigation utilized a semi-structured open-ended interview for data collection, a strategy commonly seen in qualitative studies (Merriam, 2009). Patton (2002) cited a number of reasons for using standardized open-ended interviews, most notably that the interview format can be easily reviewed by people interested in the study and that the format makes it easy to locate and compare responses to specific questions. Additional benefits include the flexibility and specificity that this type of interview provides—specific information can be elicited from participants while the exact wording and ordering of questions may vary.

In looking at crisis supervision, I was interested in hearing about the experience, behavior, opinions, and feelings of counselors working with clients in crisis. Therefore, I developed interview guides with specific questions and issues to explore within an adaptable format. Study participants received copy of the guide at the start of the interviews.

Round I interview protocol. Before starting the formal interview, I summarized the purpose of the study and reiterated the fact that the James Madison University Institutional Review Board had approved the investigation. I reviewed the informed

المنارة للاستشارات
www.manaraa.com

consent document, procedures for recording and transcribing the interview, and the member checking process. I also verified the information on the demographic data form and asked participants to identify the date that the Virginia Board of Counseling had originally issued their professional counselor license.

I assigned a number to each participant, which was recorded on the demographic data form, process notes, and transcript. Peer reviewers referred to participants by the number assigned. Participants were given gender neutral pseudonyms during the data analysis phase of the study to facilitate a discussion of the results.

An interview guide provided the structure for Round I interviews (See Appendix F). I began every Round I interview by reading a standard introduction. This statement succinctly described the research topic and question guiding the inquiry. Next, I read the following prompt,

> I am interested in the process of counselor supervision in the context of client crisis. I am using the word "crisis" to denote a state of intense emotion when a great deal seemed to be at stake. It may not have necessarily been a time when a client was actively suicidal or homicidal but it was a time during which the client was experiencing much distress and there was the potential for serious, negative consequences. I would like you to recall a time in your career when you were working with a client who was in crisis. For the purpose of this interview, please identify a crisis event that occurred after you received your graduate counseling degree and that you would feel comfortable sharing with me.

I asked participants to nod their heads when they were ready to proceed and

المنارة للاستشارات
www.manaraa.com

began asking the questions that appear on the interview guide. The exact wording and sequence of the questions varied in accordance with the strategies for effective interviewing outlined by Charmaz (2006). At times, participants spontaneously addressed questions without prompting. At the conclusion of the interview, I turned off the recorder, thanked the counselor for participating, and scheduled the second interview.

Round II interview protocol. The location for each interview remained the same during Round II. The purpose of the second interview was to build on, clarify, and enhance participants' understanding of crisis supervision. A preliminary interview guide was developed and submitted with the IRB protocol (See Appendix G). Two peer reviewers read each verbatim transcript from Round I (The peer review process will be discussed in detail under the heading "trustworthiness procedures"). I met with the reviewers three times before the start of Round II and received feedback about the interviewing process and emergent themes in the data. With their input, I refined the interview guide for Round II, integrating thematic content into the queries. I asked every participant the same questions; however, the sequencing and exact wording of items varied to enhance the flow of the conversation. At the end of the second interview, I explained the process for host verification and provided information about the complementary ethics training. Finally, I reminded participants that Dr. Lennis Echterling (expert in crisis counseling and the chair of the dissertation committee) was available for participant de-briefing.

Trustworthiness procedures. Qualitative researchers must demonstrate that their findings are honest, meaningful, credible and empirically supported (Patton, 2002). Lincoln and Guba (1985) introduced the concept of "trustworthiness" and identified four

المنارة للاستشارات
www.manaraa.com

issues that the researcher must address: credibility, transferability, dependability, and confirmability. Credibility is an assessment of whether or not the findings accurately represent the participants' experiences. Transferability is the degree to which the findings can be applied beyond the scope of the study. Dependability is an evaluation of the integrity of the data collection and analysis as well as the interpretation of the data. Confirmability is the degree to which the findings are supported by the data. A number of strategies have been suggested to enhance trustworthiness; qualitative inquirers should employ at least two (Creswell, 2007). In this study, trustworthiness was enhanced through the procedures outlined below.

Process notes. I wrote process notes during the interviews and at two different times post interview (within one hour, and after listening to the audio recording of the interview—within twenty-four hours). The form utilized had three headings to prompt the researcher: thoughts, feelings, and impressions; cultural considerations and possible researcher bias; and follow-up/revisions. Writing detailed process notes enhanced "reflexivity"—a deliberate and painstaking examination of one's biases, assumptions, and ideas and their possible impact on the research endeavor (Merriam, 2009).

Member checking. Lincoln and Guba (1985) viewed member checks as an essential technique for establishing credibility. By taking the data back to the participants, the researcher can confirm the accuracy of the information. In the present investigation, I gave each participant verbatim transcripts of their interviews and seven calendar days to review the documents. Themes that emerged during the first interview were incorporated into the interview guide for the second interview and participants were asked to reflect on

المنارة للاستشارات
www.manaraa.com

those themes. In reviewing the transcripts, participants pointed out only minor typographical errors, two during Round I, and one during Round II.

Peer review. Peer review, or debriefing, is a structured process in which colleagues, familiar with the research topic or the methodology used, provide consultation and feedback to the researcher. The role of the peer reviewer is to critically examine all aspects of the research process and to play devil's advocate—ask tough questions and prompt the researcher to explore her assumptions and interpretation of the data (Lincoln & Guba, 1885). Peer reviewers add credibility to an investigation by virtue of their status as outsiders and the role they play in enhancing researcher reflexivity.

Two peer reviewers, both Associate Professors of Graduate Psychology at James Madison University, were involved in the current study. The first peer reviewer is the Head of the Graduate Psychology Department and holds a Ph.D. in assessment and measurement, an M.A. and Ed.S. in counseling, and is a licensed professional counselor. The second peer reviewer holds a Ph.D. in counselor education and supervision, and is licensed as a professional counselor and school counselor.

Both peer reviewers met with me on five occasions, three times together and two times separately. At the outset, I provided the peer reviewers with a copy of the IRB protocol and a detailed description of the participant selection procedures. They received copies of every transcript (verbatim), which included a participant identification number and no identifying information. They read the complete transcripts, recorded their reactions to the interviews, and identified possible themes in the data. To finalize the second interview guide, I met with the peer reviewers prior to the start of Round II.

المنارة للاستشارات
www.manaraa.com

Conversations with the peer reviewers were audio-recorded, not transcribed. The audio-recordings were transferred to my password protected computer; a copy was stored in a portable password protected storage device, and the original recording was erased.

The peer reviewers provided detailed feedback about recurring patterns in the data and my role as researcher. For example, one reviewer commented on the frequency with which the word "frustrated" came up during the interviews. The second peer reviewer noted the emergence of a theme about administrative versus clinical supervision. Both reviewers commented on the way that I conducted the interviews. They pointed out strategies that seemed to be helpful in eliciting participants' experiences and views about supervision. Additionally, they identified moments in the interviews when I seemed unclear about my role. One peer reviewer commented on the words that I used to summarize a participant's response to a specific question, reflecting that my word choice suggested that I had a strong opinion about the topic.

The chairperson and members of the dissertation committee also served as reviewers, a standard practice in doctoral research. In developing the procedures to ensure trustworthiness, for example, I received feedback from the dissertation committee members. They unanimously endorsed the proposed strategies.

Research journal. I kept a journal throughout the research process. I recorded questions I had about crisis supervision, preliminary understandings about the supervision needs and experiences of counselors in times of client crisis, and detailed notes about all aspects of the investigation. The journal also contained records of the pilot interviews and focus group mentioned in Chapter II. Furthermore, it highlighted the steps taken in the current study and decisions regarding data collection and analysis. As noted

المنارة للاستشارات
www.manaraa.com

earlier in this section, the meetings with the peer reviewers were recorded and saved on the researcher's computer. These audio-files are part of the research record and provided an oral account of data collection, analysis, and interpretation.

Memo writing. Memo writing is an important qualitative tool, which helps to organize the research process. Memos are documents created by the investigator to capture her ideas, insights, and reactions during each phase of the investigation. Memo writing keeps the researcher actively engaged in data collection and analysis. Additionally, it provides a vehicle for managing the vast amount of information typically generated in qualitative research (Charmaz, 2006). According to Fassinger (2005), in writing a memo, the researcher is recording the conceptual, procedural, and analytic questions and decisions that guided the inquiry.

Memos are personal and private records of the researcher's subjective experience of the research journey, capturing thoughts, feelings, and hunches along the way. There are a number of approaches to memo writing. The present study relied on the memo writing strategies suggested by Richards (2005). She outlined general guidelines for writing memos, encouraging researchers to develop a writing routine, create an efficient way to store memos, and date every entry. Furthermore, she identified a way to categorize memos and steps for generating them. General categories of memos created during the present investigation included: memos about method (for example, the interviewing process), memos about emerging ideas (themes, insights, and hunches), memos about the researcher's subjective experience (feelings, thoughts, and reactions), and "parking lot" memos (ideas for future research).

المنارة للاستشارات
www.manaraa.com

To compose the memos, I followed the advice of Richards (2005) who identified a five-step process. These steps are:

1. Skim read, then read the document line by line
2. Record anything interesting
3. When you find something interesting, ask yourself why
4. Focus on passages and ask questions about them
5. Ask yourself "Why am I interested in that" (p. 76) and document your responses

By writing memos, the researcher starts to see what is happening in the data (Charmaz, 2006). The memo-writing format utilized in the current study enabled the researcher to identify trends in the data and create categories during the coding process.

Data analysis. The process of conducting two rounds of sixty-minute interviews generated an abundance of data. Making sense of the data is a formidable task in qualitative inquiry. The ultimate research goal is to formulate a detailed and concrete report, one that provides rich description of the phenomenon in question (Patton, 2002). In the current study, data collection and analysis proceeded simultaneously. I adopted a stance of prolonged engagement with the data, examining each record as it was generated. According to Richards (2005), themes do not emerge from the data:

> The researcher discovers themes, or threads in the data, by good exploration, good enquiry. By handling the data records sensitively, managing them carefully and exploring them skillfully, the researcher 'emerges' ideas, categories, concepts, themes, hunches, and ways of relating them. (p. 68)

المنارة للاستشارات
www.manaraa.com

This investigation of crisis supervision relied on verbatim transcripts of interviews, which is considered the best database in qualitative studies (Merriam, 2009). To enhance the integrity of the data, I listened to the recording of every interview and reviewed each transcript (data record) line by line for accuracy. Study participants verified the transcripts in the member-checking process described previously.

Data analysis was a fluid and dynamic process. Specific steps were followed to organize and manage the records; at the same time, the procedures were flexible enough to enhance the flow of the study. The first phase of analysis was "opening up the data to see what's going on" (Richards, 2005). To facilitate coding, I used NVivo 9 ®, a software package for handling and analyzing qualitative data. The final edited and validated transcripts were entered into the software, which was stored on a password-protected computer.

There are several purposes for qualitative coding. In this study, coding was done to break down the data into units of information, assign the unit to categories, and bring them back together to create a picture of crisis supervision. I read and reflected on each data record, wrote detailed process notes (general thoughts about the data), and generated a preliminary coding scheme for potentially meaningful data units. For example, during the first interview Riley (pseudonym) said, "I've had no formal supervision since all those years since '92". This comment was tentatively coded as "lack of supervision". The same process was followed to review all of the transcripts. The peer reviewers received copies of the transcripts, read the transcripts in full, and independently coded the data.

During peer review meetings, initial coding schemes were discussed, evaluated, and revised. This inductive process, commonly referred to as "open coding" (Richards,

المنارة للاستشارات
www.manaraa.com

2005) was repeated throughout the data collection phase. Following peer review meetings, I went back to the data to revise the codes. Peer reviewers also critiqued the interviewing process, which was updated as necessary.

Preliminary codes in the data were identified during the peer review process. During one session, for example, one reviewer commented on a recurring theme about harmful supervision experiences. Hence, a code was generated to reflect that idea—harmful supervision. At times I used a priori codes based on the literature and my earlier research on crisis supervision. A priori codes included “resilience”, “structure”, and “feedback”. In the early stages of data analysis, in vivo codes, words and phrases used by the study participants themselves were also used. For instance, during Round II, Casey talked about helpful elements of supervision: “The opportunity to uh, de-gas a little bit after, you know, some particularly difficult things.” The code “de-gas’ was created.

In open coding, the interviewer relied on the constant comparative method of data analysis (Glaser & Strauss, 1967). Data records were compared with each other, the data with compared with findings in the literature, and data analysis was compared across coders (peer reviewers and researcher).

Open coding was followed by axial coding, a process of linking ideas together to create categories (Merriam, 2009). Categories are formed when common elements are clustered together in “buckets” for data storage. An example of a category created in the current study was “poor supervision.” Commenting on the supervision received, Casey said,

المنارة للاستشارات
www.manaraa.com

> She (the supervisor) wrote me up one time, um, and it was because of something that I had allegedly said to a client. And I said, "I didn't say that." Well, I'm going to write you up, going to put it in a counseling memo.

Another participant, Lyric, described the actions of a current supervisor this way: "He has kind of thrown me under the bus a few times." For Rowan, the supervision experience itself was traumatic as evidenced by the words "It was a crisis for me" and "The guilt and shame I felt was enormous." It appeared that the experience of supervision was harmful for a number of the supervisees; some supervisors were reportedly acting in ways that were demoralizing and upsetting to them. Segments of data that reflected difficult moments in supervision were put in the "poor supervision" bucket. The provisional category of poor supervision was later revised to "difficult experiences in supervision" to more accurately reflect the meaning of the data.

To explore the relationships between data units and categories, I created preliminary models using newsprint. Since the study employed a basic qualitative design, the primary goal was to provide a thick and rich description of crisis supervision, not generate an emergent theory (purpose of studies utilizing grounded theory). Consequently, models were employed only as tools for conceptualizing and synthesizing results and to identify emergent themes.

Chapter Summary

Chapter Three described the rationale and purpose of the study and provided an overview of the research methodology. The chapter began with a statement reiterating the need for a conceptual framework for crisis supervision grounded in field-based counseling practice. The chief goal of the study was to illumine the supervision needs and

المنارة للاستشارات
www.manaraa.com

experiences of licensed professional counselors working with clients in crisis. Secondary goals were to understand how counselors define "crisis" in the context of counseling, and to explore the supervision experience of practitioners ignored in the literature—licensed professionals.

The chapter included a brief review of qualitative research and a description of the methods utilized in the current investigation. I outlined the participant selection process and inclusion criteria. Thirteen counselors participated in two rounds of interviews. Numerous tools were employed to enhance trustworthiness: process notes, member checking, peer review, journaling, and memo-writing. Data were analyzed using constant comparison procedures—reflecting on segments of interesting data, creating categories, and identifying themes linking categories together. NVivo 9 ® software aided the data analysis. Chapter IV presents the findings of the current study. For data reporting purposes, I utilized the intelligent verbatim transcription style, leaving out only the ums, ohs, and other mumblings.

المنارة للاستشارات
www.manaraa.com

CHAPTER IV

Results

Introduction

Chapter III provided a brief introduction to qualitative research and a detailed description of the methodology employed in the current study. The primary question guiding the inquiry was: What are the supervision needs and experiences of licensed professional counselors when working with clients in the midst of a crisis or mental health emergency? The main purpose of this research endeavor was to understand crisis counseling and supervision from the professional counselor's perspective. There were two additional aims of the current investigation—discover how counselors understand and experience crisis in the context of field-based counseling practice, and explore the supervision experiences of counselors working in the field.

As discussed in the previous chapter, purposive sampling strategies were utilized to select thirteen licensed professional counselors in Virginia. Participants worked in a variety of settings and in a number of counseling roles. Qualitative data were collected during two rounds of semi-structured interviews and analyzed simultaneously. I used open and axial coding to examine interview data, moving from descriptive accounts to higher levels of abstraction—from ideas to categories and emerging themes. Numerous procedures enhanced trustworthiness, including peer reviewers, member checking, process notes, and memo-writing.

This chapter presents the results of the data analysis. Gender-neutral pseudonyms protected the identity of the thirteen participants. The following pseudonyms were used: Ali, Amari, Casey, Charlie, Hayden, Harley, Lyric, Peyton, Quinn, Riley, Rowan, Skylar, and Teagan. I omitted any information that could be used to identify the counselors,

المنارة للاستشارات
www.manaraa.com

clients, or specific settings in which the events occurred.

Data analysis was a fluid process. I utilized open coding to identify initial codes in the data. These codes were discussed and revised during peer review meetings. Similar ideas were grouped together to form clusters. These clusters of ideas are not mutually exclusive. They are proposed as a method for organizing the findings. Next, I considered possible relationships between the idea clusters and identified recurring patterns or themes. Finally, I recognized four major categories in the data. Results are presented in a systematic way to enhance the flow of information. The findings are presented sequentially to facilitate discussion, not to indicate hierarchical relationships in the data.

The chapter is organized into four sections. Each section describes a major category of findings. Emergent themes and idea clusters within the categories are discussed in detail. Table 2 depicts the major categories, the themes, and idea clusters.

Direct quotes are reported using the intelligent verbatim transcription style. Quotations are cited in a way that makes it easy to locate the material in the original transcript. For example, (Ali, I, 14) signifies that Ali is the speaker and that the quote appears in the Round I transcript at comment number #14.

Category #1: Counselors' Understanding and Experience of Client Crisis

At the beginning of Round I interviews, I read the definition of "crisis" developed for the study (See Appendix F). I asked participants to identify a time in their counseling career (after receipt of a graduate counseling degree) when they worked with a client in crisis and to describe this experience in detail. It is important to note that an open-ended prompt elicited the counselors' narratives about crisis counseling. In response to this prompt, the counselors provided vivid accounts of client encounters which they

المنارة للاستشارات
www.manaraa.com

personally characterized as crises.

Table 2 Categories, Themes, and Clusters

Category #1:	Counselors' understanding of client crisis	
	Theme #1a:	Counselors confront a wide range of crisis situations
	Idea clusters:	Ongoing personal struggles
		Behavioral emergencies
		Tragic events
	Theme #1b:	Crises are complex
	Idea clusters:	Clinical complexity
		Systemic complexity
		Cultural complexity
Category #2:	Impact of crisis response on the counselor	
	Theme #2:	Counselors experience positive and negative outcomes from crisis counseling
	Idea clusters:	Positive and negative emotions
		Resilience
		Post-traumatic growth
		Negative outcomes
Category #3:	Crisis Supervision	
	Theme #3:	Crisis supervision is essential, generally helpful, but potentially harmful
	Idea clusters:	Essentiality
		Helpfulness
		Harmfulness
Category #4:	Clinical Supervision	
	Theme #4:	Clinical supervision is the heart of professional development throughout the counselor's career
	Idea clusters:	Necessity
		Benefits

Eight participants described a crisis scenario involving a current client. In each of these cases the counselor had been meeting with the client at least weekly for individual or group psychotherapy. Two other counselors had previous contact with the client they discussed, either in outpatient counseling or in emergency services. For three counselors, initial contact with the client occurred in the context of the crisis. Two major themes related to the concept of crisis were revealed in the data. First, counselors confront a wide

المنارة للاستشارات
www.manaraa.com

range of crisis situations. Second, crises are clinically, systemically, and culturally complex.

Theme #1a: Counselors confront a wide range of crisis situations. The first theme reflects the wide variety of crisis situations that counselors encounter. Study participants described three clusters of client crises—ongoing personal struggles, behavioral emergencies, and tragic events. Every scenario, regardless of the type of crisis involved, was characterized by significant disruption in the client's ability to function and by highly charged affective states.

Ongoing personal struggles. Five participants described times in their counseling careers when they worked with clients who were struggling with personal crises. These troubling events, while highly stressful and upsetting, did not require emergency intervention. In each case, significant depression and/or anxiety were integral components of the crisis experience. From these narratives it appeared that while these crises were destabilizing for clients and triggered intense emotional reactivity, the counselors did not perceive these situations as dangerous or highly volatile.

Casey discussed working with a man in his sixties, who presented with an "abject sense of hopelessness" (Casey, I, 5). The client had a "conflicted upbringing" and a "very poor social support system." As the man looked back over his life, he was very dissatisfied with where he's been (I, 3). Casey counseled "this gentleman" for over a year as he struggled with frustration, disappointment, and "high suicidal ideation." Casey recalled times in counseling when the client became more actively suicidal. "He would go to bed at night just praying not to wake up the next morning" and thought about ways to "end his life" by shooting himself or driving off a cliff (I, 5).

المنارة للاستشارات
www.manaraa.com

Peyton described a crisis situation that involved a high school student with severe autistic disorder. “She was from a really high achieving family that had really, really high expectations for her.” Due to her autism, she had difficulty processing social interactions and “poor emotional control” (Peyton, I, 14). During a routine vocational assessment, the client became increasingly more confused and frustrated with her performance. Peyton recalled, “every once in a while she would have a verbal outburst.” This escalated to the point where she was “in tears and she felt really, really bad about herself because she had done poorly on the assignment. . . . She continued crying and yelling and I couldn’t get her to calm down” (I, 19). The following day, the client returned to finish the evaluation and became “loud, and tearful, and crying, and made a statement that she felt like hurting herself” (I, 20).

Rowan remembered a crisis involving a college freshman. The student was in counseling to deal with unresolved grief about her father’s death during 9/11 and a difficult transition to college. She “was experiencing a lot of difficulty. . . . She hated school and of course the anniversary of 9/11 had come, she had only been at school less than a month” (R, I, 7). During the fall semester, the student suffered a minor sports-related injury which required medical attention. According to Rowan, this prompted a crisis for the client. “She couldn’t get any support. So, she already didn’t want to be here [in college], had no support, it was soon after September 11th … she was in a crisis. She couldn’t do her classes.” Rowan continued: “It wasn’t like I needed hospitalizing her, but she really needed help” (I, 8).

Riley described a crisis situation in a private practice setting. During a lunch break on a very busy work day, Riley received a call from a client “experiencing distress

المنارة للاستشارات
www.manaraa.com

and intense emotion." The client was saying "things that indicated that she felt utter despair and hopelessness. And she was saying 'I can't go on, and I don't know what to do" (R, I, 3). Riley added, "She had never attempted suicide, and I didn't think she would, but I could not be 100% sure of that" (I, 15).

The fifth reported crisis that occurred in the context of ongoing personal struggles was highlighted by Skylar. In this scenario, the client—a family—was receiving court mandated services in order to prevent the removal of the children from the home. Skylar detailed the family's concerns which included domestic violence, parental substance abuse, custody disputes, financial insecurity, and unstable housing. Skylar described one specific crisis that occurred while accompanying the mother to court: "We were leaving the courtroom and we were walking through the parking deck and she, for the first time, had this emotional letdown and confided in me that she was still using substances" (I, 12). Skylar understood this event as a positive crisis—a breakthrough for the client who could finally acknowledge that her life was out of control.

All five of these crisis scenarios involved clients who were confronted with troubling situations that challenged their ability to cope. These situations fit the definition of "crisis with a lower-case c," times of distress and heightened emotional states (Echterling, 2010). In these circumstances, counselors responded to crises that were upsetting to clients but not yet out of control. The second type of crisis, which was the most common one reported by study participants, involved behavioral emergencies—situations where there was the potential risk that someone could be seriously harmed.

Behavioral emergencies. As discussed in Chapter II, behavioral emergencies are crisis situations that require immediate intervention to prevent harm or loss of life. In

المنارة للاستشارات
www.manaraa.com

counseling practice, behavioral emergencies—crises with a capital C—may involve suicidal behavior, violence, and interpersonal victimization (Echterling, 2010). In the present study, when participants were asked to identify a time in their career when they worked with a client in crisis, seven described behavioral emergencies. Three of these crises occurred within the context of an ongoing counseling relationship with a current client.

Hayden recalled a crisis involving a client in a correctional setting. The man was "very violent," "very angry," and "very suicidal." Reportedly, Hayden received a phone call one day from someone who said, "We got your guy down here. He's threatening to kill himself. He's angry. He's banging his head. He's got a rope around his neck" (Hayden, I, 14).

In Teagan's case, the crisis involved a client brought into the clinic on an emergency custody order (ECO). As an emergency services clinician, Teagan needed to assess the need for involuntary commitment. Reportedly the man was not bathing or eating. "He was off his medication. He was urinating on himself and was refusing to come in for treatment" (I, 10). When the police brought the client in for the evaluation: "He was psychotic. He was unable to care for himself for an extended amount of time. . . . You could tell that he had not bathed in probably, probably months" (I, 11).

Another counselor responded to a crisis that involved interpersonal violence. According to Lyric, a fight broke out during a psychotherapy group. Towards the end of the session, an intruder burst into the room and assaulted one of the group members. "One [person] started yelling to the other and there started to be hair pulling and it was

المنارة للاستشارات
www.manaraa.com

getting out of hand really fast" (Lyric, I, 9). The police were called to the scene and an ambulance came to transport the intruder to the hospital.

Charlie, an emergency services clinician, recounted a crisis involving a former client:

> I received a call … that she had been de-compensating over a few weeks. We [emergency services staff] had multiple contacts with her during that time. The police had multiple contacts with her during that time, and at this particular point, she had actually become so upset that she actually cut her hair off with scissors. And she was holding scissors in her hand when the police arrived and she was shaking them and threatening her neighbor. And, so the police picked her up and brought her to the hospital. And I met her there at the hospital. (Charlie, I, 5).

Following the evaluation, the client was transported to a psychiatric hospital for inpatient admission.

Amari talked about a crisis involving a client who had been committed to a hospital on an emergency custody order. The client "had gotten intoxicated one evening and made some very superficial cuts to her wrist" (I, 9). In this case, Amari's task was to determine whether or not the client needed to remain in the hospital on a TDO (temporary detaining order). Speaking about this experience, Amari said, "I think she, she was very emotional herself, just wanting to be out. She really felt this was very damaging to her, but I don't think she realized this seriousness" (I, 13). The client's parents were present for the commitment hearing and Amari described their reaction this way: "There was a lot of emotions with the family and the parents crying and, and it really got to be

المنارة للاستشارات
www.manaraa.com

kind of everyone felt like this was just, you know, a heightened experience and there was a lot of emotion in the room" (I, 19).

The crisis that Harley described occurred during walk-in hours at a community mental health center. The client was psychotic and intoxicated. According to Harley, the client had been "in and out of the system … probably since she was a teenager" (Harley, I, 7). As the assessment progressed, the client started screaming. "She started picking up chairs and she did pick up a chair and threw it and then started pushing the table, the table away" (I, 18).

Finally, Quinn shared a crisis encounter with a highly distressed client—someone who "had a diagnosis of borderline personality, cluster B symptomology" Quinn had been seeing this client for outpatient counseling for a number of months when the emergency occurred. "She began to seriously decompensate. The emotional reactivity became quite dramatic. She began threatening to hurt herself, to cut herself, and she acknowledged some suicidal ideation and virtually every session … she cried, sobbed, sometimes yelled, screamed" (Quinn, I, 10).

All seven of these experiences were acute stage crises—behavioral emergencies requiring immediate response. These crises involved unstable and urgent situations with clients who were out of control. In every scenario there were elements of imminent danger and significant risk of physical injury. During these events, counselors had to act quickly to help the clients, stop the escalation of the crisis, and ensure the safety of everyone involved

Tragic events. The final participant talked at length about a violent tragedy that had far-reaching consequences. In this case, Ali, a school counselor, had been helping a

المنارة للاستشارات
www.manaraa.com

student cope with painful family dynamics. One day the counselor was confronted with the violent death of the student's parents. "I hadn't had a lot of training on, or a lot of experience on how to break that news to her, but we met with the police and with her, and they were actually the ones who told her" (Ali, I, 13).

Overall, these thirteen narratives depicted "crisis in counseling" as a wide range of situations. Study participants reported crisis experiences that included suicidal ideation and behavior, interpersonal violence, psychiatric emergencies, tragic loss, and acute psychological distress. While there are some similarities across situations—intense affect, disruption of normal functioning, situational instability—it is impossible to understand the counselors' crisis experience with a reductionist lens. When counselors described a time in their counseling careers when they worked with a client in crisis, their responses suggested that crisis is extraordinarily complex.

Theme #1b: Crises are complex. Participant narratives suggest that crisis may be best understood as a complex system of interacting components. Three key clusters of complexity are evident in the data—clinical, systemic, and cultural.

Clinical complexity. Study participants identified one time in their counseling career when they worked with a client in crisis. Every narrative included references to clinically significant behavioral or psychological conditions that were inextricably linked to the crisis. In each case, clients reportedly struggled with pre-existing conditions—problems and stressors—before the crisis occurred. In Rowan's case, the client was in counseling that pre-dated the crisis due to "PTSD and anxiety" (Rowan, I, 7). Another client had a history of schizophrenia and alcohol dependence (Harley), while others struggled with borderline personality disorder (Quinn), autistic disorder (Peyton),

المنارة للاستشارات
www.manaraa.com

addictive disorders (Casey; Harley; Amari; Quinn; Skylar), major depression (Casey; Riley), and psychotic disorders (Charlie; Harley; Teagan).

In addition to these complex mental health issues, all of the clients in crisis—as described by the study participants—had a host of pre-existing psychosocial and environmental problems. The concerns included: domestic violence (Ali; Skylar), economic problems (Casey; Skylar), lack of social support (Casey), legal involvement (Hayden; Skylar; Teagan), tragic death of a family member (Rowan), incarceration (Hayden), and inadequate housing—including homelessness (Harley; Skylar; Teagan). From these accounts, crisis is seen as a cascade of consequences—a situation brought on by a mix of vulnerabilities and situational stressors. The counselors in the study seemed to understand crisis as an unfolding process. All thirteen study participants eloquently spoke of longstanding client difficulties and a series of events that ultimately shattered a fragile equilibrium.

Harley talked about the challenges involved in evaluating clients in crisis, describing a situation that involved a woman with a history of schizophrenia. When she came into the clinic, "I could smell alcohol on her breath and . . . her words were slurred, and . . . her gait was off. It was difficult to tease out where the drunk stuff was and where the psychotic stuff was" (Harley, I, 10). Harley's words suggested that in times of crisis, it may be hard for counselors to discern what causes a client's distress and what type of treatment is necessary.

For Skylar, who was working with a family in crisis, there were a number of serious problems to address. The family was initially referred by a child protective worker for concerns regarding inadequate supervision of the children and domestic

المنارة للاستشارات
www.manaraa.com

violence. There were "lots of things going on, parents abusing substances and needing intensive in-home services to prevent the children from being removed from the home." Skylar recalled the challenge of coming up with a treatment plan and deciding how to prioritize goals. Some of the family dynamics included:

> Real intense emotional hurt, you know, custody issues, the break, the separation, the failed marriage, the domestic violence, and the children witnessing all of that. . . . On top of it all, financial instability, basic needs being threatened like living arrangements, losing housing for the children, no job, just like a variety of things causing this family to be in crisis. (I, 11).

It is clear from these accounts that the combination of mental health/substance abuse issues and difficult life circumstances made crisis response especially challenging and complicated for the counselors in the study. Furthermore, a number of the crises reported involved significant risk of injury—to the client, counselor, and other people on the scene. There was palpable danger in many of the counselors' narratives. For example, Quinn described one session when a client became terribly agitated and "attempted to throw the chair that she had been seated in" (I, 12). Charlie talked about a client who cut her hair off with scissors: "When I first saw her in the hospital, you could see that here were patches of hair that were gleaned almost to the skin and other patches that were maybe 6, 12 inches long" (Charlie, I, 14). Lyric intervened to stop a physical altercation between two clients (Lyric, I, 9) which ultimately led to police involvement.

In summary, the counselors in this study were faced with three difficult tasks—figuring out what was going on, devising a plan of action, and keeping themselves, and everyone around them, safe. Each of these challenges contributed to the clinical

المنارة للاستشارات
www.manaraa.com

complexity of crisis counseling for the study participants. The second cluster of complexity that emerged from the data involved systems dynamics.

Systemic complexity. Eleven counselors in the study made references to collaboration with various individuals and agencies as they managed these crisis situations. From the data, it appears that client crisis was a collective experience that precipitated powerful emotions in many concerned individuals. Furthermore, to be effective, counselors were required to communicate effectively not only with clients, but also with family members, police officers, judges, other individuals, and agency representatives—all of whom were distressed.

Teagan talked about a call that came into emergency services one day from a man concerned about his adult son. Two days later, the father called back and said, "I still can't get him to come in for treatment. He really smells horrible and he's still not taking his meds. He's talking to himself. He's responding to things that are not really there" (Teagan, I, 11). Teagan described the following intervention:

> I encouraged the father and I said, "Okay, you really need to pursue the ECO. Do you feel comfortable doing this?" And he said, Well I guess I just go to the magistrate's office and I ask them to get this ECO." And I said, "OK, why don't I meet you there at the office and ask them to get this ECO and I'll kind of walk you through the process … and leave you with an officer who can help you with the rest of the procedure". So he actually came here into the office and I … escorted him to the sheriff's office … and I said that we needed to see the magistrate. (I, 11)

المنارة للاستشارات
www.manaraa.com

According to Teagan, the magistrate issued the emergency custody order and the client was escorted back to the clinic by the sheriff and the sheriff's deputy for a pre-screening evaluation. Because the client's sister was his payee, Teagan decided to call her to gather more information and tried to locate a bed in a psychiatric hospital. Teagan said, "It was very difficult to find a hospital bed, and I was running into all kinds of obstacles because the one, two facilities that did have a bed available wanted medical clearance with all types of EKGs, things that would take several days to get" (I, 17). Teagan continued, "So I got the rescue squad to come over here and take his blood pressure … and drug or urine screen, I believe, and I faxed the medical documentation that they wanted and I faxed the prescreen" (I, 20). This crisis unfolded over the course of three days. During that time, Tegan was in contact with the client, family members, magistrate, sheriff, sheriff's deputy, staff from a number of psychiatric hospitals, members of the rescue squad, and co-workers at the clinic.

In Teagan's chronicle, the crisis occurred within a complex system. A group of individuals were brought together by a cascading chain of disturbing events. They were dependent upon each other to achieve a shared goal—resolution of the crisis. Furthermore, they appeared to share an intense emotional connection. When Teagan spoke to the client's sister about his condition, the sister was "immediately relieved and she said "Thank God. Somebody has finally done something" (I, 15). In describing her brother, the sister "reported that he was explosive" (I, 29).

The sheriff's deputies, present for the hospital pre-screening interview, apparently overheard the conversation between the counselor and the client's sister and said, "Oh, we forgot to tell you. He does have a legal charge, but we're not worried about that right

المنارة للاستشارات
www.manaraa.com

now. We want to focus on the help that he needs" (I, 15). Teagan later stated, "This particular gentleman had a history of aggression, but mainly towards police officers." The officers "began to disrupt the interview and chime in" (I, 27).

Teagan described co-workers at the clinic that day as "uncomfortable." They were "truly amazed that one, the physical appearance of him, the odor that lingered throughout the clinic." Afterwards, when "I found a hospital bed, and he left, it was funny. My colleagues were coming in and they said, 'You are amazing. How in the world could you sit through this?' (I, 28).

For this counselor, recalling the crisis precipitated a flood of emotions. "He was in bad shape, probably the worst that I have ever seen" (I, 11). "What really surprised me, shocked me … told me that he was psychotic … he said the year was 3010 (I, 12). Teagan talked about feeling extremely overwhelmed—by the physical condition of the client, the level of his psychological distress, and the difficulty of finding a hospital bed. Teagan also talked at length about feeling pressure from a number of sources.

> It's just pressure from all different angles. You know, I've got pressure to find a very sick person a hospital bed. You know, I've got pressure to, even though the police are here and he's in handcuffs, I still feel pressure to keep everyone safe around me. (I, 27)

Teagan's narrative illustrated the systemic nature of crisis. In this case, a diverse group of people were intimately and intensely connected by urgent circumstances. They all appeared to experience strong emotional reactions to the situation—concern, fear, frustration, and powerlessness—and played key roles in resolution of the crisis.

المنارة للاستشارات
www.manaraa.com

The understanding of complex systems dynamics was evident in the narratives of ten other study participants. Their vivid testimony depicted crisis as a shared experience, one that forced counselors to manage the distress, needs, and expectations of many people simultaneously. These ideas were eloquently expressed by Ali. Ali recounted a tragedy involving a high school student with whom she had been working. One day, the police came to the school to inform the principal about the violent death of the student's parents. Ali was with the principal and the police when they shared the horrible news with the student. Next, the counselor and the assistant principal accompanied the student to another school to pick up the younger siblings. Ali outlined what happened later:

> We … took them home, and then after that I started working with the family. So, it wasn't just a one-time crisis. It felt like a crisis when we found out the information, when we were telling [the client] and trying to help [the client] deal with the information. When we accompanied [the client] to the house, when we followed up with [the client] later, through the funeral services, through coming back to school, dealing, providing counseling or guidance to the student body and the faculty of how to help the children out, what would be the best way to help them. (Ali, I, 13)

It was quite clear from Ali's account that this tragic event had widespread impact. "A lot of the student body knew the family… And they were involved in different groups, so that also affected the different groups they were in." It was "a crisis that affects the whole community as well as individuals" (I, 31). Ali described her feelings at the time and the reactions of others. She was "just, just shocked and so sad for the children; and just really concerned about how to deal with each step along the way. . . . A lot of fear in

المنارة للاستشارات
www.manaraa.com

just dealing with it" (I, 18). "It was a shock to the whole community, to the school" (I, 20).

In sum, eleven counselors in the study described crises that affected many people including family members (Ali, Amari, Charlie, Rowan, and Teagan), police officers (Ali, Charlie, Harley, Lyric, and Teagan), school administrators (Ali and Rowan), teachers (Ali and Rowan), magistrates (Amari, Teagan), ambulance driver (Lyric), and the larger local community (Ali). In these situations, the counselors struggled to manage chaotic events and powerful collective emotions. These systemic concerns added a layer of complexity to crisis response for the counselors in this study. The final cluster of complexity relates to cultural issues.

Cultural complexity. The interview guides did not include specific questions or prompts relative to culturally competent crisis response. However this concept recurred throughout counselor narratives, which suggests that it is important to consider culture in crisis response. Casey described a crisis involving "a bi-cultural male, Native American and white" (I, 1). According to Casey the client, who struggled with alcohol dependence, "was going through an external crisis with the program [Alcoholics Anonymous]" (I, 3). As he told his story, Casey used words and phrases such as "higher power," the "militant Native American movement" (I, 10), "the creator," and the "ashram" (I, 44). Casey expressed a belief that in this crisis situation, counseling effectiveness was contingent upon understanding certain customs, rituals, and spiritual understandings that the client presented.

For Harley, the crisis involved a woman from Puerto Rico who came to the clinic intoxicated and psychotic. As mentioned earlier, Harley reported the struggle to

المنارة للاستشارات
www.manaraa.com

understand the precipitant of the crisis—psychosis, acute alcohol intoxication, or a combination of both. In the counselor's words:

> There was a cultural difference there as well. So she, initially I knew something was kind of off, but initially she was talking about chickens and rituals and things like that with chickens, so I was like, "Oh maybe some of this stuff was cultural." No, but as time went on, she was just really talking out of her head and very bizarre." (I, 6).

In Charlie's case, the client wielding scissors was "a deaf middle-aged female" (I, 5). Charlie recalled the interview in the emergency room.

> I started to talk with her about what happened over the past couple of weeks. And she was a little bit guarded at first and then later she opened up to me and explained kind of, what her thoughts were. And it was clear she was delusional. She stated not making sense of things. Most of the interview was done in American Sign Language but at times she would talk verbally and yell at me, or tell me what it was that she was thinking. She appeared to calm down when the doctor came into the room. (I, 8).

Charlie said that the doctor did not know sign language. Additionally, the client's sister was reportedly present for the interview and "she misperceives a lot" (I, 18). Clearly, there were barriers to providing linguistically competent services. This same issue is reflected in Lyric's story.

Lyric was facilitating a psychotherapy group for Spanish-speaking adults. According to agency policy, when the police are needed, the counselor is expected to "send someone else to call." Lyric continued, "No one in my group spoke English, so it

المنارة للاستشارات
www.manaraa.com

was a little bit tricky, so I had to go myself" (I, 15). There were other thorny aspects to this situation for Lyric, including a familiar dilemma about translating and dual roles in counseling practice.

> I mean, I don't mind interpreting occasionally for clients, but this was an energy charged situation and you know, having a trained interpreter, in that moment and that part of the moment would have been easier. . . . You really need to be neutral when you are an interpreter. So they were wanting me to interpret, but I was also in the midst of everything.

Lyric described an explosive situation, one that involved significant struggle for the counselor as well as the clients. Lyric wanted to respond in a clinically sound and culturally competent way. Best practice guidelines for providing linguistically competent services stress the importance of using trained and unbiased interpreters. Furthermore, the guidelines caution counselors to avoid the dual role of helper/translator. Lyric struggled to balance the need for immediate action with the desire to maintain the therapeutic stance. The lack of other Spanish-speaking staff at the scene of the crisis placed Lyric in an untenable position.

The event precipitated a crisis for Lyric, who felt pulled in two different directions. "It was really scary. . . . It's one of the scariest experiences that I've had" (I, 11). Lyric continued, "I was kind of frustrated that I needed to interpret for the police, just because it was such an important situation and I was kind of like, but really nervous and I was probably shaking a lot" (I, 21). Lyric's story reinforced a key point expressed by Casey, Charlie, and Harley—culture impacts crisis in considerable ways. Furthermore, to be effective in times of crisis, counselors must be culturally competent. Not only does

المنارة للاستشارات
www.manaraa.com

Lyric's narrative have implications for providing a culturally competent crisis response, it also offers compelling evidence of the impact of crisis counseling on the helping professional—the second major category of findings.

Category #2: Impact of Crisis Response on the Counselor

As discussed previously, crises are rife with danger and rich in possibilities. This idea is perhaps the key to understanding how study participants made sense of crisis counseling. One major theme emerged from the data relative to the impact of crisis counseling on the mental health professional. This them is discussed in the next section.

Theme #2:* C*ounselors experience positive and negative outcomes from crisis counseling. Everyone interviewed, regardless of the counseling setting, spoke about the difficulties encountered and the lessons learned when working with clients in the midst of a crisis. Ideas about the impact of crisis counseling formed four clusters: positive and negative emotions, resilience, post-traumatic growth, and negative outcomes.

Positive and negative emotions. Crisis response experiences elicited strong emotions in all counselors. During the interviews, participants had difficulty identifying and expressing their feelings; they appeared to "go inside" to organize to their experience, often gazing off into the distance for several moments before answering. Several interviewees, including Ali, Peyton, and Skylar, asked for questions to be repeated.

At the beginning of the interviews, the majority of the counselors described their reactions to the crisis using vague emotional terms such as "frustrated" or "concerned." As the conversation progressed, they began to use highly descriptive words and phrases to highlight and give voice to their emotional states. For example, at the start of the first

المنارة للاستشارات
www.manaraa.com

interview, Casey talked about being "very frustrated" when the client said that he was going to shoot himself or drive his motorcycle over a cliff. Later on, this counselor recalled, "I'm just sitting there going, 'Oh God, I'm killing myself here for a year, sweating bullets, trying to keep this guy alive" (I, 42). He continued, "Oh God, Oh, I tried everything. I tried a strengths perspective, I tried reframing. I tried, you know, the whole gambit of DBT" (I, 43). Casey added, "I was putting far more effort into getting him better than he was getting him better" (I, 45). The meaning of "frustrated" became clear the longer Casey talked about the crisis. It involved a host of other emotions—fear, powerlessness, anger, resentment, and envy.

The counselors' struggle to identify and express crisis emotions was clearly evident during data analysis. The transcripts were replete with "ums," "ohs," and other mumblings that reflected emotions so intense that they disrupted the narrative flow of their accounts, even though the events had taken place long ago. Reviewing the transcripts during the member-checking process, three participants (Lyric, Peyton, and Skylar) expressed surprise and dismay at the number of times they stammered during the interviews. Their bewilderment suggests that the counselors were not fully aware of their distress during the interviews. Also significant is the fact, that for two participants (Riley and Skylar), the study was the very first occasion in which they actually processed the crisis.

The counselors vividly described the emotional turmoil that the crises triggered in them. For Charlie, seeing the client in the emergency room was a shock.

> Seeing her like that was terrible. Seeing her so upset that she didn't know what to do, that she cut her hair off; and she's never hurt herself before, so having that

المنارة للاستشارات
www.manaraa.com

> history and knowing that she had cut her hair off and what had happened, you know, if the police hadn't come and intervened with the neighbor, was she going to attack the neighbor? And I mean, just the concern of her safety at that point. It was, it was, an uncomfortable feeling to be there to see her in that much pain that she was acting out in that way. And it was difficult also knowing that she maybe couldn't communicate with the staff at the hospital as well as maybe another patient could [because of her deafness]. (I, 24)

When the tragedy unfolded at school, Ali was plagued with doubt and insecurity.

> Just as I was going through it, just the fears. Am I doing the right thing? You know, is this the right step to take? What can I do to help them? You know, at times I felt like it wasn't enough. Just a lot of uncertainty, a lot of sadness for them. Just the violent nature of the whole thing was disturbing. (I, 34).

Another participant recalled feeling very worried about a client who was "exhibiting reckless, out of control behavior" and "being torn" about recommending hospital commitment. Amari was "surprised that the situation went on for so long" and "grabbed a hold of me."

> I felt sympathetic with her. . . . I felt really genuine for her . . . you know, feeling torn between that role of being just a counselor and what, what is almost, you know more friendly in the other direction. My biggest emotion is just being torn" (I, 22).

Participants frequently said that during the crises, they felt nervous and fearful. During the pre-screening evaluation, Harley's anxiety accelerated along with the rapid escalation of the client's distress.

المنارة للاستشارات
www.manaraa.com

> She started getting up out of her chair, moving around, saying she wanted to get out of there; and the other thing about her was she was actively, she was saying that she wanted to kill herself. . . . She had trouble understanding what I was saying and so she started speaking in an odd language. … My main thing was 'How am I going to get to my supervisor?'… So I picked up the phone and she got very agitated because she thought there were things in the phone. (I, 13)

Hayden described intense anger provoked by the sight of the client with a noose around his neck. "He is a young man basically abandoned . . . his mother is homeless, a crack head. He had a head injury shortly after he was born because she threw him down on the sidewalk so she could fight another woman" (I, 12).

In summary, all of the participants in the study expressed deeply troubling emotional reactions to the unfolding crisis. They experienced the negative emotions that often characterize crisis, including shock, anger, grief, anxiety, fear, panic, hopelessness, and insecurity. However, the majority of counselors also expressed the "rainbow" emotions of resolve—courage, compassion, hope, inspiration, and joy. Every crisis story, no matter how violent or traumatic, featured lessons learned from the experience and contained evidence of resilience and post-traumatic growth. These positive emotions will be featured more prominently in the following sections on resilience and post-traumatic growth.

Resilience. The detailed accounts of the crises counselors encountered in field-based practice provided considerable evidence of resilience. Resilience, as defined earlier, is the ability to bounce back—to flourish under fire. In complex and emotionally charged situations, the counselors demonstrated insight, initiative, and creativity. All of

المنارة للاستشارات
www.manaraa.com

the counselors outlined the steps they took to manage intense and complicated scenarios with highly distressed clients. Their accounts of their crisis response are filled with humility, compassion, and respect for the people involved. Examples of counselor resilience can be found throughout the transcripts. For example, when the client became increasingly more agitated and paranoid, Harley spontaneously "started playing tic-tac-toe with her and it calmed her down" (I, 13). When Hayden "came upon" the man, "he had a noose around his neck. And I talked him out of it. . . . And I was able to calm him down and able to talk about some of the positive things I saw in his life" (I, 11).

The transcript from every interview is replete with evidence of courage and optimism, illuminating the counselors' determination to help the clients and resolve the crises. Under fire, the counselors took charge. Harley found a creative way to reduce the client's distress—playing a friendly and universal game. Hayden helped the client to uncover his strengths and find hope. There is also ample evidence of strength and resourcefulness in the transcripts. For instance, the day after the fight occurred, Lyric went back to work—to facilitate five psychotherapy groups per week and manage a caseload of 40 individual clients.

It is critical to understand that although participants described only one scenario in great detail, crisis counseling was not a rare occurrence for them. On the contrary, the experience of crisis was a common denominator in their practice regardless of the setting. Furthermore, several participants—Amari, Charlie, Hayden, Skylar, and Teagan—had been working in "capital C crisis settings" for many years. Lyric, an outpatient counselor, said crisis clients are "all our clients" (II, 19).

المنارة للاستشارات
www.manaraa.com

Despite the difficulties encountered in crisis response and the frequency with which crises occur, study participants remained committed to the counseling profession. The counselors spoke about their work with clients with enthusiasm, insight, and humor. Furthermore, every account of crisis counseling included elements of post-traumatic growth for the helper.

Post-traumatic growth. One counselor, Skylar, described the crisis event itself as a positive experience—a decisive moment when the client seized the opportunity to be authentic. The client's resolve solidified the client-counselor relationship and provided a major therapeutic breakthrough.

> We were leaving the courtroom, and she, we were walking through the parking deck, and she, for the first time had this emotional letdown and confided in me that she was still using substances. That was, probably, the first time that she confided in me about that and we had, like this real connection from that day forward.

Skylar talked about the event in a way that conveyed deep respect and admiration for the client, as well as gratitude for the deepening therapeutic connection it created.

> Like a shining light that she could possibly turn things around now and move forward and get her family stable. . . . And then, that intense connection thing that we had, that she felt like she could finally confide and rely, and that she was really going to be validated for her efforts and trying to move her family forward. (I, 17)

This notion of moving forward, both in the client's life and in the counseling relation-

المنارة للاستشارات
www.manaraa.com

ship, provided compelling evidence of the potential for experiencing post-traumatic growth following a crisis.

In total, twelve counselors highlighted the value and meaning of the crisis experience. For Ali, the crisis brought her closer to her clients and enhanced her counseling effectiveness. “I grew closer to the children. . . . It was a long process of working with them closely and getting to know them really well.” She continued, “I think it was a situation that helped me learn how to deal with a crisis that affects a whole community, because that particular one did” (I, 31).

In Riley’s case, it prompted a discussion with the client about a concrete plan for managing suicide risk. For Harley, it illustrated the importance of “reading people.” “Leveling my voice tone and sitting or standing, that kind of stuff” (I, 64). Charlie provided an eloquent description of the potential for learning from crisis encounters. Initially, Charlie was very anxious about meeting with the client at the hospital and said, “I felt very nervous because I’ve had some situations that have come to bite me in the butt. . . . I have a particular history with this woman and her family” (I, 15). However, during the interview, Charlie reflected,

> I think every experience with every client teaches you something. This experience with her, I found it to be very self-affirming in the sense that what happened yesterday isn’t necessarily what is going to happen tomorrow. And, like being able to see both her and her sister kind of agreeably work with me. . . . And they plowed through it like champions. And so, to be able to see them be able to do that, and for me to be able to work with them in an effective manner. (I, 26).

المنارة للاستشارات
www.manaraa.com

Study participants recognized the potential for growth embedded in crisis. Benefits associated with crisis counseling included increased confidence, enhanced professional identity, and stronger relationships. Counselors also described outcomes of crisis counseling that were particularly challenging and upsetting for them. These negative outcomes of crisis counseling will be discussed next.

Negative outcomes. Negative outcomes of providing crisis counseling included high levels of stress, difficult counter-transference reactions, vicarious trauma, and even symptoms of post-traumatic stress disorder. Unfortunately, in some cases, the supervision experience during crisis exacerbated the stress and provoked a crisis in the counselor. Difficult supervision experiences will be described later in the context of crisis supervision, the third major category of findings.

Counselors experienced stress from the very nature of the crisis, in some cases it was violent (Ali) and shocking (Ali, Charlie). Sometimes the crisis extended over a long period of time and was not easily resolved. Ali worked with the children at school for several years following the crisis. Quinn reported that the client was in crisis throughout the entire five-month course of psychotherapy. The long-term and on-going nature of client crisis was also at the heart of the stories told by Lyric, Skylar, and Hayden.

As mentioned earlier, twelve of the crises discussed involved many people and multiple systems. For example, Ali had to support the children, extended family, student body, fellow teachers, and the larger community outside of the school—and deal "with my own feelings through it" (I, 33).

Several counselors talked at length about difficult counter-transference reactions they had. Hayden spoke about being "a little frustrated with security staff [in the

المنارة للاستشارات
www.manaraa.com

correctional center]. When Hayden was trying to convince the client to remove the noose from around his neck, "they were kind of discounting the whole thing. Kind of like, 'Oh there he goes again. And he's got exactly what he deserves.' You know, being kind of cavalier about it, kind of nonchalant" (I, 17). The correctional staff "kept power circling, piling on consequences, and having to get the last word" (I, 15). There is evidence in the transcripts that Hayden identified with the client. Several times Hayden emerged as the client's champion—advocating and fighting for him.

> I pointed out to them [correctional officers] that the procedure was not followed. You cannot do that to a kid and you can't just keep piling up consequences on him. You've got to give him time. You've got to give him a way out. You gotta give him a way to save face. And they're like, at this point, "Well, we're going to do what we got to do."... And I'm like, "No, no one's gotta get hurt here. He's just feeling boxed in" and I convinced everybody of that. (I, 17).

Amari and Casey were aware that they might be over-identifying with their clients and talked at length about the importance of maintaining appropriate boundaries in the therapeutic relationship. Amari's task was to determine whether or not a young woman needed to be involuntarily committed to the hospital. "I really felt genuine for her … I know that the economy is hard and she is young and she had a good job, but at the same time being a counselor, you kind of, you can't throw yourself all the way in that direction." Amari continued,

> You pull back and you say, "Wait a minute, she's in the hospital for a reason," and so that was probably my biggest, you know, feeling torn between that role of

المنارة للاستشارات
www.manaraa.com

> being a counselor and what is, what almost is, you know more friendly in the other direction. (I, 22)

Casey provided an eloquent description of counter-transference reactions experienced in the course of counseling, and returned to this topic several times during the first and second interviews.

> I felt envious of some of the people who he had known who were rather large figures. . . . "You've been near them and talked to them? Holy God." It was really challenging because we had a lot of things in common and, and it kind of became interesting because I guess about six or eight months into our work together, I realized we knew a lot of the same people. (I, 11)

A number of the interviewees said that they experienced significant trauma when they responded to the crisis. Amari was disturbed by the police officers' reactions to the distressed client.

> They came in and subdued her, and that was awful, you know, it was awful to see them push her down on the floor, pushed her on the floor, and you know, hold her down and she's thrashing around and cussing and stuff, and the police officers … they weren't very compassionate; and the more she thrashed, the more they were, you know, trying to control her (I, 18).

Harley shared a similar experience that was deeply upsetting. "It made me feel sad … the sad way that it had to happen. . . . She obviously needed to go to the hospital, but you know, there are different ways to go … that made me sad that she was handcuffed and shackled" (I, 56).

Fear was a major element in Lyric's story. Talking about the fight that erupted in

المنارة للاستشارات
www.manaraa.com

group, Lyric said, “It was really scary. Even just talking about it, I kind of feel like, you know, like almost like goose bumps or something” (I, 11). The narrative continued,

> I was frightened because, you know, if any, any of them had weapons that would have been really dangerous—for me, for clients. It could have been really dangerous. . . . That’s why I called the police right away, because I thought “This could get bad really fast.” I was scared. I had never really seen a fight, except . . . on television or something. So it was scary to see somebody in real life fighting. . . . Just the intensity in the room and I, you know, it happened so fast. The police were like, “How did it happen?” And I was like “I don’t even remember really.”... It was just, it seemed like, she opened the door and it was like boom and you know, like in five seconds they were fighting. (I, 13).

Counselors in this study provided vivid accounts of working with clients in the midst of crisis, giving voice to the challenges and discoveries they encountered. Their powerful narratives depicted crisis as both overwhelming and illuminating. Furthermore, their testimony captured essential qualities of crisis counselors—perseverance, optimism, and humility. The participants reported both positive and negative outcomes from their crisis counseling experiences. Their narratives portray crisis response as highly complex, dangerous, and stressful; they intervened in situations that tested their competency and resolve. Despite a host of challenges—including the threat of physical harm, a profound sense of powerlessness, and overwhelming responsibility—these counselors found meaning and purpose by helping and advocating for clients in acute distress.

Listening to these stories, I was intensely curious about the role that supervision played in managing the crises. To explore this phenomenon, I asked a series of open-

المنارة للاستشارات
www.manaraa.com

ended questions to discover and understand participants' crisis supervision experience. The third major category of findings, crisis supervision, is discussed in the next section.

Category #3: Crisis Supervision

Not only did the counselors reflect on the crisis supervision they received, they talked about the supervision for which they longed. As the data are presented, it is important to remember that participants were licensed between 1990 and 2011. Eight counselors had been licensed for at least four years. The opinions and preferences about supervision are those of experienced practitioners. The fourth key theme reflects the participants' understanding of crisis supervision.

Theme #3: Crisis supervision is essential, generally helpful, but potentiality harmful. As participants described their crisis supervision experiences, the data formed three clusters of ideas: essentiality, helpfulness, and harmfulness.

Essentiality. Participants viewed supervision as essential to effective crisis counseling. Regardless of how long they had been licensed, every professional counselor expressed a strong desire for regular, on-going supervision—particularly during mental health emergencies. While every interviewee strongly endorsed the importance and value of supervision, there was great variability in the amount and quality of supervision they obtained.

Essentiality of supervision was understood in a number of ways. First, counselors wanted and needed supervision. Second, participants made a clear distinction between administrative and clinical supervision. Administrative supervision was viewed as a host of activities related to scheduling, record keeping, and time-keeping. In some instances, counselors referred to performance management functions of administrative supervision,

المنارة للاستشارات
www.manaraa.com

including evaluating and disciplining employees. Every counselor felt that administrative supervision alone was insufficient, both in crisis and non-crisis situations. Clinical supervision, universally desired, was understood as an activity which includes in-depth discussions about clients, venting of emotions, processing of counter-transference reactions, and conversations about counselor ethics.

Four study participants reported that they were receiving only administrative supervision from individuals who were not licensed professionals. One participant explained,

> My supervisor is not licensed . . . she doesn't have a lot of clinical experience. . . . I wouldn't consult with her. She would not be my first choice. I tried to get that [clinical supervision] from her for the past three years and it didn't feel sufficient enough. It wasn't clinical enough. It wasn't concrete enough. It wasn't consistent enough.[2]

According to another counselor, "there really is minimal [clinical supervision] in general for me because most of the people are not licensed . . . not licensed anything . . . so it's administrative supervision. It's not much about processing my own experience." In another case, the counselor said that administrative guidance was readily available and critical for managing a complex emergency. "I had a lot of administrative supervision and help." At the same time, this practitioner longed for a supervisor with a counseling

[2] Several of the participants reported difficult and traumatic experiences in supervision. I have taken extra precautions to protect their identity. When data from the transcripts are included to highlight these painful experiences, the speaker is not identified.

المنارة للاستشارات
www.manaraa.com

background—"so I wouldn't be as anxious, as afraid". "My supervisors did not have counseling backgrounds."

Participants expressed a need and desire for clinical supervisors who are readily accessible. Hayden, a counselor for almost twenty years, expressed this wish succinctly, urging supervisors to "just be there" for counselors (II, 15). Skylar described an effective crisis supervisor as "being intensely available" (II, 48), while Charlie said that in times of crisis a supervisor should be available "on the fly" (Charlie, I, 41). According to Amari, supervisors should be consistently accessible throughout the crisis: "I think it's nice to have a supervisor who is accessible either by phone or by, you know, being able to go directly to their office" (II, 13). For Casey, even when situations do not involve getting an ECO or TDO, it is helpful to have a supervisor to go to for even five minutes to brainstorm "the more difficult things that you've got to deal with … that your graduate work hasn't trained you for" (II, 18). Participants talked repeatedly about the nature of crisis—unpredictable, volatile, and frightening—and stressed the need for immediate crisis supervision. According to Lyric, "Sometimes things are urgent so you have to have someone right away, speaking of crisis, the truth of crisis" (II, 17).

The counselors expressed the wish for supervisors to "be there" in clearly defined ways—as guides, witnesses, and role models. The supervisor was somebody who would "walk through stuff" with me (Charlie, II, 6) and guide me. Lyric captured the essence of the guiding function of the crisis supervisor.

> I'll present what's going on and then I'll say, "This is what I'm thinking. What do you think? Or I'll say, "I'm not sure at all what to do." And then [my supervisor] might challenge me and say, "What are your thoughts? What do you think you

المنارة للاستشارات
www.manaraa.com

> should do?" And if I have no idea, I'll say, "I'm not really sure. I don't really know, I've never dealt with this before." Or I might say, "I'll think about it for a bit," and then say, "Well, maybe this." (II, 21).

Charlie expressed similar views about the crisis supervisor's role as the counselor's guide: "I call up and say, 'Hey, this is what's going on. What should I do? Or this is what I'm thinking, what's your feedback on that?'" (I, 41). Charlie continued, "I get immediate feedback on it and I find that to be crucial in emergency situations … someone to give feedback right back to me right away while I'm still in the process of figuring out what my plan is (II, 6). Harley referred to this process as prioritizing. "You know, this is the situation, this is my thinking of what I'm going to do, you know, what are your thoughts? And them being able to say, 'Well have you thought about doing this or what about this situation?" (II, 11).

Study participants repeatedly talked about the ideal crisis supervisor as someone who is reliable, dependable, and always there. For Skylar, the need for a supervisor did not stop once the crisis had been resolved. Because in the midst of intense situations, "You've got to think quick on your toes and you're constantly reviewing if you made the right choices and it's a lot to hold" (I, 38). Following a crisis it is essential to walk through the crisis with the supervisor, looking at "how that went and what that was like" and what you might do differently (Hayden, I, 39). The process of looking back with the supervisor "instills confidence in you" and helps you to feel "you did good" (Amari, II, 15).

Counselors wanted a supervisor to witness their work with clients in crisis and provide objective, informed feedback. The supervisor, as a witness, provided important

المنارة للاستشارات
www.manaraa.com

functions during a crisis—listening to the crisis narrative, noticing the counselor's reactions and responses, and affirming that the supervisee was handling the situation effectively.

The importance of the supervisor as "guide" and "witness" was also understood in the context of helping counselors to monitor counter-transference reactions. Simply put, a crisis supervisor can "guide me through my own stuff" (Skylar, I, 38). Several interviewees expressed a strong desire for a supervisor who provides guidance on "how not to let a client suck you in" (Amari, I, 31). Amari, an emergency services clinician for more than ten years, fervently described an instance of over-identifying with a client in crisis:

> Putting myself in [the client's] shoes, like pretending if this, if that was me and just thinking, "You know I would probably be doing sort of the same thing you know." I would probably be really stubborn and just trying to tell people, you know, "Hey, I just got drunk and this was dumb and why don't you just let me out of this hospital," and just, I could feel that same if it were me. (I, 34)

To process these reactions, Amari sought out the supervisor.

> I don't know if I used the word "boundary" with my supervisor at that time, but I think I just basically used the explanation of feeling like the client was sucking me in and then that I, that I could see why the client was acting that way and it wasn't too far out of the norm in my, in my mind. And so, I think that from that my supervisor, wanting I don't know, ground me or something . . . pull me back and say okay, you know, a reminder. . . . "You know this is happening … [the

المنارة للاستشارات
www.manaraa.com

> client] is making you come over here. . . . You're letting that, that emotion happen." (I, 35)

Amari recalled that following a discussion with the supervisor and "releasing some of my emotions", it was possible to go back and deal with the situation, "not feeling like there was so much of that pull" (I, 48).

Like Amari, Casey strongly identified with the client in distress and wanted a supervisor to help with "the maintaining of the boundaries" during crisis counseling (I, 26).

> As time went on, I would run into this client in the community. . . . It's a small town, you know. . . . The [client] walks in, you know, doesn't have the whole boundaries and confidentiality thing that I do. . . . I was very clear with that, after we had, had run into each other for the first time I dealt with that and the next thing. We do a lot of the same things. (I26).

Casey needed an opportunity to talk about ethical dilemmas such as limits to self-disclosure, confidentiality, and dual relationships and sought guidance from the crisis supervisor. "I knew this [client] before, I've interacted with them beforehand and, I, you know, is this an ethical problem?" (I, 22).

Study participants also viewed supervisors as essential role models in crisis counseling. The counselors wanted supervisors who had faced similar crises and were willing to talk about their experiences. As role models, supervisors were ascribed three primary functions—normalize the situation, offer advice, and instill hope. According to Ali, the supervisor can help in several ways:

المنارة للاستشارات
www.manaraa.com

> Not only with what's going on right then and what steps to take, but also helping them with what the person is feeling and normalizing what's to be expected. "You are going to feel this way, it is okay." And then, maybe if they have a question about what that person is going through, to seek some advice from other people who have gone through similar situations. (I, 72).

Counselors viewed crisis supervision as essential for solidifying their professional identity and helping them to grow professionally (Ali, Amari, Hayden). Additionally, supervision was seen as instrumental in enhancing counselor efficacy. According to Charlie,

> Being able to access my supervisor [following the crisis], like "Gosh, that blew up in my face and it was not at all what I expected;" and to be able to just sit there and have someone to talk to, so that I don't hold it in. I think it is really helpful for me and helps me to connect better with my clients. (II, 6).

Participants in this study understood clinical supervision to be essential for counselors working with clients in crisis. The most effective supervision was immediate and consistently available. Counselors expressed a shared appreciation for crisis supervisors who, "walked through it with me;" "watched what I was doing;" and "approved of me."

Although clinical supervision was understood as essential, five counselors in this study were not receiving it. As mentioned earlier in this section, four counselors only had access to administration supervision. According to the fifth counselor, when the crisis occurred, "there was nobody to talk about it with at the time at all. . . . I remember thinking "nobody has any idea about what I am actually doing." The counselor, feeling

المنارة للاستشارات
www.manaraa.com

"frustrated, powerless, and worried," did not discuss the crisis with anyone and was able to "compartmentalize it and go on with my day."

According to these five counselors, who received no clinical supervision, they felt isolated, nervous, and inadequate. To cope with the lack of supervision, the practitioners told themselves it was not really necessary and impossible to obtain. One counselor recalled telling a clinic director many years ago about the need for some positive feedback. In response, the director "said that was more or less an unrealistic expectation and that's the kind of thing that I have to give myself." In summary, while crisis supervision was understood as essential for licensed professional counselors, more than one-third of the participants were not receiving it. The next section focuses on the shared understanding of crisis supervision as helpful.

Helpfulness. Interviewees characterized crisis supervision as not only essential but also as extraordinarily helpful to the counselor. Participants identified two broad elements of helpful crisis supervision. These elements were process components of supervision and specific qualities of the crisis supervisor. These elements will be discussed in detail.

Throughout the interviews, there were references to seven process components of helpful crisis supervision—direct, immediate, and concrete feedback; clear guidance; structure; timely de-briefing; focused discussion about counter-transference reactions; concrete resources; and hands-on assistance. Table 3 depicts the process components of helpful supervision.

The first process component was *direct, immediate, and concrete feedback*. According to Amari, this type of supervisory input is critical when a crisis is unfolding. The urgent nature of the situation requires swift and unambiguous directions.

المنارة للاستشارات
www.manaraa.com

> The nature of the crisis is that you got to make a decision right now. And it's not something where you're seeing a client for weeks and weeks, or you know, over several months, and you've got like, wow, that you can work up something. This is something that has to be decided like today. And so, I think, there's already this heightened level with everybody and so sometimes I do think that more direct guidance is helpful during a crisis situation because it kind of puts a tunnel on everything instead of stretching it out. (I, 11).

Table 3 Process Components of Helpful Supervision

Direct, immediate, and concrete feedback	Focused discussion about counter-transference
Clear guidelines	Concrete resources
Structure	Hands-on assistance
Timely de-briefing	

The desire for direct, immediate, and concrete feedback was expressed by counselors with considerable experience in crisis response. There was a consensus that in crisis situations, clear-cut instructions were especially helpful. Peyton stated, "Most of the time I felt like … it's more helpful to be directive and just say, if you have an emergency situation on hand … this is what you ought to do to stabilize the situation (II, 25). Charlie echoed these views: "I find that to be crucial in emergency situations, to have someone as a sounding board and have someone to give feedback right back to me right away" (II, 3).

Charlie offered an example of a time when immediate feedback was critical. "While I was at the hospital [conducting the hospital pre-screening evaluation] I talked to my supervisor and I said, 'You know, this person is deaf. . . . There are beds at this

المنارة للاستشارات
www.manaraa.com

hospital, you know, how do you feel about that? What do you think I should do?'" (I, 44). According to Charlie, the supervisor provided specific guidelines to follow which helped to resolve the crisis.

For Amari, direct feedback was energizing. After many years conducting pre-admission screenings, this emergency services clinician still found it beneficial for the supervisor to review and critique the evaluation "Even though I've been doing this job for a very long time, it is always good to have somebody go over kind of something that you've done and say, 'Hey, did you kind of realize you left this out?'''Amari continued, "I think that has been kind of helpful just to kind of refresh your outlook of a piece of paper that you look at, you know, everyday for the past ten years and sometimes it just starts to seem, it sometimes starts to seem old" (II, 20). For Lyric, direct feedback must be concrete. "Yeah, that's not a good time for abstractness. In a crisis I want to know like 'boom, boom, boom' what to do…" (II, 22).

The second process component of helpful crisis was *clear guidance.* Participants described clear guidance as a menu of options, or set of choices in crisis response. Counselors reported that at times when they were working with a client in crisis, it was helpful for the supervisor to make suggestions rather than be directive. Amari referred to guidance as "a little nudge" (II, 9). For Harley, clear guidance was helpful in prioritizing "what needs to happen" (II, 11). "Have someone who is able to reflect on it, reflect back to you about the steps that you're thinking of taking" (II, 13). Amari wanted the supervisor to listen and offer "a few suggestions that I could kind of pick from" (Amari, I, 57). In Hayden's opinion, it is helpful for a supervisor to identify alternative responses

المنارة للاستشارات
www.manaraa.com

to clients in distress. “You know, I would have handled that a little differently. Maybe you should have done this or should have done that, or you waited too long” (II, 44).

The professional counselors also talked about the importance of *structure*, the third element of helpful crisis supervision. For Lyric, structured supervision was essential during crises, in contrast to supervision at other times. “When I don’t have any imminent crises really in my head …. It’s kinda more loosely structured” (II, 19). In Amari’s experience,

> One of the supervisors that helped me most was someone who was very structured and you know, when we met it was a very structured kind of thing.… “Okay, what could you have done differently?” And just trying to really get me to think more. But then if I couldn’t come up with anything, “Well next time why don’t you try this, this, and this?” (I, 56)

Amari also said that during supervision, this particular supervisor was “big on summarizing our session and kind of summing it up.” The supervisor might say, “Okay, here’s what you came in with today and this is what we talked about. Here’s what happened. Here’s what you’re going to try next time—and that structure was very helpful for me” (I, 57).

The fourth process component of helpful crisis supervision was *timely debriefing*. Participants frequently discussed the need and desire to debrief with supervisors immediately after client crises. Hayden explained debriefing as an opportunity to vent feelings and explore emotions, rather than reporting procedures and protocols followed:

> Yeah, I think in the course of crisis, in crisis situations, that’s where you need debriefing. That’s where you need processing. By debriefing, I don’t mean,

المنارة للاستشارات
www.manaraa.com

> "Well, I would have done this or you should have done this." What I mean by debriefing is, "How do you feel right now? How did you feel when that was all going on?' or "Was that frustrating? Are you feeling okay now?" (II, 12)

Hayden expressed a desire that was shared by all of the participants—to process emotional reactions to crisis situations with a supervisor. Casey wanted the "opportunity to de-gas" and said,

> That's always good, you know, even, even if there is no answer. Obviously it does good to just talk about it because talking through things, you know, you're working on understanding it and conceptualizing it, and a lot of times through the process, you find your answers. (II, 6)

Counselors wanted occasions to process negative and positive emotions with supervisors. Describing the revitalizing aspect of supervision, Charlie said: "In talking with my supervisor, I always feel more refreshed and feel more ready for battle" (II, 6).

The fifth process component of helpful crisis supervision was *focused discussions about counter-transference.* As previously reported, several participants (Ali, Amari, Casey, Harley, and Hayden) experienced strong and difficult counter-transference reactions during crisis counseling. These practitioners were aware of the risks of over-identifying with clients and viewed supervision as a vehicle for exploring and monitoring their affective and cognitive responses. Candid discussions in supervision, focusing on one's inner feelings and experiences related to crisis counseling, were actively pursued and appreciated. Hayden shared an experience in supervision when he received direct feedback about his reactions to the client's narrative:

> I came to my boss, my supervisor, "I'm dealing with a crisis." And he said to me

المنارة للاستشارات
www.manaraa.com

> "Whose crisis is it, yours or theirs?" And you know, I had to think about that. It was like a kick in the gut, because in reality, it was my crisis. I was the one who was worked up." (I, 73)

The sixth process component of helpful crisis supervision was *concrete resources*. Simply stated, the licensed professional counselors appreciated supervisors who identified current and available resources that could be accessed during crises. Casey found it helpful for a supervisor to say, "Here, look at this book, or look here, or look at this website" (II, 20). Lyric recalled a supervision session that focused on a client threatening suicide. The supervisor explained the process for initiating a "welfare check," which involves contacting the police and asking them to verify the client's safety. The suggestion was helpful to Lyric in two ways: identifying a concrete course of action and reducing the counselor's anxiety.

The final process component of helpful supervision was *hands-on assistance*. Seven counselors in the study reported a crisis involving a client in acute distress. Each of these situations was volatile and dangerous. In two of these cases, the counselor's supervisor immediately stepped in to assist. Harley said the supervisor "took a very proactive approach, and had worked with a variety of different types of clients, so the way she was acting was like this is a piece of cake" (I, 47). Harley continued, "Yeah, she wasn't freaking out and like I was" (I, 48). The supervisor called the hospital and the police, working alongside the counselor to manage the crisis.

In Quinn's case, the crisis occurred at a clinic on campus. Quinn was a resident-in-counseling at the time. During an outpatient counseling session, the client became "terribly agitated," and "attempted to throw the chair she was seated in. . . . She was

المنارة للاستشارات
www.manaraa.com

screaming at the time" The supervisor "came running down the hall, came into the room with me and we calmed the client down." Quinn continued the story saying,

> We got her seated again and [my supervisor] basically said that any further behavior of that kind would result in calling the police or declaring a mental health emergency and requiring an ambulance to be called. (I, 12)

Recalling these incidents, Harley and Quinn remembered feeling frightened and overwhelmed. Both of these counselors expressed tremendous relief and gratitude that the supervisors stepped in. Quinn said the supervisor came in on "the white horse and sort of helped me take charge" (I, 13). These narratives suggest that to be helpful, supervisors must be ready and available to join counselors on the frontlines of crisis; additionally, they must have the wisdom to know when to hold back. The second element of helpful supervision encompassed personal qualities of the crisis supervisor.

Personal qualities of the supervisor. Interviewees described attributes of the crisis supervisor that they felt were particularly important. Many of these qualities were discussed previously. Table 4 summarizes the qualities of the helpful supervisor.

Table 4: Qualities of a Helpful Crisis Supervisor

Accessible	Deliberate	Objective
Affirming	Dependable	Optimistic
Calm	Direct	Self-disclosing
Clinically focused	Flexible	Skilled
Culturally competent	Insightful	

The ideal crisis supervisor, as portrayed by the counselors in this study, is accessible, dependable, direct, deliberate, and affirming. A good role model, the crisis supervisor openly shares personal stories about navigating crises. This mentor is insightful, sees where counselors are "getting caught up" in client dynamics, and encourages reflectivity.

المنارة للاستشارات
www.manaraa.com

Other characteristics that were noted in helpful crisis supervisors included optimism, flexibility, calmness, objectivity, and cultural competency. Counselors also said that they preferred supervisors with "equal or superior credentialing."

As counselors talked about the personal attributes of supervisors, it was evident that their current understanding of "helpful" was based on both positive and difficult experiences with supervisors in the past. Counselors wanted supervisors who "believed that counseling works," "keeps our time sacred," "sticks up for me," "defends me," and "has my back." Painful or difficult experiences in supervision are discussed in more detail in the next major section of this chapter.

In summary, ideas that formed the cluster of helpful crisis supervision represented two major elements: process components (direct, immediate, and concrete feedback; clear guidance; structure; timely debriefing; focused discussion about counter-transference reactions; concrete resources; and hands-on assistance), and specific qualities of the effective crisis supervisor (accessible, direct, deliberate, and affirming). Every counselor wanted helpful crisis supervision.

In this study, five counselors consistently portrayed the crisis supervision that they received as helpful. Their supervision narratives were replete with references to all seven of the helpful supervision process components. Moreover, these participants described their supervisors as highly effective—available, supportive, and direct. The counselors felt confident that supervisors would intervene if necessary and would be available for debriefing. One participant jokingly said that sometimes the supervisor was "too available" and that an "open door policy" can inhibit reflectivity. Overall, these practitioners were satisfied with their supervision and felt comfortable with their

المنارة للاستشارات
www.manaraa.com

supervisors. Two areas in which the supervisors could improve were noted—addressing counter-transference reactions and managing conflict among staff. While these counselors reported primarily positive experiences, other participants recalled instances when supervision was difficult and at times, traumatic. Difficult experiences in crisis supervision formed the third cluster of ideas related to crisis supervision—harmfulness.

Harmfulness. Five practitioners identified supervision experiences that left them feeling anxious, annoyed, and insecure. Recalling painful situations at work that involved upper level administrators or peers, the counselors wished their supervisors "had my back" or "defended me." In one case, the counselor expressed anger and disappointment that the supervisor did not intervene to stop "the verbal harassment," and said [my supervisor] "has no backbone." In general, when these interviewees felt mistreated at work, they wanted their supervisors to step in and protect them. When the supervisors did not stand up for them, the counselors felt disappointed and discouraged. Moreover, three of these five participants said that supervision itself was traumatic, precipitating a crisis for them.

In recounting the events, these counselors became irritable, anxious, and tearful. The supervision narratives were filled with unresolved emotions including shock, fear, powerlessness, and uncertainty. One account depicted a tumultuous relationship with a supervisor who frequently missed meetings. "I would say, you know, the odds were even on that whenever we had supervision scheduled [the supervisor] wasn't there. It was highly frustrating for me….I couldn't trust that it would happen." The counselor recalled being reprimanded by the supervisor for seeking guidance from an agency psychiatrist.

المنارة للاستشارات
www.manaraa.com

"My supervisor told me not to do that again." There was a "constant diet" of "I'm missing the mark or screwing up" and constantly "getting written up."

A second counselor—struggling to tell the crisis supervision story—frequently began sentences, backed up, and started anew. During the crisis, the counselor managed a volatile situation that unfolded quite rapidly. The supervisor was initially very supportive and affirming. However, when the administration became involved, the supervisor "threw me under the bus." During a staff meeting, the "super supervisor" was "yelling at me almost" and "I was like, eek, and kind of like shut down." The counselor continued,

> I'm having trouble explaining this, but I think it's just an uncomfortable place to be where you don't know if you do something wrong that if you're going to get into trouble because of your supervisor's supervisor…. I needed someone there as a supervisor, and he was kind of like, "Oops, sorry you can take the bullet."

Finally, a third practitioner recounted the supervision experience during the time of client crisis. "It was a crisis for me." "It was horrible, just horrible." It was evident during the interviews that this counselor still struggled with the shame and guilt triggered by the supervision experience.

> [The supervisor] couldn't acknowledge that I was scared and that I didn't trust her to help me. So, it was hard. It was really bad. It's, it's one of the worse things that has ever happened in my life…. It continues to be difficult even though I have another supervisor.

In this section, I reported how crisis supervision was understood by the counselors as essential, but with the potential for being helpful or harmful. Study participants spoke eloquently and at length about the importance of crisis supervision. Without exception,

المنارة للاستشارات
www.manaraa.com

counselors yearned for a clinical supervisor—a seasoned clinician who could "hold their stuff" and help them to grow. Each participant told one crisis story in great detail and recounted their supervision experiences during that time. The quality of supervision varied tremendously. While crisis supervision was highly desired, less than half of the participants received consistent and helpful clinical guidance from licensed professional counselors. In some cases, clinical supervision was not available. At other times, the supervision itself was traumatic and provoked a crisis for the counselor. In the next section, the fourth and final category of findings is presented.

Category #4: Clinical Supervision.

During the interviews, not only did the counselors speak about crisis supervision, they discussed clinical supervision in general. The final theme reflected in the data is the importance of clinical supervision for counselors throughout their professional lives.

Theme #4: Clinical supervision is the heart of professional development throughout the counselor's career. The study participants unanimously agreed that, although regulations governing the profession do not require post-licensure supervision, it is beneficial and necessary to remain a skilled, effective, and thriving counselor.

Several interviewees reflected that not only is supervision beyond licensure not required, there is a tendency in the counseling field to assume that competent practice is "being out there on your own." The need for ongoing clinical supervision is often viewed as a weakness. One participant commented,

> People in this field in general probably don't take supervision as, clinical supervision, as serious as they should…. I've come to the realization that this is a much bigger issue and that once people, once you become licensed, there's a

المنارة للاستشارات
www.manaraa.com

> notion that you don't need anything else and I truly thought that it was something that only I struggled with (Teagan, II, 2).

The stigma associated with post-licensure supervision was raised several times throughout the interviews. As a licensed professional counselor, Harley is "guarded and reluctant to express vulnerability for fear of looking stupid. …It would be a positive thing if it could be, if supervision could be seen as a learning process and not so much worrying about being judged" (II, 49).

Counselors in the study appeared to have internalized the belief that post-licensure supervision is neither necessary nor available. Several licensed professional counselors who were receiving good supervision considered themselves to be "lucky" or "extremely fortunate." Their comments reinforce the idea that good supervision is "too much to expect."

Several participants reported that as a result of participating in this study, they were actively seeking clinical supervision. One counselor stated emphatically, "I do need it and it doesn't have to be looked at as a weakness. …I need a mentor…. I need a seasoned person." After the first interview, another counselor demanded clinical supervision—five years into the job.

Three primary reasons for wanting post-licensure supervision were identified—grow professionally, practice ethically and connect with other counselors. Casey said, "I want to be the best kind of counselor I can be" (I, 51). Amari felt that supervision "stretches me" and supervisors "challenge me clinically" (I, 56). Several participants viewed ongoing supervision as an opportunity to get a different perspective and warned that without supervision, you can "get into a rut."

المنارة للاستشارات
www.manaraa.com

> It can certainly point you in the right direction and give you things to think about that you know, that you're not thinking about, and that the problem is right in your face and, and you know, a fresh eye is always helpful (Casey, I, 47).

Lyric viewed supervision as a vehicle for increasing proficiency in several key areas—cultural competency, trauma-informed care, and evidence-based practices. For Teagan, supervision serves a protective function.

> Well you know this is really a safety risk for me by not having supervision because I need to process what's going on with consumers and it's healthy for the person providing the service like myself to be able to just talk to someone else about their experiences and their troubles and it reduces burnout" (II, 3).

Counselors perceived clinical supervision as mechanism for getting "answers, affirmation, and validation." Furthermore, supervision was highly valued as a forum for processing feelings and exploring difficult counter-transference reactions.

> Sometimes, I mean, when you're seeing a kid who has been molested or something and to go and think about that, and think about when you were a kid, and if you have kids yourself … just all of the things that brings up for you….and it's [supervision] really helpful, I guess is the bottom line. It's really helpful to be able to talk about that stuff and not to carry it inside.

Finally, counselors want supervisors to challenge, celebrate, and comfort them. Skylar said, "I like directives, and I like guidance … and the hard stuff, but I also like somebody to be solid and trustworthy and safe with my stuff" (II, 31). According to Charlie, "If things aren't going well, I want to point it out to them and say, "Hold my hand and tell me what to do" (I, 25).

المنارة للاستشارات
www.manaraa.com

Chapter Summary

This chapter presented the results of the data analysis. Data were collected during two rounds of qualitative interviews with thirteen licensed professional counselors. The primary purpose of this study was to understand the supervision needs and experiences of licensed professional counselors working with clients in crisis. Additionally, the investigation explored the counselors' understanding of client crisis and the supervision experience of field-based practitioners. Participants identified one time in their post-graduate counseling careers when they worked with a client in crisis and described this experience in great detail. Subsequently, interviewees were asked a series of open-ended questions about their supervision experience, both as it relates to this one crisis and to counselor supervision in general. I used open and axial coding to examine recurring patterns in the data.

Five major themes within four major categories were reflected in the data. These themes represent participants' understanding of crisis counseling, crisis supervision, and counselor supervision in general. The counselors confronted a wide range of crisis situations that included suicidal ideation and behavior, interpersonal violence, psychiatric emergencies, tragic loss and acute psychological distress. Crises were understood by the counselors as clinically, systemically, and culturally complex. The participants reported a host of positive and negative outcomes from the experience of providing crisis counseling.

The amount and quality of clinical supervision reported by the counselors in this study varied widely. Clinical supervision, and crisis supervision in particular, was understood as essential, generally helpful, and potentially harmful. Finally, participants

المنارة للاستشارات
www.manaraa.com

unanimously agreed that effective clinical supervision is beneficial and necessary throughout the counselor's career. Discussion of the results, including methodological considerations and future implications, appears in the final chapter.

المنارة للاستشارات
www.manaraa.com

CHAPTER V

Summary, Discussion, and Recommendations

The results of the data analysis appeared in the previous chapter. In this final chapter, the findings are discussed. The chapter begins with an exploration of methodological considerations and study limitations. Next, a brief summary of the five emergent themes is presented. The implications of the results for counselors, supervisors, and counselor educators are explained. Finally, the chapter concludes with specific recommendations for future research.

Methodological Considerations, Potential Limitations, and Challenges

The primary purpose of this qualitative study was to illumine the supervision needs and experiences of licensed professional counselors when working with clients in crisis. As the researcher, my ultimate goal was to discover how professionals experience the phenomenon of crisis supervision. I was also interested in discerning the impact of providing crisis services on the counselors themselves and in exploring their attitudes regarding counselor supervision in general.

Research design. The investigation utilized a basic design, the most common form of qualitative research (Merriam, 2009). As mentioned previously, this approach is typically chosen as a strategy for uncovering and interpreting the meaning of a phenomenon. The product of basic qualitative research is thick, rich description. In this study, there were distinct advantages and potential limitations associated with the basic methodology.

Two rounds of interviews with 13 participants generated a sizable amount of data. Reflecting on the design choice, there are at least three distinct advantages. First, the basic qualitative approach enabled me to explore the phenomenon of interest from the

المنارة للاستشارات
www.manaraa.com

counselors' vantage point. Second, the methods used generated sufficient data to answer the primary research question. And finally, the research design made it possible for me to make sense of the data. Since I am a novice qualitative inquirer, my analytic skills were rudimentary at the start of the project and grew as the study progressed.

Analyzing the data using the constant comparison method, I compared one segment of data to another to identify similarities and differences between them. I grouped similar ideas together to form clusters. I identified recurring patterns or themes that linked clusters together. Finally, I recognized four major categories in the data. Data analysis procedures were efficacious, both in terms of providing a framework for managing, streamlining, and organizing a substantial amount of data, and in answering the question guiding the inquiry. At the same time, this approach had limitations inherent in a basic qualitative design.

First, it is evident from participants' narratives that crisis counseling, crisis supervision, and counselor supervision in general are processes that unfold over time. Second, while the data are organized into groups and categories, these data units are not mutually exclusive or linear. Rather, the participants' narratives suggest that the categories and idea clusters are interrelated in important ways. According to Merriam (2009), a researcher could develop a model using grounded theory to understand the relationships between categories and subcategories. This level of analysis was beyond the scope of the current investigation. Therefore, one important consideration is that the study was not designed to explore interrelationships in the data or develop a theory about crisis supervision.

Participant selection. The present study was purposefully limited by the

المنارة للاستشارات
www.manaraa.com

inclusion criteria. Eligibility requirements were: (1) hold a current and active license to practice as a LPC in Virginia; (2) be employed full-time in a counseling position; (3) spend at least 50% of time at work providing counseling services; (4) desire and ability to participate in two qualitative interviews. The intent of the study was to understand how licensed professional counselors experience and interpret specific phenomena. The sample was limited to counselors in Virginia currently working in the field. The experiences of practitioners who left the counseling profession, or no longer hold active licenses are not represented.

The sample was primarily Caucasian (11) and female (10). The findings may not accurately reflect the counseling and supervision needs and experiences of counselors who do not identify as female or Caucasian. Furthermore, during data analysis participants were assigned study identification numbers which were used during the peer review process. To aid in the presentation of results, gender neutral pseudonyms were assigned. While these strategies may have been helpful in reducing the potential for gender bias during the peer review process, gender neutral treatment of the data ignored the influence of gender—not only on the experience of crises and crisis supervision, but also on the research process itself.

Additional limitations were self-selection and self-report. Participants volunteered for the study, understanding that the primary purpose was to explore their supervision needs and experiences during crises. Therefore, the sample only included counselors who had these experiences and wished to talk about them. During the interviews, participants were asked to recall a time in their post-graduate counseling careers when they worked with a client in crisis. Since the phenomenon of interest occurred in the past, participants

المنارة للاستشارات
www.manaraa.com

might not have accurately recalled earlier thoughts and feelings. Also, self-report may lead to biased responses. There is a possibility that counselors responded to interview questions based on social desirability factors, a desire to help me with the research, or both.

A major challenge of completing this study concerns my role as researcher. I am a licensed professional counselor, clinical supervisor, and supervision trainer. Additionally, I work in an environment in which serious crises and psychiatric emergencies are common occurrences. As an insider, I brought to this study certain biases, assumptions, and experiences related to crisis supervision. Moreover, when I started the enquiry, I did not anticipate the impact it would have on me personally.

While cognizant of the virtual absence of supervision for licensed professional counselors in Virginia, I was not prepared to see the pain and loneliness it engendered. Also, I was not fully aware of how much I had compartmentalized my own difficult supervision experiences. Drawn into the counselor narratives, I often felt conflicted about my role. As a researcher, I was committed to maintaining a stance conducive to gathering rich data. However, at times I also wanted to join the conversations, both as a witness to the anguish the counselors expressed and as the supervisor for whom they wished who would "watch their back" and "hold their stuff." To address my personal reactions, I continually engaged in a process of reflexivity—keeping a research journal and writing process notes and memos (Lincoln & Guba, 2000). I also relied on my peer reviewers for their perceptive feedback and willingness to walk with me through every transcript.

Despite the limitations, this study generated a wealth of relevant information. The findings are significant and have important implications for counselors, clinical

المنارة للاستشارات
www.manaraa.com

supervisors, and counselor educators. The major discoveries are summarized in the following section.

Summary of the Findings

Five major themes within four major categories were reflected in the data. Themes represent participants' understanding of crisis, crisis counseling, crisis supervision, and clinical supervision. The first theme is that counselors confront a wide range of crisis situations. Second, crises are clinically, systemically, and culturally complex. Third, crisis counseling impacts the counselor and precipitates a host of negative reactions and potentially positive outcomes. Fourth, crisis supervision is essential, generally helpful, but potentially harmful. Finally, clinical supervision is the heart of professional development throughout the counselor's career. These findings are highly robust. The results contribute both a cogent framework for crisis supervision and a compelling argument for post-licensure clinical supervision.

Discussion of the Themes

Concept of crisis. The first major category of findings reflects the participants' understanding and experience of crises. Results suggest that current conceptualizations of crisis in the counseling field are simplistic and narrow. Two themes about the nature of crisis emerged. First, counselors confront a wide range of crisis situations. Second, crises are clinically, systemically, and culturally complex. Considered together, these themes portray crisis as multifaceted, dynamic, and relational.

The counselors in this study encountered three types of crisis situations: distressing events that occurred as outcomes of the client's ongoing personal struggles, behavioral emergencies, and unexpected tragic events. Crises that occurred in the context

المنارة للاستشارات
www.manaraa.com

of ongoing personal struggles involved highly stressful and upsetting circumstances. While highly emotionally charged, these situations were not perceived as imminently dangerous or volatile. The counselors understood these crises as times of heightened distress for clients who struggled with a host of long-term challenges. The concept of crisis as an exacerbation of long-standing difficulties was described as "a slow boiling stew" by Everstine and Everstine (2006).

The second type of crisis, behavioral emergency, involved suicidal behavior, violence, and interpersonal victimization. These situations involved significant and imminent risk of harm. The counselors intervened quickly to help the clients, stop the escalation of the crisis, and ensure the safety of everyone involved. Behavioral emergencies are well documented in the literature, conceptualized alternately as functional impairment (Callahan, 2009), acute emergency (Everstine & Everstine, 2006), and psychological emergency (Thomas & Woodall, 2006).

The third type of crisis involved only one of the participants, but clearly represented a distinctly separate category of a tragic event. The event was not an exacerbation of the client's personal struggles or a psychiatric disorder. Nor was the crisis a highly volatile incident that presented imminent threat of suicide, homicide, or violence. Rather, the client was victimized by the tragedy of a violent crime. In this case, the crisis appeared to come out of nowhere. This finding serves as a powerful reminder that people are constantly faced with the vicissitudes of random tragedies and catastrophic events.

The complexity of crisis emerged as the second key theme, with three idea clusters related to complexity: clinical, systemic, and cultural. The first level of

المنارة للاستشارات
www.manaraa.com

complexity reflected the complicated clinical dynamics embedded within every crisis narrative. Counselors stated that before the crises even occurred, every client was struggling with serious mental health concerns (major depression, anxiety, posttraumatic stress disorder, substance use disorders, borderline personality disorder, autistic disorder, and psychotic disorders, including schizophrenia). Furthermore, many of these clients had pre-existing psychosocial and environmental problems (financial instability, lack of social support, legal involvement, and inadequate housing).

The complexity of crisis is also reflected in the cluster of ideas related to systems dynamics. Counselors understood crisis as a collective experience, a process that involved and impacted many people in powerful ways. Managing these chaotic situations required collaboration with many individuals and agencies. The participants emphasized the daunting challenges of helping the client, simultaneously coordinating services with a host of other people, and also dealing with the powerful collective emotions of crisis.

The final element of complexity reflected in the data relates to cultural and linguistic competency. Throughout the crisis narratives, there were references to cultural issues that impacted crisis counseling. These comments reflected the understanding that when crisis occurs, the client's culture places the events in a framework of meaning. Furthermore, culture provides customs, rituals, and social relationships that promote successful resolution of crises. Finally, counselors must take a proactive approach to addressing barriers to providing culturally and linguistically competent crisis services.

These findings have several important implications. To begin with, current definitions of crisis in the counseling field do not capture the complexity of the phenomenon. The typical definitions of crisis in the literature reflect four narrow

المنارة للاستشارات
www.manaraa.com

assumptions. First, crisis is conceptualized as the result of a single precipitating event. Second, it is a given that the crisis is a time-limited period of distress. Third, the crisis event is portrayed primarily an individual experience. Finally, it is assumed that crisis services are provided by a dispassionate helper—someone standing on the outside of the crisis.

In addition to this simplistic theory of crisis, the focus in the professional literature regarding the practice of crisis counseling has been on "how to" strategies—specific crisis intervention protocols based on type of crisis event (such as sexual assault, suicide attempt, and school violence). These approaches are rooted in a belief that the nature of the intervention varies significantly depending on the type of crisis that has occurred. For example, Everstine and Everstine (2006) devoted eight chapters of their text to specific crises, while Roberts (2005) presented step-by-step intervention strategies for 27 crisis precipitating events such as turbulent divorces, stalking, and bioterrorism. Every type of conceivable crisis that a counselor might face appears in the literature. While the taxonomy may be helpful in understanding the nuances of crisis, it can also overwhelm the helper. Furthermore, it promotes the misconception that each crisis event requires a unique and distinct "right way" to do crisis intervention.

The first two themes that emerged from the data suggest that crisis is far more complex. The lived experience of crisis is highly subjective and variable. In this study, several participants helped clients who were acutely psychotic. Understanding these situations to be "crises" was not predicated solely on the fact that the clients were hallucinating or disoriented. Rather, the "experience of crisis" was mediated by a number of other factors, including situational constraints (such as lack of a hospital bed, and

المنارة للاستشارات
www.manaraa.com

police involvement), counselor characteristics (lack of clinical experience, perceived lack of self-efficacy relative to managing emergencies), the amount of support from other professionals at the scene, and supervisor availability.

For study participants, crisis was neither a brief nor discrete event. Crisis was an unfolding and dynamic process that was not easily resolved. Moreover, the unsettling circumstances were collectively experienced by the client, counselor, family members and a host of other people at the scene. Finally, in some cases the urgent nature of the situation provoked a crisis for the counselors themselves.

The first two emergent themes are highly relevant for counselors, supervisors, and counselor educators. First, these findings suggest that crisis counseling is extraordinarily complicated. During crises, helping professionals are faced with a number of critical and often competing tasks: develop a therapeutic alliance with a highly distressed individual, rapidly assess the client's psychological state, devise a crisis intervention plan, manage the reactions of concerned individuals, and ensure the safety of everyone on the scene. Counselors must also manage their own affective reactions, while providing assistance that is ethically grounded and culturally sensitive.

Crisis counseling places helping professionals in stressful situations that require encyclopedic knowledge of mental health disorders, experience in crisis intervention, knowledge of family systems theory, understanding of the laws pertaining to civil commitment, and familiarity with community resources.

To function effectively during crisis, counselors must be adequately prepared and supported. In this study, several counselors described situations that were new to them. For one counselor, the crisis was a tragic event involving an adolescent at school; for

المنارة للاستشارات
www.manaraa.com

another, it was a volatile situation with a client who was psychotic and agitated. In both cases, the counselors felt unprepared to manage the complexity of these situations. During crises, it is natural for helping professionals to feel apprehensive and powerless. However, for theses counselors, lack of adequate training and preparation intensified these feelings, undermining the counselor's sense of competence and well-being.

Counselor training in crisis intervention varies significantly. Most of the participants completed their graduate degree prior to the release of the 2009 CACREP standards, which mandated coursework in crisis and emergency response. For these counselors, learning to manage crises occurred on the job. Only two participants completed a class in crisis and emergency services during their graduate programs. One of these counselors reported that the class did not cover the types of crises commonly encountered in clinical practice. Rather, the coursework focused primarily on disaster mental health and large-scale emergencies—situations most counselors rarely encounter.

Results from this study reinforce the importance of training in crisis and emergency response in graduate school, during the residency in counseling, and throughout the counselor's career. The participants' comments about emergency preparedness support the need for the revised CACREP standards. However, the findings also suggest that current standards are insufficient for preparing practitioners to offer effective crisis counseling services in the field. Counselor education programs must ensure that graduates possess the requisite knowledge, skills, and abilities for crisis counseling across a wide range of situations. Moreover, counselor preparation must address the clinical, systemic, and cultural complexity of crisis.

المنارة للاستشارات
www.manaraa.com

Another important implication of the research findings concerns the strategies counselor education programs employ in response to revised accreditation standards. There is a tendency for programs to add single courses to the curriculum to address training needs in "specialized" areas such as multicultural counseling, substance abuse, and more recently—crisis and emergency services. While this strategy ensures that students are exposed to content in these critical areas, it does not provide a useful framework for understanding how these issues are intricately woven into the fabric of counseling. For students to develop competency in crisis and emergency response, pertinent information must be integrated throughout the curriculum in a systematic way. Based on the findings from this study, the place to start should include incorporating crisis counseling techniques into existing courses such as psychopathology, multicultural counseling, and consultation and supervision.

Impact of crisis counseling. The third emergent theme focused on the impact of crisis counseling on the helper. Four sub-themes are reflected in the data: positive and negative emotions, resilience, post-traumatic growth, and negative outcomes. Several researchers have documented the same potential outcomes of crises directly on clients (Echterling, Presbury, & McKee, 2005). These findings reinforce the idea that crisis is a parallel process that occurs in counselor-client dyads. In urgent situations, counselors have extreme emotional, cognitive, and behavioral reactions that are both natural and potentially destabilizing. As a result, crisis work can lead to confusion and disorientation, triggering a host of maladaptive responses in the helper.

Providing crisis services elicited strong positive and negative emotions in the counselor. Initially, the narratives were filled with vague references to feeling

المنارة للاستشارات
www.manaraa.com

"frustrated" or "concerned." As the conversations progressed, participants used phrases such as "sweating bullets" and "a lot of sadness" to describe the distress they felt counseling clients in crisis. The interview process helped participants to access and express troubling emotions, in the same way that counseling can help clients in crisis. Many feelings were expressed repeatedly throughout the interviews—fear, powerlessness, anger, resentment, envy, compassion, and shock. Several participants struggled with deep insecurities about their ability to manage the disturbing circumstances that they encountered.

In addition to these negative emotions, the participants also expressed in the interviews their emotions of resolve —courage, compassion, hope, inspiration, and joy. The counselors described their clients in ways that conveyed deep caring and profound. Despite the challenges they faced, every practitioner remained steadfast in resolving the crises. The crisis narratives contained considerable evidence of the resilience that survivors experience—insight, initiative, creativity, and morality (Echterling, Presbury, & McKee, 2005; Wolin & Wolin, 1993).

In complex and emotionally charged situations, the participants were insightful, creative, and determined. As mentioned earlier, crisis intervention was not a rare occurrence for these participants; in fact, it was a common denominator in counseling regardless of the work setting. In the face of crisis, counselors were skillful and courageous. Participants eloquently described the rewards of crisis counseling—enhanced interpersonal relationships, increased proficiency in crisis services, and heightened self-efficacy. The data support the concept of vicarious resilience, whereby counselors are empowered by clients who overcome adversity (Hernández, Gangsei, &

المنارة للاستشارات
www.manaraa.com

Engstrom, 2007). Furthermore, the counselors' narratives also support theories about posttraumatic growth (Tedeschi, Park, & Calhoun, 1995) and posttraumatic success (O'Hanlon, 1999).

Counselors also described negative outcomes of crisis counseling, experiences that were particularly challenging and upsetting. Negative outcomes included high levels of stress, difficult counter-transference reactions, vicarious trauma, and symptoms of acute and post-traumatic stress disorder. In some cases, crisis counseling was experienced as destabilizing for the counselor.

Participants understood crisis counseling as highly stressful for four main reasons. First, it exposed counselors to shocking and violent behavior. Second, client crisis was typically not confined to a single counseling interlude; in fact, it was ongoing and not easily resolved. Third, these chaotic situations involved many people and multiple systems (families, schools, hospitals, law enforcement agencies) that were also under duress. Finally, throughout crises, counselors had to manage the unfolding events while simultaneously dealing with their own feelings and counter-transference reactions.

The understanding of crisis as stressful was intertwined with the idea of crisis as an extraordinarily complex phenomenon. Elements of complexity intensified the pressure associated with crisis counseling. In volatile clinical situations, helping professionals had to manage multiple roles within complicated and dynamic systems.

In summary, the third emergent theme depicted the impact of crisis counseling on the helping professional. Counselors reported positive and negative outcomes from working with clients in the midst of a mental health emergency. Crisis response, while dangerous and stressful, also provided abundant opportunities for growth. Despite the

المنارة للاستشارات
www.manaraa.com

challenges inherent in crisis counseling, participants found meaning and satisfaction in helping clients in acute distress.

The findings relative to the impact of crisis work on the counselor expand our knowledge in several important ways. First, crisis is a parallel process—it impacts the client and counselor simultaneously. In the midst of crisis, counselors in this study experienced a host of outcomes that mirrored the clients' responses. These consequences included powerful emotions (including shock, fear, powerlessness, and anger) and symptoms of acute and posttraumatic stress disorder. Second, the understanding of crisis as both danger and decisive moment (Echterling, Presbury, & McKee, 2005) is relevant not only for clients, but also for counselors. Third, strategies for enhancing resilience and promoting posttraumatic growth in survivors can be used to support and protect crisis counselors.

These ideas have important implications for counseling and supervision. Traditionally, the focus of the crisis intervention literature has been on the needs of clients in distress. The findings from this study suggest that immediately following crises, counselors also require opportunities to process their own emotions. Crisis supervision must incorporate strategies to explore affective reactions and promote crisis resolution of supervisees. Specific techniques used with crisis survivors may be especially helpful in supervision, including offering the "LUV Triangle—listen, understand, and validate" (Echterling, Presbury, & McKee, 2005, p. 17), and promoting pathways to resilience—making contact, making meaning, managing emotions, and taking action (Echterling & Stewart, 2008). Additionally, creative crisis interventions—play, dancing, drawing, and making music can be powerful vehicles for engaging supervisees in experiences that

المنارة للاستشارات
www.manaraa.com

facilitate post-crisis recovery. Crisis supervision is discussed in more detail in the next section.

Findings about the impact of crisis work also have significant implications for counselor education. In order to prepare counselors-in-training to effectively intervene during crises, several issues need to be addressed. First, since crises are parallel processes, not only do they cause disequilibrium in the client, they provoke instability in the helper. Second, because there is the potential for serious negative effects from crisis counseling, self-care strategies are essential. Counselor educators play an important role in fostering the development of these skills by promoting, practicing, and modeling self-care themselves. Third, crisis work is intense and the stakes are high. At the same time, these highly distressing situations provide opportunities for positive outcomes for the client and counselor. Counselor educators can help students to recognize the opportunities that crises present for post-traumatic growth. Finally, findings from this study indicate that as counselors gain experience in crisis intervention, their self-efficacy increases. Therefore, students would benefit from opportunities to shadow emergency services clinicians, home-based counselors, and other professionals working in settings where crises commonly occur.

Crisis supervision. The fourth emergent theme focused on the counselors' experience of supervision in the midst of client crises. Every participant considered crisis supervision to be absolutely essential. The counselors, keenly aware of their personal supervision needs and preferences, articulated both without hesitation. This finding is intriguing because many participants had not received clinical supervision in years. Within the data, there is a clear distinction between administrative (record keeping,

المنارة للاستشارات
www.manaraa.com

scheduling, performance management) and clinical supervision (talking about clients, expressing emotions, processing counter-transference reactions). Participants wanted *clinical* supervisors who were "intensely available" and there "on the fly" to help them navigate crises.

The data revealed an unambiguous image of the effective supervisor as a guide, witness, and role model. The professional counselors longed for a supervisor who would shepherd them through crisis situations. Participants used phrases to describe the guiding function of crisis supervision such as "walk through stuff with me," "help me figure it out," and "help me not get sucked in."

The counselors expressed a need to be seen and validated by a more experienced mentor. The role of the witness in crisis situations was understood in many ways, "listen to my story," "look back with me," and "validate me." Additionally, participants felt it was critical to have a crisis supervisor who was a dynamic role model—clinically astute and self- revealing. As role models, supervisors help by normalizing crisis reactions, offering advice, and instilling hope.

The essentiality of supervision was also understood in terms of providing a framework for exploring ethical issues (self-disclosure, confidentiality, dual relationships and professional boundaries), enhancing professional identity, increasing self-efficacy, and promoting growth. While clinical supervision was seen as essential in crisis counseling, only eight counselors were receiving it. The lack of supervision left counselors feeling anxious, inadequate, and isolated.

Crisis supervision was characterized as not only vital for providing effective crisis services during these intensive circumstances, but also helpful to the counselor's overall

المنارة للاستشارات
www.manaraa.com

professional development. Two elements of helpful crisis supervision emerged from the data analysis—seven process components and qualities of the helpful crisis supervisor. The process components of helpful crisis supervision are: direct, immediate, and concrete feedback; clear guidance; structure; timely de-briefing; focused discussion about counter-transference reactions; concrete resources; and hands-on assistance.

In addition to the seven process components, helpful supervision also entailed specific qualities of the crisis supervisor. The ideal crisis supervisor is accessible, dependable, direct, deliberate, and affirming. The crisis supervisor is a good role model and shares personal stories about navigating crises. This mentor is insightful, sees where counselors are "getting caught up" in client dynamics, and provides direct feedback. Additional characteristics of helpful crisis supervisors include optimism, flexibility, calmness, objectivity, and cultural competency. Counselors preferred supervisors with equal or superior credentialing. Finally, helpful supervisors believe that counseling works, keeps supervision time sacred, and protects supervisees.

In summary, the third main category of findings depicts crisis supervision as situationally essential, generally helpful, and potentially harmful. Study participants understood clinical supervision to be critical in crisis counseling. Every licensed clinician wanted a supervisor to "hold their stuff" and help them to grow. The frequency and quality of crisis supervision varied greatly. Less than half of the participants received consistent and helpful clinical guidance from licensed professional counselors. In some cases, clinical supervision was not available. At other times, the supervision itself was traumatic and provoked a crisis for the counselor.

These findings have important implications for counselors and supervisors. To

المنارة للاستشارات
www.manaraa.com

begin with, helping professionals enter the field for altruistic reasons, including the desire to help others and to make a positive difference in the world. However, the innate capacity for empathy, in combination with repeated exposure to troubling events, males for a dangerous combination that can lead to a host of defensive reactions. In the midst of crisis, counselors may over-identify with clients or assume inordinate amounts of responsibility for fixing chronic and complicated situations. Crisis supervision can help counselors to manage these difficult counter-transference reactions and maintain the empathetic stance. Experienced counselors want and need supervisors to help them identify the ways they become emotionally drawn into the crises. To facilitate this process of self-reflection, supervisors must create a safe environment for telling the crisis counseling story. Incorporating projective methods and techniques (such as mandala drawing, sand tray work, and dramatherapy) into supervision can help counselors express feelings that are difficult to verbalize.

The data from this study reveal several disturbing realities in the counseling field. First, despite compelling evidence that crises are ubiquitous and hazardous, many counselors do not receive supervision. Second, not only do mental health practitioners respond to crises without guidance and support, professionals are traumatized by the supervision experience itself. Third, counselors believe that there are no mechanisms in place to safeguard them against the mistreatment they experience in supervision.

These findings have important implications for counselor education programs. Crisis coursework must emphasize the essentiality of clinical supervision. Conversely, supervision courses must address the specific needs and strategies of crisis supervision. Program faculty and internship supervisors have a responsibility to prepare and supervise

المنارة للاستشارات
www.manaraa.com

students and counseling residents in crisis response. Furthermore, counselor educators have an important role to play in advocating for post-licensure clinical supervision.

A final implication of the crisis supervision findings concerns the professional literature. As mentioned in Chapter Two, developmental models of supervision dominate the field. These models apply developmental theory to counselors and supervisors, identifying distinct stages of professional growth that occur in sequential order. The most frequently cited developmental model is the Integrated Developmental Model (IDM) proposed by Stoltenberg, McNeil, and Delworth (1998). This model is based on two assumptions that are relevant to this inquiry. The first supposition is that as supervisees gain experience, their confidence increases while their need for supervisory approval decreases. Second, progressing through discrete developmental stages, supervisees need less structure and direction.

The results from this study challenge these assumptions and suggest that developmental models may not be widely applicable. In this study, seasoned professional counselors, who had one to 22 years of post-licensure experience, still wanted direct feedback and structure in supervision. Participants unanimously agreed that during crises, it is helpful for the supervisor to be directive and clear; moreover, structured supervision provides an important function—it organizes the debriefing process, promoting crisis resolution. Given these findings, the need for structure in supervision may be mediated by contextual variables such as crisis versus non-crisis situations. Developmental approaches to supervision may not be helpful in times of crisis.

Results from this study strongly support the Attachment-Caregiving Model of Supervision (ACMS) developed by Fitch, Pistole, and Gunn (2010) and suggest that it

المنارة للاستشارات
www.manaraa.com

may a useful framework for understanding crisis supervision. While participants did not describe supervision using attachment constructs, they talked repeatedly about wanting a supervisor to "hold my stuff," "hold me in my vulnerabilities," and "hold that space for me." Counselors provided eloquent descriptions of the supervisor-supervisee relationship, "It's kind of like parenthood," "I'm part of the flock." One participant jokingly wished for supervision where, "I tell you the hard stuff, and then you take me out to lunch." The narratives captured the essence of the secure base and safe haven functions in supervision. Furthermore, the process components of helpful supervision and qualities of a helpful supervisor that emerged from this study are consistent with the essential supervisory characteristics and behaviors that contribute to the formation of a secure base (Pistole & Fitch, 1995).

Clinical supervision. The final theme reflected in the data is the importance of clinical supervision for counselors throughout their professional lives. Participants unanimously agreed that, although regulations governing the profession do not require post-licensure supervision, it is beneficial and necessary. The counselors identified three troubling assumptions at the heart of their profession. First, since post-licensure supervision is not required, competent practitioners do not need it. Second, the need or desire for post-licensure clinical supervision is seen as a sign of weakness or counselor incompetence. Third, counselors desirous of post licensure supervision have unrealistic expectations.

The majority of counselors in this study internalized the belief that post-licensure supervision is "too much to expect." Participants understood clinical supervision to be a matter of luck, rather than a right that all counselors have. Despite their understanding

المنارة للاستشارات
www.manaraa.com

that supervision is usually not available for licensed counselors, participants yearned for it. Three primary reasons for wanting post-licensure supervision were identified—grow professionally, practice ethically, and connect with other counselors.

The data reflect another significant concern about post-licensure supervision. Professional counselors have significantly different experiences in supervision than counselor trainees and residents-in-counseling. One key difference, which has been discussed at length, relates to the availability of supervision. Licensed professionals do not have consistent access to supervision. A second critical distinction concerns the structure and content of the supervision received. Before counselors are licensed, supervision from faculty members and training site supervisors is more clinically focused and organized. CACREP standards and licensing regulations require supervision contracts that structure the experience in important ways. Prior to supervision, counselors are informed of two important ethical concerns: due process and informed consent. As Bernard and Goodyear (2009) astutely observed, these practices safeguard the counselor: "Simply put, the surprises in store for the supervisee should be due to the learning process itself and the complexity of human problems, not to oversights on the part of the supervisor" (p. 56). Additionally, contracts identify goals, objectives, and strategies that guide the supervision process. The data from this study suggest that post-licensure supervision occurs in the absence of contractual agreements. While several counselors stated that they "could not remember" talking about ethical issues in supervision, the majority emphatically stated that these conversations never took place. Furthermore, although most participants had a detailed job description, no one had a current supervision contract in place.

المنارة للاستشارات
www.manaraa.com

The third important difference between pre- and post-licensure supervision concerns the content of the sessions. Counselor trainees and residents typically receive supervision that is clinically focused. However, once practitioners in the field become licensed, the emphasis in supervision shifts to administrative tasks such as scheduling and documentation. The transition may be predicated on the practice of assigning supervisors multiple and conflicting roles, which is common in community counseling agencies. This practice undermines the supervisory relationship. Furthermore, it deprives counselors of vital clinical support. This finding suggests that post-licensure supervision would be more effective if administrative and clinical functions were independently assigned.

The counselors also commented on the different supervision modalities and methods utilized during pre- and post-licensure supervision. Counselor education programs rely on direct observation—watching counselors in action via videotape review, live supervision, and role-playing. However, evaluation of the counseling effectiveness of residents and licensed practitioners relies primarily on self-report and chart reviews, which are notoriously unreliable (Hipple & Beamish, 2007).

The implications of these findings are clear—we must change the culture of the counseling profession to value clinical supervision as a necessity and a right. While licensed professionals in the United States are permitted to work without clinical supervision, this is not the case in other countries (Bernard & Goodyear, 2009). Mental health professionals in the United Kingdom, for example, are required to receive supervision throughout their careers. According to the British Association for Counselling and Psychotherapy's ethical code (BACP, 2007), "Regular monitoring and reviewing of one's work is essential to maintaining good practice" (p. 5). However in this

المنارة للاستشارات
www.manaraa.com

country, once counselors are licensed, they are considered independent practitioners and are permitted to work without any oversight whatsoever.

Postgraduate credentialed practitioners, including the counselors in this study, want clinical supervision even if it is not required. Not only is post-licensure clinical supervision critical for ensuring the welfare of clients, it serves important protective and restorative functions as well. Supervision is a safeguard against professional isolation and burnout, and also a vehicle for promoting resilience.

Counselor educators must assess their role in supporting program graduates who are practicing in the field. It is commonly assumed that when a student graduates, the burden of training and support shifts to the community. However professional counselors frequently do not receive the ongoing assistance or support they need. Counseling faculty members have an obligation to advocate on behalf of licensed practitioners to ensure their health and well-being.

Future Research Recommendations

This study generated a wealth of data in a number of key areas. Five major themes emerged, representing participants' understanding of crisis, crisis counseling, crisis supervision, and clinical supervision. The findings fill a number of major gaps in the professional literature. There are many opportunities for continuing this line of research. While the current results provided rich information relative to the primary phenomenon of interest, it also generated a host of new and fascinating questions.

As a follow-up to this study, I will revisit the data. First, I will explore the relationships between and among categories, themes, and idea clusters. Next, I will attempt to develop a model using NVivo 9® to more clearly understand the process

المنارة للاستشارات
www.manaraa.com

components of helpful supervision. Second, I will interrogate the data to answer questions relative to the influence of gender on the experience of crisis and crisis supervision, as well as its impact on the data collection and analysis procedures.

As mentioned throughout this dissertation, previous research has not explored the supervision needs or experiences of professional counselors in their careers following licensure. During the interviews, I was struck both by the passion and commitment that professional counselors bring to their work, and the absence of their voices in the literature. It is my hope that the current investigation will serve as a springboard for future research in a number of important areas.

Additional studies exploring similar phenomena are clearly needed. Future research, employing a variety of methodological approaches would lead to a better understanding of field-based supervision. Studies utilizing grounded theory, for example, would be useful in developing a model, or unifying framework, for crisis supervision. A mixed methods design could be employed to gather both quantitative and qualitative data. For example, to examine counselors' perception of helpful supervision, a survey could be sent to a sample of participants drawn from the population of licensed professional counselors in Virginia. Qualitative interviews or focus groups could be conducted simultaneously. This approach may provide a more complete picture of post-licensure supervision.

To capture a broader perspective of crisis supervision, future studies could be conducted utilizing different participant selection criteria. For example, licensed professional counselors from other geographical regions could be included in the sample.

المنارة للاستشارات
www.manaraa.com

The inquiry could also be replicated with counseling trainees and residents to explore the supervision needs of less experienced and emerging counselors.

The present investigation highlighted significant gaps in the literature, which provide abundant opportunities for future research. Three areas appear especially pertinent and rich. First, results demonstrated that counselors are resilient and experience post-traumatic growth following their experiences of providing crisis services. While scholars described distinct types of resilience and pathways to resilience, vicarious resilience is a relatively new concept (Echterling, Presbury, & McKee, 2005; Hernández, Engstrom, & Gangsei, 2010; Wolin & Wolin, 1993). Research is needed to uncover and interpret the phenomenon of counselor resilience during client crises. Future studies could focus on identifying the key factors that mediate this process.

The second important area of research is the application of attachment theory to supervision. Fitch, Pistole, and Gunn (2010) developed a compelling argument for the Attachment-Caregiving Model of Supervision. Crisis situations, characterized by chaos and uncertainty may activate the supervisee's attachment system. The supervisor's response is critical at these times to restore the supervisee's equilibrium. While this model may be useful in conceptualizing the process of crisis supervision, it is not yet supported by research.

The use of play therapy techniques in supervision is the third area in which research is needed. Creative expression in many forms—playing, drawing, dancing, singing, sculpting, and making music—have been successfully incorporated into crisis intervention and trauma counseling (Echterling & Stewart, 2008). Stewart described the utility of play therapy techniques for clinical supervision (personal communication,

المنارة للاستشارات
www.manaraa.com

May 17, 2011). Dupré, Stewart, and Echterling (2011) combined the core ingredients of resilience, attachment theory, play therapy, crisis intervention, and self care to develop a new model for crisis supervision. This approach has been used effectively in clinical settings and delivered in workshop format. Research is needed to demonstrate the model's utility in crisis supervision practice.

Chapter Summary

This chapter brought the investigation of crisis supervision to a close. The chapter began with an exploration of the methodological considerations, potential limitations, and challenges, followed by a summary of the findings. Next, the chapter explored important implications of these results for counselors, supervisors, and counselor educators. The chapter concluded with recommendations for future research.

المنارة للاستشارات
www.manaraa.com

Appendix A

Demographic Questionnaire

1. Primary Job Location (Name of city and/or county): _____
2. Gender: ____ Female _____ Male _____ Other (Please specify): _____
3. Age (in years): _____
4. Racial/Ethnic Background:

   ___ African-American
   ___ Caucasian
   ___ Hispanic
   ___ Asian
   ___ Bi-Racial/Multicultural
   ___ Other (Please specify): _____

5. Licensed as a Licensed Professional Counselor in Virginia: ___ Yes ___ No
6. License expiration date (Licensed Professional Counselor only): _____
7. Current employment status:

   ___ Full-time
   ___ Part-time
   ___ Per diem/Fee for service

8. Describe your primary work setting:

   ___ Community Services Board (CSB)
   ___ Private counseling agency/program
   ___ Private practice
   ___ Hospital/inpatient program
   ___ Criminal justice/corrections/probation
   ___ School
   ___ Other (please specify): _____

9. On average, what percentage of your work time is spent providing direct, face-to-face counseling services to clients?
   ___ Less than 25% ___ 25% to 49% ___ 50% or more

10. On average, how often do you meet with a supervisor for clinical (not administrative) supervision?
    ___ At least weekly___ Every 2 weeks___ 1 x month ___ Less than once a month ___ Rarely

11. Overall, how would you rate the clinical supervision that you have received since you completed your graduate degree?
    ___ Poor ___ Fair ___ Good ___ Very good ___Excellent

12. Overall, how would you rate the clinical supervision that you received when you were working with clients in the midst of a crisis or mental health emergency?
    ___ Poor ___ Fair ___ Good ___ Very good ___Excellent

المنارة للاستشارات
www.manaraa.com

Appendix B

JAMES MADISON UNIVERSITY.

SPONSORED PROGRAMS ADMINISTRATION

MEMORANDUM

TO: Ms. Madeleine Dupre, Principal Investigator

FROM: Carolyn Strong, IRB Research Coordinator CS

DATE: August 24, 2011

RE: Human Research Protocol Approval

The Human Subject Research protocol entitled, "*Crisis Supervision: Promoting Counselor Resilience*" has been approved by James Madison University's Institutional Review Board (IRB). A signed copy of the Action of the Board form is enclosed for your records. Your research protocol has been assigned the ID Number 12-0060.

As a condition of the IRB approval, your protocol is subject to annual review. Therefore, you are required to complete a follow-up report before your project end date. You *must* complete the follow-up report regardless of whether you intend to continue the project for another year. For your convenience, a hard copy is enclosed. An electronic copy of the follow-up report form can be found on the Sponsored Programs Administration web site at the following URL: http://www.jmu.edu/sponsprog/allforms.html#IRBform.

You are reminded that any changes in your protocol that affects human subjects must be submitted to the IRB for approval *before* implementing new procedures. This requirement applies to changes in subjects, equipment, procedures, investigators, survey tools, and location of the data collection site. Also, should any adverse events occur during your study, you are required to *immediately* notify Carolyn Strong, IRB Research Coordinator. To avoid confusion, please use the assigned protocol number when communicating with the IRB Research Coordinator about your project.

Federal Guidelines stipulate that you are required to keep a copy of your approved human subjects' protocol, including the approved informed consent form and site letter of permission, for at least three years after completion of your research. The protocol must be accessible for inspection and copying by authorized representatives of the department or agency supporting or conducting the research at reasonable times and in a reasonable manner. Please let me know if you need additional assistance or further clarification.

From the desk of...
Carolyn Strong, CIM
IRB Research Coordinator
Sponsored Programs Administration
James Madison University
JMAC Building 6, Suite 26, MSC 5728
Harrisonburg, VA 22807

strongcd@jmu.edu
Phone: 540-568-2318
Fax: 540-568-6240

Cc: Dr. Lennis Echterling, Department of Graduate Psychology

المنارة للاستشارات
www.manaraa.com

Appendix C

Crisis Supervision: Promoting Counselor Resilience

E-MAIL SUBJECT LINE: Supervision Research Project Assistance Requested

As a Licensed Professional Counselor (LPC) and current doctoral student, I am writing to invite you to participate in a research project that I am conducting with Dr. Lennis G. Echterling from James Madison University. This study will examine the crisis supervision needs and experiences of LPCs in Virginia. The primary question guiding the inquiry is: ***What are the supervision needs and experiences of licensed professional counselors working with clients in the midst of a crisis or mental health emergency?***

I am conducting this research in partial fulfillment of the requirements for the Ph.D. in Counseling and Supervision and to make a contribution to the field of counselor education and supervision. The intended participants are LPCs whose primary current job responsibility is to provide direct, face-to-face counseling services. Inclusion criteria include: active license to practice as an LPC in Virginia, full-time employment in a counseling position, desire and ability to participate in the study, willingness to be interviewed and tape recorded (audio).

My study has been approved by the James Madison University Institutional Review Board (Protocol # _____). Participation includes receiving an overview of the project, discussing questions about the study, reviewing and returning a consent form, completing a brief demographic questionnaire via e-mail, and participating in two interviews lasting approximately one hour each, scheduled one to three months apart.

Upon completion of the study, participants will be eligible to receive a complimentary two-hour ethics training.

If you are interested in participating in this study, or need more information, please contact me via e-mail at duprema@jmu.edu.

Thank you very much.

Madeleine Dupré, LPC, LSATP, ACS
James Madison University
Ph.D. Program in Counseling and Supervision

المنارة للاستشارات
www.manaraa.com

Appendix D

Consent to Participate in Research

Identification of Investigators & Purpose of Study

You are being asked to participate in a research study conducted by Madeleine Dupré from James Madison University, under the supervision of Dr. Lennis Echterling. The purpose of this study is to illuminate the supervision needs and experiences of Licensed Professional Counselors in Virginia working with clients in the midst of a crisis or mental health emergency. The primary question guiding the inquiry is*: What are the supervision needs and experiences of licensed professional counselors working with clients in the midst of a crisis or mental health emergency?* I am conducting this research in partial fulfillment of the requirements for the Ph.D. in Counseling and Supervision and to make a contribution to my field of study. The primary objectives of this research are:

1. Illuminate the supervision needs and experiences of licensed professional counselors in Virginia working with clients in crisis
2. Identify common themes in crisis supervision
3. Identify supervisory attitudes and practices that promote counselor resilience
4. Translate these findings into recommendations for crisis supervision practice.

Research Procedures

Should you decide to participate in this research study, you will be asked to sign this consent form once all your questions have been answered to your satisfaction. This study consists of a demographic questionnaire and two approximately sixty-minute interviews approximately one to three months apart. Interviews will be conducted face-to-face either in person via voice and video calling technology such as Skype. You will be asked to provide answers to a series of open-ended questions related to a previous experience of crisis counseling and counselor supervision. It will be your choice to decide upon a particular experience to discuss. Interviews will be audio-recorded with your permission. Tapes will be transcribed by a paid transcriptionist who has been trained to respect confidentiality and to follow ethical practices. All identifying information will be removed from the transcript. Quotes from the transcript may be used in the report to demonstrate themes. Any quotes used in the report will not contain any identifiable information. Your identity will not be disclosed. The recording will be stored in a locked cabinet in the investigator's home office. The recordings will be destroyed upon completion of the study. Upon your request, the investigator will provide copies of the transcripts from your interviews and a summary of the results.

المنارة للاستشارات
www.manaraa.com

Time Required

Participation in this study will require the completion of a brief demographic questionnaire and two separate interviews lasting approximately 60 minutes each.

Risks

The investigator does not perceive more than minimal risks from your involvement in this study.
You may have emotional reactions to the material that is elicited. Your participation is voluntary and you may withdraw from the study at any time without consequences of any kind. You may also skip questions during the interviews. Dr. Lennis Echterling, faculty advisor for this project, will be available to participants for supportive debriefing as needed. He has more than 30 years of experience in crisis response.

Benefits

By participating in this study, you may develop a deeper understanding of your supervision needs and experiences when working with clients in crisis. Another potential benefit is that you may become more aware of the needs of your own supervisees in crisis situations. Upon completion of both rounds of interviews, participants will be eligible to receive a complimentary two-hour ethics training that will fulfill licensing regulations set forth by the Board of Counseling, Virginia Department of Health Professionals.

Confidentiality

No personal identifying information about any participant will be released. Names and addresses will be removed from the demographic data form and will be replaced with an identifier code for data transcription and analysis. The researcher reserves the right to use and publish non-identifiable data. The results of this investigation will be presented at James Madison University's Department of Graduate Psychology Student Symposium in Research and Practice (April, 2012), professional conferences, and in classroom presentations. While individual responses are confidential, aggregate data will be presented representing averages or generalizations about the responses as a whole. All identifying information will be removed from the transcript. Quotes from the transcripts may be used in the report to demonstrate themes. Any quotes used in the report will not contain any identifiable information. All data will be stored in a secure location accessible only to the researcher. Upon completion of the study, all information that matches up individual respondents with their answers, including audio-tapes, will be destroyed.

There are limits to confidentiality, including the disclosure of abuse or injury to a child or dependent adult, or threat of harm to self or others. When this information is shared with the principal investigator, she will be required by law to make a report to the appropriate authorities.

المنارة للاستشارات
www.manaraa.com

Participation & Withdrawal

Your participation is entirely voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of any kind.

Questions about the Study

If you have questions or concerns during the time of your participation in this study, or after its completion or you would like to receive a copy of the final aggregate results of this study, please contact:

Researcher:

Madeleine Dupré

Department of Grad Psychology

James Madison University

Dupréma@jmu.edu

Academic Advisor:

Dr. Lennis Echterling

Department of Grad Psychology

James Madison University

Telephone: (540) 568-6522

echterlg@jmu.edu

Questions about Your Rights as a Research Subject

Dr. David Cockley

Chair, Institutional Review Board

James Madison University

(540) 568-2834

cocklede@jmu.edu

Giving of Consent

I have read this consent form and I understand what is being requested of me as a participant in this study. I freely consent to participate. I have been given satisfactory answers to my questions. The investigator provided me with a copy of this form. I certify that I am at least 18 years of age.

☐ I give consent to be audio-taped during my interview. _____ (initials)

المنارة للاستشارات

www.manaraa.com

_____ _____

Name of Participant (Printed) Date

_____ _____

Name of Participant (Signed) Date

_____ _____

Name of Researcher (Signed) Date

المنارة للاستشارات

www.manaraa.com

Appendix E

"Web" / "E-mail" Consent to Participate in Research

Identification of Investigators & Purpose of Study

You are being asked to participate in a research study conducted by Madeleine Dupré from James Madison University, under the supervision of Dr. Lennis Echterling. The purpose of this study is to illuminate the supervision needs and experiences of Licensed Professional Counselors in Virginia working with clients in the midst of a crisis or mental health emergency. The primary question guiding the inquiry is*: What are the supervision needs and experiences of licensed professional counselors working with clients in the midst of a crisis or mental health emergency?* I am conducting this research in partial fulfillment of the requirements for the Ph.D. in Counseling and Supervision and to make a contribution to my field of study. The primary objectives of this research are:

1. Illuminate the supervision needs and experiences of licensed professional counselors in Virginia working with clients in crisis
2. Identify common themes in crisis supervision
3. Identify supervisory attitudes and practices that promote counselor resilience
4. Translate these findings into recommendations for crisis supervision practice.

Research Procedures

Should you decide to participate in this research study, you will be asked to return this consent form with an e-mailed acknowledgement of your consent once all your questions have been answered to your satisfaction. This study consists of a demographic questionnaire (sent via e-mail) and two approximately sixty-minute interviews roughly one to three months apart. Interviews will be conducted face-to-face either in person or via voice and video calling technology such as Skype. You will be asked to provide answers to a series of open-ended questions related to a previous experience of crisis counseling and counselor supervision. It will be your choice to decide upon a particular experience to discuss. Interviews will be audio-taped with your permission. Tapes will be transcribed by a paid transcriptionist who has been trained to respect confidentiality and to follow ethical practices. All identifying information will be removed from the transcript. Quotes from the transcript may be used in the report to demonstrate themes. Any quotes used in the report will not contain any identifiable information. Your identity will not be disclosed. The recording will be stored in a locked cabinet in the investigator's home office. The recordings will be destroyed upon completion of the study. Upon your request, the investigator will provide copies of the transcripts from your interviews and a summary of the results.

المنارة للاستشارات
www.manaraa.com

Time Required

Participation in this study will require the completion of a brief demographic questionnaire and two separate interviews lasting approximately 60 minutes each.

Risks

The investigator does not perceive more than minimal risks from your involvement in this study.
You may have emotional reactions to the material that is elicited. Your participation is voluntary and you may withdraw from the study at any time without consequences of any kind. You may also skip questions during the interviews. Dr. Lennis Echterling, faculty advisor for this project, will be available to participants for supportive debriefing as needed. He has more than 30 years of experience in crisis response.

Benefits

By participating in this study, you may develop a deeper understanding of your supervision needs and experiences when working with clients in crisis. Another potential benefit is that you may become more aware of the needs of your own supervisees in crisis situations. Upon completion of both rounds of interviews, participants will be eligible to receive a complimentary two-hour ethics training that will fulfill licensing regulations set forth by the Board of Counseling, Virginia Department of Health Professionals.

Confidentiality

No personal identifying information about any participant will be released. Names and addresses will be removed from the demographic data form and will be replaced with an identifier code for data transcription and analysis. The researcher reserves the right to use and publish non-identifiable data. The results of this investigation will be presented at James Madison University's Department of Graduate Psychology Student Symposium in Research and Practice (April, 2012), professional conferences, and in classroom presentations. While individual responses are confidential, aggregate data will be presented representing averages or generalizations about the responses as a whole. All identifying information will be removed from the transcript. Quotes from the transcripts may be used in the report to demonstrate themes. Any quotes used in the report will not contain any identifiable information. All data will be stored in a secure location accessible only to the researcher. Upon completion of the study, all information that matches up individual respondents with their answers, including audio-tapes, will be destroyed.

There are limits to confidentiality, including the disclosure of abuse or injury to a child or dependent adult, or threat of harm to self or others. When this information is shared with the principal investigator, she will be required by law to make a report to the appropriate authorities.

المنارة للاستشارات
www.manaraa.com

Participation & Withdrawal

Your participation is entirely voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of any kind.

Questions about the Study

If you have questions or concerns during the time of your participation in this study, or after its completion or you would like to receive a copy of the final aggregate results of this study, please contact:

Researcher:

Madeleine Dupré

Department of Grad Psychology

James Madison University

duprema@jmu.edu

Academic Advisor:

Dr. Lennis Echterling

Department of Grad Psychology

James Madison University

Telephone: (540) 568-6522

echterlg@jmu.edu

Questions about Your Rights as a Research Subject

Dr. David Cockley

Chair, Institutional Review Board

James Madison University

(540) 568-2834

cocklede@jmu.edu

Giving of Consent

I have read this consent form and I understand what is being requested of me as a participant in this study. I freely consent to participate. I have been given satisfactory answers to my questions. The investigator provided me with a copy of this form. I certify that I am at least 18 years of age. By e-mailing this form with an acknowledgement of consent to duprema@jmu.edu, I am consenting to participate in this research and to be audio-taped during my interview.

☐ I give consent to be audio-taped during my interview.

___Madeleine A. Dupré_____

Name of Researcher (Printed)

المنارة للاستشارات

www.manaraa.com

Appendix F

Semi-structured Interview: Round One

Background Information:

Research Topic: Counselors' supervision experience in the context of client crisis

Research question: What are the supervision needs and experiences of licensed professional counselors working with clients in the midst of a crisis or mental health emergency?

Introduction: I am interested in the process of counselor supervision in the context of client crisis. I am using the word "crisis" to denote a state of intense emotion when a great deal seemed to be at stake. It may not have necessarily been a time when a client was actively suicidal or homicidal but it was a time during which the client was experiencing much distress and there was the potential for serious, negative consequences. I would like you to recall a time in your career when you were working with a client who was in crisis. For the purpose of this interview, please identify a crisis event that occurred after you received your graduate counseling degree and that you would feel comfortable sharing with me.

Questions:

1. Describe the situation in as much detail as possible.
2. Describe your reactions to this situation.
3. Describe the steps that you took to manage or resolve the crisis.
4. Describe the impact of this situation on you professionally and personally.
5. What lessons did you learn from the experience?
6. Describe the supervision that you typically received in the time period that this event occurred.

المنارة للاستشارات
www.manaraa.com

7. Describe the supervision that you received specifically related to this crisis situation.
    a. What elements of this supervision are especially memorable?
    b. As you look back now, what may have been missing that you had expected or hoped for in supervision?
8. As you reflect on the supervision that you received specifically related to this crisis event, please comment on the impact (if any) it had on your ability to:
    a. Manage your emotions
    b. Assist the client in managing the crisis
    c. Make meaning of the crisis event
    d. Process the experience.
9. Please describe the personal and professional growth that you may have experienced as a result of your experience with supervision during this crisis.
10. What suggestions do you have for supervisors working with counselors who have clients in crisis?
11. Is there anything else that you would like to say about supervision in general or about crisis supervision specifically?
12. What has it been like to talk about your experience with supervision?

Thank you.

المنارة للاستشارات
www.manaraa.com

Appendix G

Semi-structured Interview: Round Two

Background Information:

Research Topic: Counselors' supervision experience in the context of client crisis

Research question: What are the supervision needs and experiences of licensed professional counselors working with clients in the midst of a crisis or mental health emergency?

Introduction: I am interested in the process of counselor supervision in the context of client crisis. I am using the word "crisis" to denote a state of intense emotion when a great deal seemed to be at stake. It may not have necessarily been a time when a client was actively suicidal or homicidal but it was a time during which the client was experiencing much distress and there was the potential for serious, negative consequences.

During our last interview, I asked you to recall a time in your career when you were working with a client who was in crisis. I asked you a series of questions about your supervision experience during that time. I have conducted similar interviews with other LPCs in Virginia. Data from the interviews in round one were analyzed to uncover and interpret crisis supervision experiences and identify supervision themes. During this second interview, I will present these themes to you for further reflection, clarification, reconsideration, modification, and possible disagreement.

Questions:

1. As you look back on our first interview, is there anything that stands out in your mind?
2. Is there anything that you would like to add to our previous discussion about crisis supervision?
3. Is there anything that you would like to ask me at this point?
4. During our first interview, you described your supervision needs and experiences when working with clients in the midst of a crisis or mental health emergency. Can you say more about:

المنارة للاستشارات
www.manaraa.com

   a. (specific theme identified during data analysis)
   b. (specific theme identified during data analysis)
   c. (specific theme identified during data analysis)

5. Additional themes emerged from the data analysis of all interviews conducted during the first round. I'm curious about your views concerning:
   a. (specific theme identified during data analysis)
   b. (specific theme identified during data analysis)
   c. (specific theme identified during data analysis)
6. What do you think are the most important elements of crisis supervision?
7. I would like to know if and how your views and/ or actions related to supervision have changed since you joined this study.
8. What advice would you give to supervisors about crisis supervisor?
   a. What advice would you give to supervisees about crisis supervision?
9. Is there anything else that you think I should know to understand the needs and experiences of LPCs working with clients in the midst of a crisis or mental health emergency?
10. Is there anything else that you would like to ask me?

Thank you.

المنارة للاستشارات
www.manaraa.com

References

Aguilera, D. C. (1998). *Crisis intervention: Theory and methodology* (8th ed.). St. Louis, MO: Mosby.

American Association of Suicidology. (2010). *Suicide in the USA based on current statistics*. Retrieved from http://www.suicidology.org

American Counseling Association. (1990). Standards for counseling supervisors. *Journal of Counseling and Development, 69*, 30-32.

American Counseling Association. (2005). *ACA code of ethics*. Retrieved from http://www.counseling.org

American Counseling Association. (2011). *Who are licensed professional counselors?* Retrieved from http://www.counseling.org/PublicPolicy/WhoAreLPCs.pdf

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Barnes, L. S., Ikeda, R.M., & Kresnow, M. J. (2001). Help-seeking behavior prior to nearly lethal suicide attempts. *Suicide & Life-Threatening Behavior, 32(supplement),* 68-75.

Berg, I. K. (1994). *Family-based services: A solution-focused approach*. New York, NY: W.W. Norton.

Berg, B. L. (2001). *Qualitative research methods for the social sciences* (4th ed.). Boston, MA: Allyn & Bacon.

Bernard, J. M., & Goodyear, R. K. (2009). *Fundamentals of clinical supervision* (4th ed.). Upper Saddle River, NJ: Pearson Education.

المنارة للاستشارات

www.manaraa.com

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

Berthold, S. M. (2011). Vicarious trauma and resilience. *CME Resource, 136*(11), 67-107.

Borders, L. D. (2005). Snapshot of clinical supervision in counseling and counselor education: A five-year review. *The Clinical Supervisor, 24*(1-2), 69-113. doi:10.1300/J001v24n01_05

Borders, L. D., & Brown, L. L. (2005). *The new handbook of counseling supervision*. New York, NY: Routeledge.

Bordin, E. S. (1983). A working alliance model of supervision. *The Counseling Psychologist*, *11*, 35-42.

Bowlby, J. (1977). The making and breaking of affectional bonds I: Aetiology and psychopathology in the light of attachment theory. *British Journal of Psychiatry*, *130*, 201-210.

Brammer, L. M. (1985). *The helping relationship: Process and skills* (3rd ed.). Englewood Cliffs, NJ: Prentice-Hall.

British Association for Counselling and Psychotherapy (BACP). (2007). *Ethical framework for good practice in counseling and psychotherapy*. Retrieved from http://www.bacp.co.uk/ethical_framework

Callahan, J. (2009). Emergency intervention and crisis intervention. In P. M. Kleespies, (Ed.), *Behavioral emergencies: An evidence-based resource for evaluating and managing risk of suicide, violence, and victimization.* (pp. 13-32). Washington DC: American Psychological Association. doi:10.1037/11865-001

المنارة للاستشارات
www.manaraa.com

Callahan, J. (2009b). Crisis theory and crisis intervention in emergencies. In P. M. Kleespies (Ed.), *Emergencies in mental health practice: Evaluation and management*. (pp. 22-40). New York, NY: Guilford Press.

Caplan, G. (1964). *Principles of preventive psychiatry*. New York, NY: Basic Books.

Cavaiola, A., & Colford, J. E. (2006). *A practical guide to crisis intervention.* Boston, MA: Houghton Mifflin.

Center for Credentialing and Education. (2011). *Requirements for standard entry to ACS certification*. Retrieved from http://www.cce-global.org/

Center for Substance Abuse Treatment (CSAT). (2009). *Clinical supervision and professional development of the substance abuse counselor. Treatment Improvement Protocol (TIP) Series 52.* HHS publication No. (SMA) 09-4435. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment (CSAT). (2009b). *Addressing suicidal thoughts and behaviors in substance abuse treatment. Treatment Improvement Protocol (TIP) Series 50*. HHS publication No. (SMA) 09-4381. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Centers for Disease Control and Prevention. (2010). *2009 National youth risk behavior survey overview*. Retrieved from http://www.cdc.gov/yrbs/

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* Thousand Oaks, CA: Sage.

Cherry, M. F. (2001). *The sources of stress, burnout, and supervisory needs of psychiatric emergency services clinicians* (Doctoral dissertation). Retrieved from ProQuest Dissertations & Theses. (UMI No. 3026604)

المنارة للاستشارات

www.manaraa.com

Cook, M. (1997). Systems-oriented supervision in an agency setting. In Thomas C. Todd and Cheryl L. Stozm (Eds.). *The complete systemic supervisor.* Needham Heights, MA: Allyn & Bacon.

Corey, G., Haynes, R., & Moulton, P., & Muratori, M. (2010). *Clinical supervision in the helping professions* (2nd ed.). Alexandria, VA: American Counseling Association.

Council for Accreditation of Counseling and Related Educational Programs. *2009 CACREP accreditation manual.* Alexandria, VA: Author.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Crockett, S. A., Byrd, R., Erford, B. T., & Hays, D.G. (2010). Counselor education and supervision golden anniversary publication pattern review: Author and article characteristics from 1985 to 2009. *Counselor Education and Supervision, 50*(1), 5-20.

Council on Rehabilitation Education (CORE). (2010). *What is CORE?* Retrieved from http://www.core-rehab.org

Doyle, W. W., Foreman, M. E., & Wales, E. (1977). Effects of supervision in the training of nonprofessional crisis intervention counselors. *Journal of Counseling Psychology*, *24*(1), 72-78. doi: 10.1037/0022-0167.241.72

Dubi, M., & Sanabria, S. (2010). Understanding and working with acute stress disorder. In J. Webber & J. B. Mascari, (Eds.). *Terrorism, trauma, and tragedies* (3rd ed.), (pp. 7-8). Alexandria, VA: American Counseling Association.

Dupré, M. A. (2009). [Crisis supervision: A qualitative interview]. Unpublished raw data.

المنارة للاستشارات

www.manaraa.com

Dupré, M. A. (2011). *Crisis supervision: Promoting counselor resilience*. Virginia Counselor, 6. Retrieved from http://www.vacounselor.org

Dupré M. A. (2011b). [Crisis supervision: Qualitative interviews]. Unpublished raw data.

Dupré, M. A. (2011c). [Crisis supervision: A focus group]. Unpublished raw data.

Dupré, M. A., Stewart, A., & Echterling, L. G. (2011, June). *Resilience-based crisis supervision: The use of play therapy techniques to promote resilience*. Workshop conducted at the Virginia Association for Play Therapy 2011 Summer Conference, Harrisonburg, VA.

Echterling, L. G, & Stewart, A. (2008). Creative crisis intervention techniques with children and families. In *Creative interventions with traumatized children* (pp. 189-210), Cathy A. Malchiodi (Ed.). New York, NY: Guilford Press.

Echterling, L. G., Presbury, J. H., & McKee, J. (2005). *Crisis intervention: Promoting resilience and resolution in troubled times*. Upper Saddle River, NJ: Merrill/Prentice Hall.

Efstation, J. F., Patton, M. J., & Kardash, C. M. (1990). Measuring the working alliance in counselor supervision. *Journal of Counseling Psychology*, *37*, 322-329.

Engstrom, D., Hernandez, P., & Gangsei, D. (2008). Vicarious resilience: A qualitative investigation into its description. *Traumatol*, *14*(3), 13-21.

Erford, B. T., Miller, E. M., Schein, H., McDonald, A., Ludwig, L., & Leishear, K. (2011). Journal of counseling and development publication patterns: Author and article characteristics from 1994 to 2009. *Journal of Counseling and Development, 89,* 73-80.

Erikson, E. H. (1963). *Childhood and society*. New York, NY: W.W. Norton.

المنارة للاستشارات

www.manaraa.com

Everstine, D. S., & Everstine, L. (2006). *Strategic interventions for people in crisis, trauma, and disaster*. New York, NY: Routledge.

Figley, C. R. (Ed.). (2002). *Treating compassion fatigue.* New York, NY: Routledge.

Figley, C. R. (1983). Castastrophes: An overview of family reactions. In C. R. Figley & H. I. McCubbin (Eds.), *Stress and the family: Volume 2, Coping with Catastrophe* (pp. 3-20). New York, NY: Brunner/Mazel.

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* (pp. 1-20) Philadelphia, PA: Brunner/Mazel.

Fitch, J. C., Pistole, M. C., & Gunn, J. E. (2010). The bonds of development: An attachment-caregiving model of supervision. *The Clinical Supervisor, 29*(1), 20-34. doi:10 1080/07325221003730319

Foster, V. A., & McAdams, C. R. (1999). The impact of client suicide in counselor training: Implications for counselor education and supervision. *Counselor Education and Supervision, 39*, 22-33.

Frawley-O'Dea, M. G., & Sarnat, J. E. (2001). *The supervisory relationship: A contemporary psychodynamic approach.* New York, NY: Guilford Press.

Friedlander, M. L., Siegel, S. M., & Brenock, K. (1989). Parallel processes in counseling and supervision: A case study. *Journal of Counseling Psychology, 36*(2), 149-157. doi:10.1037/0022-0167.36.2.149

المنارة للاستشارات

www.manaraa.com

Hawkins, P., & Shohet, R. (2000). *Supervision in the helping professions: An individual, group, and organizational approach* (2nd ed.). Philadelphia, PA: Open University Press.

Hernández, P., Engstrom, D., & Gangsei, D. (2010). Exploring the impact of trauma on therapists: Vicarious resilience and related concepts in training. *Journal of Systemic Therapies, 29*(1), 67-83.

Hernández, P., Gangsei, D., Engstrom, D. (2007). Vicarious resilience: A new concept in work with those who survive trauma. *Family Process, 46*(2), 229-241.

Hipple, J., & Beamish, P. M. (2007). Supervision of counselor trainees with clients in crisis. *Journal of Professional Counseling, Practice, Theory, & Research, 35*(2), 1-16.

Hoffman, R. M. (2009). *The process of counselor supervision for counselor trainees who work with suicidal client* (Doctoral dissertation). Retrieved from ProQuest Dissertations & Theses. (UMI No. 3367672)

Holloway, E. L. (1987). Developmental models of supervision: Is it development? *Professional Psychology, Research and Practice, 18*(3), 209-216. doi:10.1037/0735-7028.18.3.209

Holloway, E. (1995). *Clinical supervision: A systems approach.* Thousand Oaks, CA: Sage Publications.

Kahill, S. (1988). Interventions for burnout in the helping professions: A review of the empirical evidence. *Canadian Journal of Counselling Review, 22*(3), 162-169.

Kleespies, P. M. (2009). Emergencies in mental health practice: Evaluation and management. New York, NY: Guilford Press.

المنارة للاستشارات

www.manaraa.com

Knox, S., Burkard, A. W., Jackson, J. A., Schaack, A. M., & Hess, S. A. (2006). Therapists-in-training who experience a client suicide: Implications for supervision. *Professional Psychology, Research and Practice, 37*(5), 547-557. doi:10.1037/0735-7028.37.5.547

Kuzel, A. J. (1992). Sampling in qualitative inquiry. In B. F. Crabtree & W. L. Miller (Eds.), *Doing qualitative research. Research methods for primary care, Vol. 3* (pp. 31-44). Newbury Park, CA: Sage.

Lecompte, M. D., & Preissle, J., with Tesch, R. (1993). *Ethography and qualitative design in educational research* (2nd ed.). Orlando, FL: Academic Press.

Liddle, H. A., Breulin, D.C., Schwartz, R.C., & Constantine, J.A. (1984). Training family therapy supervisors: Issues of content, form and context. *Journal of Marital and Family Therapy, 10*(2), 139-150. doi:10.1111/j.1752-0606.1984.tb00577.x

Lindy, J. D. (1989). Transference and post-traumatic stress disorder. *Journal of the American Academy of Psychoanalysis*, *17*, 397-43.

Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic inquiry.* Thousand Oaks, CA: Sage.

Lincoln, Y. S., & Guba, E. G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In Norman K. Denzin & Yvonne S. Lincoln (Eds.), *Handbook of Qualitative Research* (2nd ed.). Thousand Oaks, CA: Sage.

Martinez, J. M. (2010, June). *Differences in civil commitment practice in Virginia.* Retrieved from http://www.dbhds.virginia.gov/OMH.../2010-Diff-Civil-Commit-Practices...

المنارة للاستشارات

www.manaraa.com

Marvin, R., Cooper, G., Hoffman, K., & Powell, B. (2002). The circle of security project: Attachment-based intervention with caregiver-pre-school child dyads. *Attachment & Human Development, 4*(1), 107-124. doi:10.1080/14616730252982491

Maslach, C. (1982). *The cost of caring.* Englewood Cliffs, NJ: Prentice Hall.

McAdams, C. R. III., & Keener, H. J. (2008). Preparation, action, recovery: A conceptual framework for counselor preparation and response in client crises. *Journal of Counseling and Development, 86*(4), 388-398.

McAdams, C. R., & Foster, V. A. (2000). Client suicide: Its frequency and impact on counselors. *Journal of Mental Health Counseling, 22*(2), 107-121.

McCann, L. M., Pearlman, L. A. (1992). Constructivist self-development theory: A theoretical model of psychological adaptation to severe trauma. In D. K. Sakheim & S. E. Devine (Eds.), *Out of darkness: Exploring Satanism and ritual abuse* (pp. 185-206). New York, NY: Lexington Books.

Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation*. San Francisco, CA: Jossey-Bass.

Mitchell, M., & Jolley, J. (1988). *Research design explained*. New York, NY: Holt, Rinehart, & Winston.

Morse, J. M. (1994). Designing funded qualitative research. In Norman K. Denzin & Yvonne S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 220-235). Thousand Oaks, CA: Sage.

National Board for Certified Counselors (2005). *Code of ethics*. Retrieved from http://www.nbcc.org/Ethics

المنارة للاستشارات

www.manaraa.com

National Coalition Against Domestic Violence. (2012). *Domestic violence facts*. Retrieved from http://www.ncadv.org/files/DomesticViolenceFactSheet(National).pdf

National Institute of Health (2011). *NIH fact sheets: Post-traumatic stress disorder (PTSD)*. Retrieved from http://reportnih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=58

National Institute of Mental Health. (2011). *NCS-R lifetime prevalence estimate*. Retrieved from http://www.hcp.med.harvard.edu/ncs

National Institute of Justice (2000, November). *Full report of the prevalence, incidence, and consequences of violence against women: Findings from the National Violence against Women Survey*. Retrieved from http://www.nij.gov/pubs-sum/183781.htm

O'Hanlon, B. (1999). *Evolving possibilities.* Philadelphia, PA: Brunner/Mazel.

Onwuegbuzie, A. J., & Leach, N. L. (2007). A call for qualitative power analyses. *Quality & Quantity, 41*(1), 105-121. doi:10.1007/s11135-005-1098-1

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology Research and Practice, 26*(6), 558-565. doi: 10. 1037/0735-7028.26.6.558

Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York, NY: W.W. Norton.

المنارة للاستشارات

www.manaraa.com

Pines, A. M., & Aronsonson, E. (1988). *Career burnout: Causes and cures.* New York, NY: Free Press.

Pistole, M. C., & Fitch, J. C. (2008). Attachment theory in supervision: A critical incident experience. *Counselor Education and Supervision*, *47*, 193-205.

Pistole, M. C., & Watkins, C. E. (1995). Attachment theory: Counseling process and supervision. *The Counseling Psychologist*, *23*(3), 457-478.

Polkinghorne, D. E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology, 52*(2), 137-145. doi:10.1037/0022-0167.52.2.137

Powell, D. (1993). *Clinical supervision in alcohol and drug abuse counseling: Principles, models, methods*. San Francisco, CA: Jossey-Bass.

Presbury, J. H., Echterling, L. G., & McKee, J. E. (2008). Beyond brief counseling: An integrative approach. Upper Saddle River, NJ: Merrill/Prentice Hall.

Presbury, J. H., Echterling, L. G., & McKee, J. E. (1999). Supervision for inner vision: Solution-focused strategies. *Counselor Education and Supervision, 39*(2), 146-155.

Preston, S. D., & deWaal, F. B. M. (2002). Empathy: Its ultimate and proximate bases. *The Behavioral and Brain Sciences, 25*(1), 1-20. doi:10.1017/S0140525X02000018

Rainer, J. P., & Brown, F. F. (2007). *Crisis counseling and therapy*. Binghamton, NY: Haworth Press.

المنارة للاستشارات

www.manaraa.com

Ramachandran, V. S. (2005). *Mirror neurons and imitation learning as the driving force behind "the great leap forward" in human evolution.* Retrieved from http://www.edge.org/3rd_culture

Ramachandran, V. S. (2009). *Self-awareness: The last frontier. An Edge Original Essay.* Edge Foundation Web Essay. Retrieved from http://www.edge.org/3rd_culture/rama08/rama08_index.html

Richards, L. (2005). *Handling qualitative data: A practical guide.* Thousand Oaks, CA: Sage.

Roberts, A. R. (2005). *Crisis intervention handbook: Assessment, treatment, and research* (3rd ed.). New York, NY: Oxford University Press.

Rodolfa, E. R., Kraft, W. A., & Reilly, R. R. (1988). Stressors of professionals and trainees at APA-approved counseling and VA medical center internship sites. *Professional Psychology, Research and Practice, 19*(1), 43-49. doi:10.1037/0735-7028.19.1.43

Rogers, J. R., Guelette, C. M., Abbey-Hines, J., Carney, J. V., & Werth, J. L. (2001). Rational suicide: An empirical investigation of counselor attitudes. *Journal of Counseling and Development, 79*(3), 365-372. doi:101002/j1556-8676-2001.tb01982x

Rønnestad, M. H., & Skovholt, T. M. (2003). The journey of the counselor and therapist: Research findings and perspectives on professional development. *Journal of Career Development, 30*(1), 5-44. doi:10.1023/A:1025173508081

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

المنارة للاستشارات

www.manaraa.com

Salston, M. D., & Fidley, C. R. (2003). Secondary traumatic stress effects of working with survivors of criminal victimization. *Journal of Traumatic Stress, 16*(2), 167-174. doi:10.1023/A:1022899207206

Shallcross, L. (2011, September). A day that changed a nation and a profession. *Counseling Today, 54(3),* 36-40.

Slaikeu, K. A. (1990). *Crisis intervention: A handbook for practice and research* (2nd ed.). Needham Heights, MA: Allyn & Bacon.

Stamm, B. H. (2010). *The concise ProQOL manual* (2nd ed.). Pocatello, ID: ProQOL.org. Retrieved from http://www.ProQOL.org

Stewart, A., & Echterling, L.G. (2008). Playful supervision: Sharing exemplary exercises in the supervision of play therapists. In A. Drewes & J. A. Mullen (Eds.), *Supervision can be playful: Techniques for child and play therapist supervisors* (pp. 281-307). Lanham, MD: Jason Aronson.

Stoltenberg, C. D., McNeill, B. W., & Delworth, V. (1998). *IDM supervision: An integrated developmental model for supervising counselors and therapists.* San Francisco, CA: Jossey-Bass.

Substance Abuse and Mental Health Services Administration. (2009, September). *SAMHSA news release*. Retrieved from fttp://www.samhsa.gov/newsroom/advisories/090917suicide0907aspx

Tedeschi, R. G., Park, C. L. & Calhoun, L. G. (Eds.). (1998). *Posttraumatic growth: Positive growth: Positive changes in the aftermath of crisis*. Mahwah, NJ: Erlbaum.

المنارة للاستشارات

www.manaraa.com

Thomas, J. A., & Woodall, S. J. (2006). *Responding to psychological emergencies: A field guide.* Clifton Park, NY: Thomson Delmar Learning.

Tracey, T., Ellikson, J., & Sherry, P. (1989). Reactance in relation to different supervisory environments and counselor development. *Journal of Counseling Psychology*, *36*(3), 336-344.

Trippany, R. L., Whitekress, V. E., & Wilcoxon, S. A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling and Development, 82*(1), 31-37.

Virginia Board of Counseling (2011). *Supervised experience requirements for the delivery of clinical services for professional counselor licensure, Guidance Document 115-.7.* Retrieved from http://www.dhp.state.va.us/counseling/

Virginia Department of Behavioral Health and Developmental Services (2010, December). *Item 304.N Fiscal Year 2010 Annual Report.* Richmond, VA: Author.

Virginia Department of Health Professions. (2011). Retrieved from http://www.dhp.virginia.gov

Watkins, C. E. (1993). Development of the psychotherapy supervisor: Concepts, assumptions, and hypotheses of the supervisor complexity model. *American Journal of Psychotherapy, 47*(1), 58-74.

Wilson, J. P., & Lindy, J. D. (Eds.). (1994). *Countertransference in the treatment of Post Traumatic Stress Disorder.* New York, NY: Guilford Press.

المنارة للاستشارات

www.manaraa.com

Wilson, J. P., Lindy, J. D., & Raphael, B. (1994). Empathic strain and therapist defense: Type I and II In J. P. Wilson & J. D. Lindy (Eds.), (pp. 31-61). *Countertransference in the treatment of PTSD*. New York, NY: Guilford Press.

Wilson, J. P., & Thomas, R. B. (2004). *Empathy in the treatment of trauma and PTSD*. New York, NY: Brunner-Routledge.

Wolin, S. J., & Wolin, S. (1993). *The resilient self: How survivors of troubled families rise above adversity.* New York, NY: Willard Books.

المنارة للاستشارات

www.manaraa.com