

1

The Context of Caring

We live in a dynamic and unpredictable world where change is ever present. Some changes are intentional, growth producing, and within one's control, while others, particularly those associated with exposure to a crisis, trauma, or disaster, are arbitrary, injurious, and beyond one's control. Crisis or traumatic events are, by definition, unpredictable and threatening; they disorder and devastate lives. They challenge our perceptions, coping skills, and resources—we are in unfamiliar territory. Many respond to these challenges by seeking and hopefully returning to previous routines despite the ever-evolving backdrop of possibility, transformation, and disruption. Those unable to access previous ways of coping may find themselves in episodic crises or traumatized by their exposure.

Crises, trauma, and disaster (CTD) events range from the personal—death of a loved one, to the communal—Flint water crisis, to the societal—terrorist attacks. They may occur simultaneously and vary in meaning, scope, intensity, frequency, and duration. How one responds to a CTD event varies from the deeply personal to shared concerns within or among a group to the more customary or universal. In sum, CTD responses are contextual, personal, and intersect deeply with individual and group contexts, cultures, and ways of being. Because of your skill and training as a clinician, you will be called upon to provide specialized treatment. With that said, it is important for you to understand not all exposed to CTDs seek or receive acute services or ongoing treatment.

It is impossible to determine the percentage of individuals who might benefit from CTD counseling, yet a report from the Substance Abuse and Mental Health Services Administration (SAMHSA) provides some insight. The authors note that in 2014, approximately 45% of United States (US) citizens, with a diagnosable mental condition, sought professional treatment (Center for Behavioral Health Statistics and Quality, 2015). This means *more*

than half of those identified as eligible for professional treatment did not seek it. Therefore, it is quite likely that fewer than half of individuals affected by a CTD will seek professional treatment; others will opt for help from natural or lay helpers; and a substantial number will seek not treatment due to personal and or cultural reasons, proximity to care, stigma, or confidence in counseling. Given the extent and gravity of these events, it is important to remember that although 70% to 80% of the U.S. population will experience at least one traumatic event in their lifetime and 7% to 9% will develop PTSD, most will never seek counseling or therapeutic services. This book focuses on the theoretical foundations and skills related to crisis, trauma, and disaster counseling within the context of counselor's professional development. We hope you find it a useful resource throughout your career.

Learning Objectives

After reading this chapter and participating in the reflective exercises provided, you will be able to

1. Differentiate helping professionals from natural helpers
2. Distinguish important issues related to the development and training of helping professionals
3. Understand key aspects to reflective practice and self-awareness
4. Compare key techniques at each stage of your development
5. Understand and discuss the spectrum of crisis, trauma, and disaster

Organization of the Text

From the moment we conceived this book, we designed it with you, the reader, in mind. We have three goals: (a) to present the historical contexts, theories, models, and skills necessary to conduct effective CTD counseling; (b) to support your learning relative to a continuum of professional development, regardless of your level of experience; and (c) to provide strategies for self-care and wellness. Because students take their CTD counseling course at different points in their education, we begin by briefly revisiting and reinforcing content you have previously studied. We discuss different types of helpers, components of your professional education and development, and the importance of self-awareness and reflective practice. In-text examples and end of chapter exercises focused on CTDs help you apply your learning.

Beginning with Chapter 2, we deepen and extend your learning by first presenting a chapter on the historical context, theoretical foundations, and treatment models of crisis, followed by Chapter 3, which details specific skills and dispositions for crisis counseling at each stage of your professional development; Chapters 4 and 5 focus on trauma and its treatment and Chapters 6 and 7 on

disaster. Chapters 3, 5, and 7 provide a ready reference—the *Counselor's Toolkit*, which details specific knowledge, skill(s), awareness, techniques, and resources used in CTD counseling for individuals, groups, and communities at each stage of your professional development. Chapter 8 provides you strategies for self-care and wellness and the text concludes with emergent trends in Chapter 9. Each chapter begins with learning objectives to guide your reading and terminates with case examples and resources for applied practice. Throughout the text, we use the term *clinician* to describe all professional helpers, to be inclusive and to aid the readability of the text. When global references to gender are made, we intentionally use the term *they*, rather than the binary terms he and she, despite the traditional conventions of grammar.

Many Kinds of Helpers

Help and support come in many forms. Those dealing with crisis, trauma, or disaster may seek help with safety, medical issues, food or housing needs, transportation, resources, vocation, spiritual or religious support, or longer-term planning. In the immediate aftermath of a CTD event, individuals turn to those in closest proximity, some of whom may be natural helpers. Natural helpers are friends, loved ones, religious or spiritual laypersons, or members of support groups. These helpers are often known to and trusted by the individual(s) in distress. Natural helpers are sympathetic listeners who offer encouragement, instrumental support like childcare or transportation or hope, and a connection to informal social networks with limited support and resources. In contrast, professional helpers are typically not known to those seeking assistance. Professional helpers provide structured support, professional services, and have greater access to resources. Graduate-level training allows clinicians to systematically identify and respond to the unique and common needs of those exposed to crisis, trauma, or disaster and is why you are reading this book!

Educating Clinicians

Your advanced education focuses on theories, skills, and assessments and occurs in classrooms, counseling laboratories, and field placements over your professional lifespan. But this is only one form of education. You may also have had training at the baccalaureate and associate levels, which may or may not have involved applied or supervised practice or resulted in a certification or credential. Generally, CTD Clinicians seek post-degree professional development, certifications, and self-study specific to CTD counseling like Red Cross certification, nonviolent crisis intervention training, Eye Movement Desensitization and Reprocessing [EMDR], and trauma informed care. Although formal education is critical, so too is your personhood, personal awareness, and ways of being. In the sections that follow, we describe the perspective—clinician as instrument; context—accreditation standards and educational programs; and processes—self-awareness, reflective practice, supervision, and professional development that provide the foundation of your CTD education.

Perspective—Clinician as Therapeutic Instrument

For well over 50 years, clinicians have been called to learn about *who* they are as a person and how their personhood influences or impacts clients. Morey Appell writing in 1963 said,

The most significant resource a counselor brings to a helping relationship is himself. It is difficult to understand how a counselor unaware of his own emotional needs, of his expectations of himself well as others, of his rights and privileges in relationships, can be sensitive enough to such factors in his counselee. (p. 146)

The professional expectation for personal awareness and accountability is not new! Contemporary authors like Gerald Corey agree and highlight the interconnectedness of the person and the professional. Corey (2013) noted, “one of the most important instruments counselors have to work with is themselves” and that the “person and professional are intertwined facets that cannot be separated in reality” (p. 18). Unlike almost any other profession, your professional training *and* personhood matter. Their importance is evidenced by their inclusion in accreditation standards, graduate curricula, expectations of reflective practice, and professional development. With respect to CTD counseling, clinicians aid their clients and themselves when they are aware of and address their personal histories of crisis or trauma, burnout, and personal and professional wellness. We address these elements in the sections that follow. Matters related to burnout and wellness are presented in Chapter 8.

Context—Accreditation Standards and Educational Programs

Accreditation

Many graduate programs are accredited by national organizations like the Council for Accreditation of Counseling and Related Educational Programs (CACREP), the American Psychological Association (APA), or the Council on Social Work Education (CSWE). Accrediting organizations are populated with members from the professions they govern. These organizations establish operating standards focused on the institution, faculty, curriculum, and program support; conduct periodic formal reviews to determine the extent to which the standards are met; and publicize their findings. Accredited programs engage a continuous review process to meet and maintain standards set by the profession. In many states, a graduate degree, from an accredited program, is necessary to achieve licensure for professional practice. The goal of accreditation is to ensure that education, provided by institutions of higher education, meets acceptable levels of quality (U.S. Department of Education, 2016) and our client needs for ethical and quality treatment. Accreditation standards or requirements focused on CTD counseling are relatively recent and reflect the growing body of research, theory, and knowledge in this subspecialty. We encourage you to review the CTD standards in your graduate program.

Educational Programs

Students in graduate counseling, psychology, or social work programs typically complete a minimum of two years of study and supervised practice. Likely, you have completed courses on counseling theories; core counseling skills for individual, groups, and families; assessment and treatment planning; case management; cultural competence; advocacy; and supervised practice. Within the last decade, accrediting bodies (CACREP, APA, CSWE) and university faculty have determined clinicians need additional and specialized education related to crisis, trauma-informed counseling, and client advocacy within an ethical and social justice framework. Thus, many graduate programs have at least one academic course dedicated to CTD counseling as well as expectations that clinicians will work with clients experiencing crisis, trauma, or disaster during their field placements.

Advanced CTD education provides you specialized knowledge and skills focused on individual, family, or community treatment and services. Students use conceptual and procedural knowledge (deJong & Ferguson-Hessler, 1996) to address a variety of client needs, to promote stability, to improve coping, and to aid the client's return to adaptive functioning. Adaptive functioning is described as the necessary cognitive and social skills, comprehension, and communication required to navigate environmental demands. In sum, clinicians are educated to support the health, recovery, and well-being of those experiencing acute or chronic crisis, trauma, or disaster. Advanced education is the hallmark of a professionally trained clinician and includes the ability to engage in a reflective practice and continuous personal and professional development. Three elements—advanced education, reflective practice, and continued personal and professional development—form the pillars of your professional practice. These pillars are highlighted throughout professional codes of ethics, standards of practice, and distinguish clinicians from other helpers.

Processes—Self-Awareness, Reflective Practice, and Professional Development

Self-Awareness

Awareness of self emerges around 18 months of age (Stern, 1985), yet researchers struggle to identify how it develops over the remainder of the life span. Self-awareness is conscious knowledge of one's existence, feelings, thoughts, motives, desires, and ways of being separate from others and the environment. Duval and Wicklund (1972) conceptualized self-awareness as an active process in which one evaluates and compares their current behavior to their internal standards and values. This process simultaneously engages introspection and meta-cognition. Perhaps you've experienced increased self-awareness during your practicum or internship supervision. How aware were you of your actions, thoughts, and feelings? As you focused on yourself, did you feel momentarily separate from your environment and others? It's incredible that human beings can think, act, and experience while thinking *about* what they are thinking, doing, and experiencing *while* they are thinking, acting, and experiencing. Active self-awareness aids

clinician's reflective practice, combats burnout, and helps clinicians empathize with clients who feel overwhelmed, anxious, or hypervigilant after exposure to a crisis, trauma, or disaster.

There are two types of self-awareness—public and private (Lewis & Brooks-Gunn, 1978). Public self-awareness recognizes that each of us is perceived and evaluated by others *and* that those perceptions and evaluations matter. What we perceive others think about us is believed to stimulate socially acceptable behavior and adherence to social norms. For example, consider your response to peers' feedback in practicum, internship, or a team meeting. In what manner, if any, did you modify your behavior or beliefs about yourself considering their feedback or perceptions? Alternatively, private self-awareness, commonly described as conscious knowledge, is the perception or recognition of one's emotions, thoughts, motives, desires, and ways of being. Private self-awareness is not self-understanding or insight; it is simple recognition. Again, consider your internal feelings, thoughts, experiences, and self-talk related to your appraisal of your performance in practicum or internship or in your present clinical work. What do you say to yourself about your performance?

Time for an example; consider the student clinician who has experienced intimate partner sexual violence. Their self-talk centers on self-blame, self-recrimination, and fear of others' judgement. The student clinician is privately aware of their trauma, unsure how or if it might impact their work with similarly traumatized clients, is anxious and fearful about peer feedback or criticism in practicum, and terrified their story will come out in class. During post-session feedback, the student clinician responds to peers with anger, agitation, and tears. The student clinician ruminates on self-statements like: "Who are they to judge me?" "I *am not* scared of my client." "The rape does not affect me, anymore." "Feedback is stupid." With their supervisor, the student clinician is distant, disengaged, and at times tearful. The supervisor invites the student clinician to describe their experience and expectations of peer feedback and supervision. The student clinician does not respond. The supervisor gently asks if they think some type of support, like personal counseling outside of the training setting, may help. Without responding, the student clinician abruptly terminates the supervision session and resigns from the program. The research of Cavanaugh, Wiese-Batista, Lachal, Baubet, and Moro (2015) sheds light on our student's reactions. They found therapists, with an individual or family history of trauma, used more defense mechanisms with clients in therapy, had more confused feelings, and exhibited stronger countertransference emotions and reactions than those without this history. This example illustrates how public and private self-awareness may function and demonstrates these are necessary, but not sufficient components of your training and supervision.

Self-Awareness and the CTD Clinician

Self-awareness is not to be confused with self-concept, self-efficacy, or self-esteem as these terms imply a combination of analysis, insight, and understanding in addition to recognition. Authors studying the role of self-awareness and

emotional intelligence (Mayer & Salovey, 1997; Sternberg, 1990; Goleman, 1995) distinguish it from general intelligence. Mayer and Salovey identified five categories of emotional intelligence: knowing one's emotions or private self-awareness; managing one's emotions; motivation; recognizing emotions in others; and managing relationships. The abilities contained in these five categories are at the heart of any therapeutic relationship, particularly CTD counseling.

Nonconscious processing, implicit versus explicit awareness of clients (Fosshage, 2005; Schore & Schore, 2008), clinicians' perceptions of self vis-a-vis their clients, and professional roles (Sue et al., 2007) have been examined to understand how clinicians make sense of themselves, clients, and counseling. Other researchers studied the role self-awareness plays in acquisition of theoretical orientations (Guiffrida, 2005; Hanna, 1994; Wong-Wylie, 2007), culturally competent counseling (Collins & Arthur, 2010; Roysircar, 2004; Ho, 1995), as well as the management of transference and countertransference in the counseling relationship (Williams, Judge, Hill, & Hoffman, 1997; Cashdan, 1988; Grayer & Sax, 1986). Pearlman and Saakvitne (1995) suggest clinicians, who exclusively treat clients traumatized by incest, develop a specific form of countertransference not related to clinical interactions or clients. This form of countertransference presents as a broad negative attitude toward counseling and life in general. Adams and Riggs (2008) examined vicarious trauma in relation to the history of trauma, experience level, trauma-specific training, and defense style in a sample of 129 graduate clinicians. They found over half their participants indicated a self-sacrificing defense style, a known risk factor for vicarious trauma. Trauma symptoms—anxious arousal, intrusive experiences, defensive avoidance, disassociation—were significantly associated with the defense style and moderated clinician's personal trauma history and experience level. Research findings detail that clinicians attempt to block out unwanted thoughts and feelings through conscious suppression or unconscious repression. Whether such attempts are successful or not, they are controversial. Despite the controversy, credible research findings will improve clinicians' education and the importance of self-awareness, which in turn, should improve clinical outcomes for clients.

Clinicians, who provide CTD counseling, are repeatedly subjected to horrific and often tragic descriptions of client experiences. The cumulative impact of clients' traumatic stories can foster feelings of doubt, anxiety, and professional inadequacy and negatively influence how clinicians view themselves, their clients, and the world. Wilson and Dunn (2004) believed that research psychologists had "artfully dodged" (p. 494) investigations of self-knowledge, opting to avoid questions about the nature of unconsciousness, limits of consciousness, or an individual's desire to avoid the anxiety that accompanies self-knowledge. Given the intensity and impact of CTD counseling, we wondered if this statement may also be true of clinicians and, perhaps, their faculty or supervisors. Do we avoid self-knowledge to lessen our stress related to client's CTD experiences? As you progress through your education related to CTD counseling, we encourage you to use supervision and reflective practice to examine and address how you respond to CTD clients concerns and how you are impacted by them.

Reflective Practice

Clinician self-awareness is a critical competency for clinicians and supervisors (Rosin, 2015; Collins, Arthur, & Wong-Wylie, 2010) and is “closely associated” (Rosin, 2015, p. 89) with reflective practice. Wong-Wylie (2010) stated reflective practice is a primary method for *how* counselors advance their self-awareness, clinical skills, and professional development (Skovholt & Rønnestad, 1995). Simply put, reflective practice is an intentional, step-wise process which allows you, the clinician, to learn from your experiences by making the implicit explicit and by associating thoughts related to an event with the outcome of the event. Let’s say you feel unsettled after a session with a traumatized client. You wonder if their story triggered your uneasy feelings. You attempt to identify when the discomfort emerged and recall the verbal exchanges between yourself and the client. By examining, rather than ignoring or avoiding your experience with the client, you may reveal the interactions that triggered your distress.

“Know thyself” is an Ancient Greek aphorism or saying. In 1997, Meier and Davis noted the importance of clinicians *knowing themselves* when they wrote “In no other profession does the personality and behavior of the professional make such difference as it does in counseling. Beginning counselors need to work at increasing their self-awareness as well as their knowledge of counseling procedures” (p. 61). We contend that knowing *that* you need to work at increasing your self-awareness is different from knowing *what* works on or *how* you might increase it. Knowing you may be negatively impacted by providing CTD counseling is only the first step. Reflective practice is a method that turns that first step in to your professional journey.

Reflective practice is predicated on reflective thinking, thinking that is active, purposeful, methodical, and “impels inquiry” (Dewey, 1933, p. 7). Reflective thinking is sequential and persistent; it is neither random nor haphazard. According to Dewey, reflective thinking begins when one is in state of doubt, hesitation, or is perplexed. To resolve this state, one intentionally seeks to “puzzle out the entanglement” by “turning a subject over in the mind and giving it serious consecutive consideration” (p. 3). Recall the example of the student clinician who was traumatized by intimate partner sexual violence. If the student clinician takes a moment to think reflectively about their peers’ feedback, they could suspend judgment about themselves and their peers and seek support from their supervisor. Over time and with repeated practice, the student clinician can embrace ambiguity, employ skepticism, and engage personal and professional humility. Their self-talk changes from recriminations and blame to statements like: “At times I *am* scared. I don’t know what they want from me.” “I bet everyone else is scared too.” “When I am confused by feedback I can talk to my supervisor.” In sum, reflective thinking challenges one’s cognitive certainty, reductionistic thinking, habitual responding, and desire for simplistic answers. Slowing down and engaging formal reflective thinking frees the clinician to consider alternative explanations, acknowledge the pain associated with clients’ crises or trauma, and support emotional self-regulation.

Donald Schön (1983) described two modes of reflective practice in education: *reflection-in-action* and *reflection-on-action*. Wong-Wylie (2007), Pedro (2005), Osterman (1990) and Knott and Scragg, (2016) contextualized Schön's work for mental health professionals. Reflection-in-action is thinking about something while you are doing it, then making in-the-moment improvements to the situation. This type of reflection integrates your tacit and implicit patterns with your spontaneous and intuitive actions. For example, a CTD clinician assessing a person in crisis recognizes the depths of their pain. In the middle of the assessment, in the moment, the clinician asks the individual to focus their breathing and directs them to center their thoughts in the here and now. Alternatively, reflection-on-action is more akin to the earlier description of Dewey's reflective thinking as it occurs *after* the event or interaction. This type of reflection involves an evaluation of what occurred, what could have been different, and what could be done differently in the future. Purposeful engagement with a supervisor allows you to explore your thoughts, actions, and reactions to traumatized clients is an example of reflection-on-action. For example, let's say you feel tense and on the verge of tears each time a child client describes being beaten by their parent. You examine your in-session behaviors and thoughts with your supervisor and realize three things: Almost every time the child begins to describe being beaten you shift the conversation to something more positive, you fantasize about rescuing or adopting this child, and you feel overwhelmed and uncertain about what to do next. Reflection-on action allows you to examine and correct your productive and nonproductive therapeutic behaviors and to identify needed education or support.

Although Schön's work (1983; 1987) faced criticism (Edwards & Thomas, 2010; Court, 1988, Finlay, 2008; Munby, 1989) reflective practice is "considered to be the *sine qua non* [essential condition] of professional development" (Edwards & Thomas, 2010, p. 403) and professional training. Finlay (2008), writing about teacher education, provides an additional cautionary note,

some consensus has been achieved amid the profusion of definitions. In general, reflective practice is understood as the process of **learning through and from experience** towards gaining **new insights** of self-and/or practice (Boud, Keogh, & Walker, 1985; Boyd & Fales, 1983; Jarvis, 1992). This often involves **examining assumptions** of everyday practice. It also tends to involve the individual practitioner in being **self-aware** and **critically evaluating** their own responses to practice situations. The point is to recapture practice experiences and mull them over critically to gain new understandings and so improve future practice. This is understood as part of the process of **life-long learning**. Beyond these broad areas of agreement, however, contention and difficulty reign. There is debate about the extent to which practitioners should focus on themselves as individuals rather than the larger social context. There are questions about how, when, where and why reflection should take place. For busy professionals short on time, reflective practice is all too easily applied in bland, mechanical, unthinking ways. Would-be practitioners may also find it testing to

stand back from painful experiences and seek to be analytical about them.
(p. 1) (Emphasis original)

We respectfully disagree with Finlay's and others' statements that professionals should focus on the larger social context, are too busy, and may be challenged to engage in reflective practice. Intentional actions taken to improving one's professional practices serves the client as well as the clinician. Effective clinicians take the time to consider themselves and their practice through increased self-awareness, personal reflection, and formal supervision (Orchowski, Evangelista, & Probst, 2010; Ward & House, 1998). Do you want to be treated by a physician who is too busy to reflect on their interactions with their patients? How else is one to gain perspective on their therapeutic stance or counseling practice?

Researchers in counseling, psychology, and social work note the benefits reflective practice (Furr & Carroll, 2003; Knott & Scragg, 2016). Numerous authors have expanded on Schön's original concepts (Wong-Wylie, 2007; Collins, Arthur, & Wong-Wiley, 2010) within the field of counseling (Rosin, 2015). Schön's model focuses on practitioners' professional experiences; in contrast, Wong-Wylie (2007) focused on the personhood of the clinician and coined the term *reflection-on-self-in/on action*. Reflection-on-self-in/on action "emphasizes salient personal experiences" (p. 60) believed to augment clinicians' *personal practical knowledge* (Connelly & Clandinin, 1988) and fosters increased self-awareness and professional growth. Engaging Wong-Wylie's mode of reflection requires you to develop personal capacity for cognitive and emotional maturity (Kitchener, 1986) through clinical supervision or direct instruction, to possess enhanced emotional intelligence (Goleman, 1995) and to engage critical reflectivity (Kondrat, 1999). Critical reflectivity is a deeper level of understanding of yourself, your assumptions, and their interaction with social structures. For example, using the reflection of self in-/on action process, our practicum student who experienced intimate partner sexual violence, could ask, "Why do I feel responsible for what happened to me?" "How am I different from my client who was raped?" "What would happen if I told my supervisor I was terrified of practicum?" These reflections challenge the social constructs of rape myth, self-blame, and desire for perfection.

Developing personal capacities and learning the process of reflective practice occurs in varying degrees. Hopefully you will encounter or have encountered these processes during numerous classes, specifically practicum or internship. Reflective practice is an intentional and systematic process learned during clinical supervision and developed and incorporated into one's practice over time. In her exploratory research, Wong-Wylie (2007) identified conditions, presented in Table 1.1, that facilitate or hinder reflective practice for doctoral students in counselor education.

Wong-Wylie's findings should be viewed with caution due to the exploratory, point-in-time nature of the study. She and others (Rosin, 2015; Kramer, 2000; Collins, Arthur, & Wong-Wylie, 2010; Guiffrida, 2005) illuminate a long standing and often unspoken concern in counselor, psychology, and social work

TABLE 1.1 • Conditions Facilitating or Hindering Reflective Practice in Doctoral Level Counselor Education

Facilitating	Hindering
Experiencing a trusting relationship	Experiencing mistrust/unsafe relationship
Opening up to fellow students	Interacting with nonreflective fellow students
Engaging in reflective tasks	Receiving unsupportive/jarring feedback
Having self-trust/risking	Facing a systemic barrier
Interacting with supportive academic personnel	Interacting with unsupportive academic personnel

education—challenging the *inner and outer* worlds of the clinician (Kramer, 2000). Overtly challenging students in this manner is fraught with ethical, boundary, and gatekeeping concerns as well as great opportunities (Jungers & Gregoire, 2013; Reamer, 2013). With respect to CTD education, graduate clinicians would be challenged to engage in reflection related to their personal histories of crisis or trauma, strategic processing of their therapeutic interactions, and may be encouraged or required to attend counseling, external to their program, to address previous crisis situations or traumatic exposure. This type of education requires intentional changes and modifications in graduate programs (Tobin, Willow, Bastow, & Ratkowski, 2009). Are you willing to disclose and process your personal assumptions and history with crisis and trauma? Regrettably, not all graduate programs specifically educate clinicians about reflective practice or supervise in a manner that enhances clinicians' critical reflection leaving us to speculate when or *if* novice and experienced professionals gain these critical experiences.

Clinical Supervision

Clinical supervision is/was a separate component of your practicum or internship experience. Through evaluation, supervision is designed to improve your performance on behalf of your clients. Bernard and Goodyear (2009) define clinical supervision as a hierarchical, evaluative relationship designed to enhance professional functioning, clinical skills, and the clinician's understanding, performance, dispositions, and interventions with clients. Their definition does not explicitly address the personal functioning of the supervisee, yet, as we stated earlier, clinical training, by its very nature involves the intimate intertwining of the personal and the professional (Corey, 2013). Therefore, because supervisory feedback is supportive and corrective in nature, the supervisory relationship can feel simultaneously tough and tender. Therefore, it is not surprising researchers have found some graduate clinicians experience disputes, disappointment, or unmet

needs during supervision (Gray, Ladany, Walker, & Ancis, 2001; Ladany, Hill, Corbett, & Nutt, 1996; Dupre, Echterling, Meixner, Anderson, & Kiely, 2014). We assert that supervisors, at all levels of the profession, have a responsibility to clearly articulate the foci, purpose, goals, and processes of supervision, specifically elements that address the personhood of the clinician, including the nature and extent of personal disclosures. With respect to the supervision of clinicians providing CTD counseling, we believe supervisors must possess a combination of experience, professional development, and advanced certifications in trauma-informed treatment and disaster responding. The combination of supervisor's CTD education and experience allows the supervisor to more critically examine the treatment approaches and experiences of CTD clinicians, including the precursors of burnout.

Rønnestad and Skovholt (2013) identified five supervisory principles to structure, organize, and describe the relational nature of supervision to trainees. The first principle encourages supervisors to "lay the ground work" (p. 178) and ensure appropriate field placements and supervision. For CTD clinicians, this means having the opportunity to provide supervised services to clients exposed to crisis and traumatic events. The second principle asks the supervisor to establish a supervisory alliance—a safe environment for learning with clear expectations and specific learning goals. Supervisors recognize and discuss that supervision can be an intense and emotional experience. Graduate clinicians may be uncertain about expected levels of self-disclosure, ethical and cultural responsibilities, and issues of power, communication, and interpersonal boundaries. This is particularly important for supervision of CTD cases because personal and professional reactions to traumatized clients are intertwined with the clinician's history. The third principle recommends supervisors create a reflective culture in supervision. Rønnestad and Skovholt state reflection is "a prerequisite for successful cycling through the phases characterizing optimal professional development" (p. 184). Specific to CTD counseling, your supervisor might pose a series of content-based or reflective questions: "What information do you need to learn about suicide assessments, treatment and referral?" "What thoughts and emotions come up for you as you think about working with a client who is actively suicidal? Homicidal?" "What are your strengths and vulnerabilities related to working with person actively considering suicide or homicide?" "What is a positive treatment outcome for a traumatized person?" Recall our example of the student clinician who experienced intimate partner sexual violence; their supervisor, who does not know of the student's history, might ask the student to reflect how their life experiences are similar and dissimilar to those of their client. Assuming the supervisory relationship is structured, authentic, and transparent a broadly focused question, not focused on the student's traumatic experience, provides an open and less threatening environment. For our now anxious student, this opportunity potentially promotes trust and provides a platform of increased self-awareness and reflection. To extend your learning a set of reflective questions adapted and expanded from the works of Johns (2004; 2006) are presented in Table 1.2. You can use these on your own or in supervision, with your supervisor's permission. We encourage you to create your own list.

TABLE 1.2 • Sample Reflective Questions for Clinical Supervisors and Supervisees

Questions	Area of Focus
<p>What was my experience?</p> <p>What essential factors contributed to this experience? (identifying a cause)</p> <p>What are the significant background factors to this experience? (Context)</p> <p>What are the key processes (for reflection) in this experience?</p>	Description of the experience
<p>What was I trying to achieve?</p> <p>What are the assumptions I hold about the client?</p> <p>Why did I intervene as I did? Or why did I choose not to intervene?</p> <p>What were the consequences of my actions for myself? The client/family? The people with whom I work?</p> <p>What do believe the client was feeling?</p> <p>What evidence demonstrates how the client felt?</p> <p>What was I feeling?</p> <p>Have I had these feelings before? If so, under what conditions? How did I feel about this experience when it was happening?</p> <p>How do I feel about this experience now?</p>	Reflection
<p>What internal factors influenced my decision making/action?</p> <p>What external factors influenced my decision making/action?</p> <p>Under what circumstances have I made similar decisions/actions?</p> <p>What is/are the consequences for the client, for me?</p> <p>What sources of knowledge did/should have influenced my decision making?</p> <p>What role, if any, did personal identities play in the decision/action?</p>	Influencing factors
<p>What other choices/options did I have?</p> <p>What are the consequences (positive/negative) of those choices?</p> <p>What role could the client have played in the decision/action?</p> <p>What, if anything, would I do differently?</p>	Choices
<p>How do I feel now about this experience?</p> <p>How do my feelings and thoughts about this experience influence my feelings or thoughts about previous experiences? About future practices?</p> <p>How has this experience changed my perceptions of myself, my practice, or my view of my client?</p> <p>What have I learned about myself?</p>	Learning
<p>What do I need from my supervisor?</p> <p>What would I like my supervisor to tell me?</p> <p>What do I would I like to hear from peers?</p> <p>What additional learning might benefit my understanding or perspectives?</p>	Resources

We believe these questions provide a basis for reflective conversations or dialogues with your peers and supervisors. Researchers are exploring reflective dialogues in supervision (Borders et al., 2014; Hill, Crowe, & Gonsalvez, 2015; McLean & Whalley, 2004). Their initial findings hold the promise of improving clinical supervision. The fourth supervision principle calls supervisors to “be attuned” (Rønnestad & Skovholt, 2013, p. 186) to the level of challenge faced by the supervisees, particularly the nature and number of clients served as well as the severity and intensity of client concerns. Clinicians treating those affected by CTDs have particular needs in supervision—interpersonal support, instruction in trauma-informed care, risk management, vicarious trauma, cultural conflicts, and emergency procedures. An attuned supervisor demonstrates empathy and understanding for your experiences *while* holding you accountable for your performance. As noted earlier, some supervisees experienced supervision as unsupportive and unhelpful. These experiences may be exacerbated by stressful interactions with CTD clients making it critical for you, the supervisee, to speak up. The fifth and final supervision principle focuses on accurate and timely evaluation of the supervisee. Timely, formative evaluative feedback provides the foundation for self-awareness and reflective practice, supports growth in your CTD skills and treatment, and aids your professional development.

Professional Development Process

Like other professionals, clinicians are believed to progress through a series of professional development stages or sequences. The concept of development, according to Lerner, (1986) implies change over time that occurs in a systemic or somewhat predictable manner. Historically, scholars (Hogan, 1964; Hill, Charles, & Reed, 1981; Loganbill, Hardy, & Delworth, 1982; Stoltenberg, McNeill, & Delworth, 1998) conceptualized professional development through the lens of a stage theory. They believed development was discontinuous, occurred in discrete stages, and was segmented into stage specific tasks. In the developmental model, clinicians remain at a stage of development until most of the identified tasks are completed. In contrast, Rønnestad and Skovholt (2013) assert professional development is more continuous, occurs in phases rather than stages, and is iterative and recursive. As you gain conceptual and procedural knowledge, increase your personal and professional understanding and reasoning, and continue to integrate your personal and professional selves, the process of change continues. For Rønnestad and Skovholt, each phase has generally agreed upon tasks which are continually learned and relearned in a recursive manner and over time results in growth and change. Assuming you remain engaged, utilize skilled supervision, and practice purposeful self-reflection, you should experience improvements in your knowledge, skills, and abilities during your formal education and throughout your career.

Throughout this text, we rely on Rønnestad and Skovholt’s (2013) professional development framework of therapists and counselors, which depicts five phases—novice student, advanced student, novice professional, experienced professional, and senior professional. We briefly introduce the novice student phase as a reference point and focus, in greater detail, on the next three phases: advanced

students, novice professional, and experienced professional. Although novice students may find the content in this text helpful, we believe those with advanced education and supervision are more likely to direct the treatment of individuals facing crisis, trauma, or disaster.

Novice Students

Graduate students or clinicians vary in age, life experiences, and personal and employment histories. Variation in students' background and identities provides great richness to the training environment. Generally, novice students are a more homogenous group comprised of white females 24 to 30 years old. Thus, the developmental tasks, influences, and phases described in this model are not expected to fully represent all students' experiences or world views. For example, a 40-year-old Latinx male will most likely demonstrate performance anxiety differently than a 24-year-old white female. What is important is that both students, and all students, have opportunities to be understood and to identify, contextualize, and address their needs in a manner befitting their learning styles and cultural backgrounds within the framework of the program's standards. Novice students spend most of their first two years in academic classrooms learning the foundations of their profession, and sometime during their second year, encounter their first lab- or field-based practicum or extended internship. This is often a time of great excitement and emotional intensity as students negotiate the acquisition-application-validation model of learning (Rønnestad & Skovholt, 2013). The model works like this: You acquire or learn an abundance of information in a variety of contexts. This knowledge draws on theories and research; direct and indirect client feedback; modeling and feedback from professional elders; personal life experience; peers' and colleagues' experiences; and your social cultural environment. As you apply this knowledge in all facets of your life and experience positive results, your knowledge and beliefs are validated even when they conflict with previous personally held beliefs or experiences. Ideas not validated or those yielding negative results gradually lose their influence and are typically discarded.

This is a stimulating and perplexing phase, fraught with anxiety, self-doubt, and insecurity related to academic and professional performance. Students, like you, spend much of the first year to year and a half evaluating the match between personal expectations of the graduate program and the program's expectations of you. This evaluation is most often demonstrated by conflict between your desire for professional autonomy and your needs for appropriate dependency on your faculty and supervisors. Table 1.3 presents a summary of the critical elements of the novice student phase.

Novice students report a vibrant and dynamic time marked by the demands of acquiring extensive theoretical, conceptual, and procedural knowledge; maintaining a sense of openness to new ideas and approaches; managing intense and often unpredictable emotions; and negotiating the challenges of learning *while* doing. With respect to CTD counseling, the feelings and expectations of the novice student may be exacerbated by their personal history, the acuity, magnitude, and

TABLE 1.3 ● Novice Graduate Student Phase

Description	Development Crises	Emotional/Cognitive Experiences	Developmental Tasks	Sources of Influence
First 1 to 2 years of graduate study *primarily engaged in academic study *nature and quality of experiences depend on students' culture and demographics	Students question their: *intellectual and emotional appropriateness for the profession *capacity for graduate study *degree of fit with demands of professional versus lay helping *desire to foreclose on one theory or practice to reduce confusion and feelings of being overwhelmed	*increased performance anxiety, intensity, psychologizing, self-doubt; fluctuating motivation; *overwhelmed/confused by the amount and diversity of information/knowledge *possible foreclosure on more complex methods and models—opts for specific, less complex, unambiguous interventions/theories *fluctuating feelings: stress, anger, happiness, fear, excitement, disappointment	*acquire extensive conceptual and procedural knowledge of the field *recognize and anxiety/fear as a part of the learning process *explore ways conceptually organize the complexity *maintain openness to various theories and approaches *manage confusion *define and clarify professional role of student *manage experience of vulnerability in supervision including degree of disclosure and need for honest feedback *use pragmatic, less complex approaches to develop mastery *initial role adoption	*in-class discussion of theories and research, feedback from clients, feedback from professional elders, modeling personal-peers, faculty, family

Adapted from Rønnestad and Skovholt (2013).

tragic nature of CTD clients' concerns and the sheer volume of new knowledge specific to CTD diagnosis and treatment. Self-awareness, reflective practice, and supervision support your progression to the advanced student phase.

Advanced Student

The Advanced Student phase builds on the challenges, successes, and experiences of the previous phase. In this phase, you begin to reconcile your performance with academic and professional expectations set by you, your clinical supervisors, and your graduate program. You may vacillate between feeling overconfident and feeling overwhelmed, leading researchers to dub this phase of counselor development *Confusion* (Loganbill, Hardy, & Delworth, 1982) or *Conditional Autonomy* (Skovholt & Rønnestad, 1995). At times, you may experience increased confidence in your skills particularly after positive client and supervisory experiences. Alternatively, you may experience feelings of doubt and uncertainty related to

your perception of your mastery of counseling skills and belief that your peers have met or will meet the training standards before you do. The central task in this phase is to function at a professional level while remaining a student who is open to learning and not knowing. With respect to CTD counseling, the uncertainty and role ambiguity of this phase might result in heightened anxiety and cognitive confusion. This is uncomfortable and normal. Crisis, trauma, and disaster counseling requires advanced knowledge and skill; because you are eager to work independently, yet are still learning, you behave cautiously and conventionally with your clients. The supervisory relationship takes center stage as you attempt to process and balance supervisors' confirmatory feedback with their negative feedback. Table 1.4 presents a summary of the critical elements of the Advanced Student phase.

Advanced students value quality supervision. The opportunity to see multiple clients with diverse concerns provides you a range of experiences, increases the opportunities for positive outcomes, and reduces your self-imposed expectations to be perfect.

Novice Professional

The Novice Professional phase described by Rønnestad and Skovholt (2013) is a highly intense and engaging period, lasting from two to five years post-graduation. It is further segmented into three subphases—confirmation, disillusionment, and exploration. Clinicians in the *Confirmation* subphase have a multitude of decisions to make about employment, types of clients, and development of a clinical specialty. Novice professionals feel free from professors or supervisors, value networking and continuing education, and are excited to start their therapeutic careers. Some novice professionals experience a sense of loneliness and isolation due to the loss of their peer group and identity as a student. Clinicians in the second subphase, *Disillusionment*, may feel dismayed or discouraged. They are disenchanted with their professional performance, graduate education, and profession. They realize clients do not improve as much or as quickly as expected or hoped; acknowledge current theories or techniques are insufficient; experience unfulfilling supervisory relationships; and recognize psychotherapy is a complex and multifaceted processes. Table 1.5 presents a summary of the critical elements of the Novice Professional phase.

The third and final subphase, *Exploration*, is best described as a rebirth or revival of professional interest. Clinicians move away from the stagnation of the *Disillusionment* subphase into a more active and dynamic time where they question professional beliefs and prior education, develop congruence between personal and professional selves, and experience increased creativity, stimulation, and personal reflection. The desire to learn is reawakened as clinicians evaluate the meaning and relevance of their work. Many novice professionals seek to distinguish themselves by developing expertise in an area by seeking additional education, experiences, and supervision. In this phase, CTD counselors may engage in advanced professional development like EMDR or Red Cross Crisis and Disaster training or join local emergency response networks.

TABLE 1.4 • **Advanced Student Phase**

Description	Development Crises	Emotional/Cognitive Experiences	Developmental Tasks	Sources of Influence
<p>2nd year of formal study to the end of graduate study</p> <ul style="list-style-type: none"> *involved in a field placement *independent practice with supervision *has completed most academic coursework 	<p>Students are</p> <ul style="list-style-type: none"> *aware of their personal issues and less productive ways of being *experiencing independence/dependence conflict *more critical of others as student gains independence and autonomy-process of professional individuation *traversing feelings of vulnerability and agency *negotiating the supervisory relationship 	<ul style="list-style-type: none"> *eager to work independently yet still risk adverse *increasing expectations to "do things right" while still feeling uncertain about skill level *in the early part of this phase behavior is cautious and conservative *professional self at times is fragile *more refined use of modeling *increased ability to assess, accept, or reject suggested interventions/processes *more critical of educational program, professors, and assumed experts *oscillating feelings of competence and incompetence *improved understanding of the professional role sympathy ≠ counseling *persistent exploration of knowledge 	<ul style="list-style-type: none"> *learn and understand the complexities of conceptual and procedural knowledge required by the educational institution *sufficient mastery of therapeutic and assessment skills as assessed by supervisors *continue to maintain openness to various theories and approaches at a meta level *modify perfectionistic or unrealistic images of psychotherapy and the role of the clinician *manage perplexity that originates from viewing counseling as increasingly complex 	<ul style="list-style-type: none"> *those identified in earlier phase continue *evaluation of self is based on comparison with assumed competence of more experienced clinicians, skill level of other interns, skill level of beginning practicum students *peer and client feedback become more important sources of feedback *measures of success are more nuanced and extend beyond whether or not the client returns for next session

Adapted from Rønnestad and Skovholt (2013)

TABLE 1.5 • Novice Professional Phase

Description	Development Crises	Emotional/Cognitive Experiences	Developmental Tasks	Sources of Influence
First 2 to 5 years of professional practice	<p>This phase is divided into three subphases:</p> <ul style="list-style-type: none"> *Confirmation *Disillusionment *Exploration <p>*Each phase is navigated through increased experiences with clients;</p> <p>*Supervision is less focused on skill acquisition and development and more focused on treatment planning, client feedback, and client outcomes</p> <p>*apply rule guided learning</p> <p>*recognize situations in a holistic manner</p> <p>*distinguish important from unimportant material</p>	<p><i>Confirmation</i></p> <ul style="list-style-type: none"> *pride *sense of freedom *excitement *intensified association with the profession *desire for formal continuing education/certifications <p><i>Disillusionment</i></p> <ul style="list-style-type: none"> *recognition that one approach does not work for all clients *isolation—fewer peers *dismay that not all clients improve as much as expected *turmoil with others during collaboration *disheartened as one's training or abilities seem insufficient for clients *continued consideration of theoretical orientation(s) <p><i>Exploration</i></p> <ul style="list-style-type: none"> *creative *developing congruence between personal and professional selves *increased self-reflection *self-directed attention toward personal and theoretical issues *reduction of imitative modeling *learning renaissance 	<ul style="list-style-type: none"> *develop professional identification and commitment *complete transformation from states of dependency to independence expected of a professional *address disillusionment and disappointment with graduate education, professional performance, and profession that may surface post-graduation *continue to explore and define professional role *continue role adoption 	<ul style="list-style-type: none"> * feedback from clients, feedback from professional elders, modeling personal-peers, faculty, family *these sources while still present have less influence *increased reliance on self *anchored conceptual structures—integration of personal ways of knowing and worldview with professional self *introspection

Adapted from Rønnestad and Skovholt (2013)

Experienced Professional

Experienced professionals have a minimum of six years or more of professional experience and have mastered the developmental tasks of the novice professional phase. Typically, experienced professionals have experience in a variety of settings—inpatient, outpatient, private practice, or community and agencies with a wide range of clients who have a diverse set of concerns. Clinicians in this phase embody a more well-defined professional self-concept, that is, they know who they are as a clinician, professional, and person. Experienced professionals have moved beyond the simplistic or unidimensional view of themselves and now enjoy a rich and multidimensional understanding of themselves. The match between clinician's self-concept and characteristics of their work setting is critical. The degree of congruence between these two factors bolsters clinicians' desires to be helpful clients and is associated sense of competence. This phase is often when one extends their expertise or specialty techniques like the Advanced Training Certificate Program offered by the International Society for Trauma Stress Studies (ISTSS) and may include supervision to other clinicians. Clinicians providing CTD counseling may experience burnout due to a mismatch or dissatisfaction between their self-concept and the work setting. This mismatch may lead to a waning interest or apathy in helping clients. It is important to note that not all clinicians progress to this phase despite having many years of experience. Some do not progress because they have not mastered the tasks of earlier phases while others do not progress because they were not able to manage the expectations of more complex conceptual or advanced procedural knowledge, display a distant or detached interpersonal style with clients, or because they remain confused when encountering the complexities of psychotherapy. Interestingly, clinicians who develop into Experienced Professionals seem to develop a natural style of psychotherapy, which fuels feelings of competence and professional humility. Table 1.6 presents a summary of the critical elements of the Experienced Professional phase.

Ethical Expectations of CTD Counselors

Rønnestad and Skovholt (2013) note optimal professional development involves integration of the counselor's personal self with her or his coherent professional self as evidenced by increasing consistency between the professional's personality and theoretical or conceptual beliefs. Understandably, graduate students and many early career professionals work to gain a coherent understanding of general counseling, let alone the specialized knowledge required to provide CTD treatment. This integration takes time and dedication; with work and supervision, you can get there! Regardless of your phase of development, clinicians are expected to maintain professional role and responsibilities. This means you practice within the scope of your training, abide by your respective professional society's code of ethics (ACA, 2014; APA 2010; NASW, 2008), and practice in a culturally competent and socially just manner (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015; APA, 2002). Specifically, you are to protect client welfare through the application of mandatory and aspirational ethics (ACA, 2014; APA, 2010; NASW, 2008), engagement in a culturally responsive and ethical decision-making model(s), and the understanding that each client or family or community has a particular culture and individual variations within that culture. You must be aware of your privilege, power, and status

TABLE 1.6 • Experienced Professional Phase

Description	Development Crises	Emotional/Cognitive Experiences	Developmental Tasks	Sources of Influence
6+ years in the profession	*continue to find meaning in therapeutic work appropriateness for the profession	*satisfaction with colleagues, professional autonomy, self-concept, and perception of work role *more willing to share information about personal life and its relationship to therapy *increased use of disclosure *interaction between personal life and professional practice influences clinicians' perceptions of self and their development *more comfortable confronting clients *see power in the therapeutic residing in the client rather than the clinician *more flexible with approaches and techniques *better regulation of interaction with clients-appropriate therapeutic distance	*maintain a sense of professional growth and resiliency *avoid burnout *continue to integrate personal and professional self coherently *seek extensive and varied experiences with clients	feedback from clients, feedback from professional elders, modeling personal-peers, faculty, family *influence is now experienced in the role of supervisor, mentor, instructor *continuing learning in diverse fields other than counseling, marriage and family therapy, psychology, or social work

Adapted from Rønnestad and Skovholt (2013)

and of the intersectionality of those statuses with the lives of your clients and the multiple contexts in which they live. Intersectionality describes the interconnected social categorizations such as race, class, sexual orientation, genders, religion, and socio-economic status as they apply to an individual or group. These categorizations create overlapping and interdependent systems of discrimination or disadvantage.

The Counselor's Toolkit

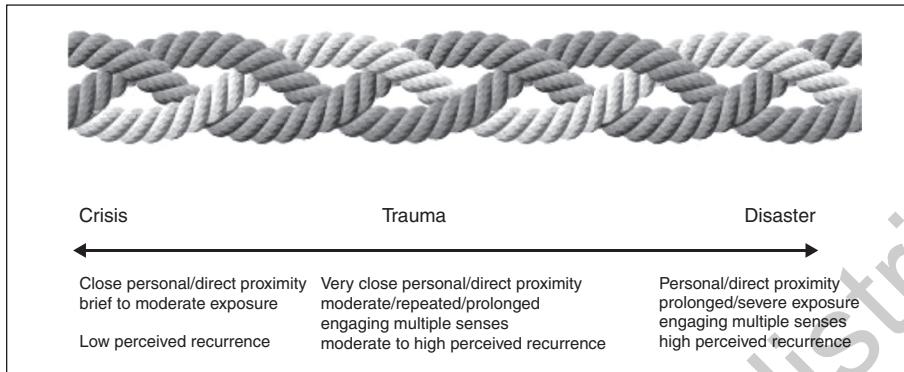
In the chapters that follow, we present a counselor's toolkit for caring for those experiencing crisis, trauma, or disaster. Each toolkit provides multiple tools to address individuals, groups, or communities that are affected by crisis, trauma, or disaster. Specific tools include essential knowledge, skills, awareness, techniques,

and resources for individuals, groups, and communities at each level of professional development.

- Knowledge—the foundational information and understandings clinicians possess
- Skills—specific abilities or proficiencies in counseling
- Awareness—perceptions of self, clients, situations, and environments
- Techniques—intentional combinations of counseling skills with identifiable processes or procedures resulting in specific outcomes
- Resources—access, relationships, means, connections, services, supplies that may be brought to bear in service of clients and communities

Spectrum of Crisis, Trauma, and Disaster

Oftentimes clients and, for that matter, clinicians and researchers, use the terms crisis, trauma, and disaster interchangeably. The conflation or overlapping of these terms is understandable for those we serve, yet clinicians require more precise language. Yeager and Roberts's (2003) framework for differentiating stress, acute stress, disorder, and crisis provides a useful model for consideration. In their discussion, they identify three potential measures of the impact of crisis producing events; *spatial dimension*, *subjective time clock*, and *perceived reoccurrence*. Spatial dimension describes the proximity or distance between the client and the crisis event or relationship to the victim of an event. The closer the individual or group is to the event or the person who experienced the event, the greater the magnitude of impact. The subjective time clock is a measure of the intensity and the duration of the exposure to sensory experiences—sight, sound, smell, touch, and hearing; the more intense and prolonged the exposure, the greater the impact. Finally, perceived recurrence describes a subjective state of the individual's expectation or anticipation that the crisis will reoccur. Perceived recurrence contributes to an active crisis state for the survivor (Young, 1995, as cited in Yeager & Roberts, 2003). Using these three concepts we offer you, the following conceptual framework (Figure 1.1) and caveats. The image below presents three braided ropes representing the spectrum of crisis, trauma, and disaster. The image of the braided rope illustrates the interconnectedness of the three in experiences in which individuals experience increasing levels distress and dislocation. Crisis events are represented at the left of the diagram and describe their proximity (near) or direct (to) the event, the degree of exposure (brief to moderate), and perception of event reoccurrence (low). Traumatic events, positioned in the center represent very close proximity or direct experience of the traumatic event, with moderate to prolonged exposure affecting multiple senses. These individuals perceive a moderate to high risk of a trauma or traumas reoccurring. Disaster events, represented on the right

FIGURE 1.1 • Spectrum of Crisis, Trauma, and Disaster

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side of the spectrum describe direct and personal proximity to the disaster event with prolonged and severe exposure affecting multiple senses and status (housing, vocation, transportation). These individuals perceive a high likelihood that a disaster will reoccur.

The double-headed arrow and image of a braided rope exemplifies our belief that experiences of crisis, trauma, and disaster are not a linear process; rather, they are dynamic, interconnected, multiply influenced, and multi-directional. For example, one can experience a disaster event that becomes a crisis and which is experienced traumatically. This framework is neither meant to represent *hard and fast truths* nor will it represent all clients' experiences. It is offered as one method for you to organize and categorize voluminous amounts of information about which hundreds of texts have been written.

Summary

The context in which clinicians learn and develop professional skills and dispositions and the foundational elements of self-awareness, reflective practice, clinical supervision, and professional development intersect in the life of the clinician and their clients. Clinical education of counselors, psychologists, and social workers

takes place during phases of professional development and is the lens through which CTD counseling is viewed. The spectrum of crises, traumas, and disaster delineates unique and common elements of these client experiences or events and sets the framework for the remainder of the text.

Extended Learning Exercises

Exercise 1

The questions below are provided for you to consider on your own or in small groups. The groupings reflect the major sections of the preceding chapter and are designed to promote a process of dialogue and thought rather than a singular answer.

Experience

What are my experiences of crisis, trauma, or disaster?

What are my assumptions about people experiencing crisis, trauma, or disaster?

Under what conditions would I seek counseling or therapy?

What assistance or services might benefit me?

How might my personal experiences aid or impede my work with clients?

How do I discern sympathy from empathy?

Self-Awareness

How do I describe myself to others?

How would my partner, spouse, or family members describe me?

Why do I want to become a clinician?

What do I like about psychotherapy?

What do I dislike about psychotherapy?

What are my strengths as a clinician?

What are my vulnerabilities as a clinician?

Reflective Practice

What do I want to achieve in psychotherapy or counseling?

What do I want the client to achieve in psychotherapy or counseling?

What do I do in counseling that facilitates client change?

What do I do in counseling that impedes client change?

What skills or ways of being do I want to change about how I conduct counseling?

What skills or ways of being do I want to enhance about how I conduct counseling?

Who can assist me in making improvements to my practice?

Supervision

What do I believe is the purpose of supervision?

How much safety do I experience in supervision?

How honest am I with my supervisor?

How much do I trust the feedback from my supervisor?

To what degree is supervision helpful?

To what degree can I ask my supervisor for what I need?

Professional Development

How well do I reflect the advanced graduate student, novice professional, or experienced professional phase?

How are my experiences similar? How are they different?

What experiences, education, or feedback do I need to continue to progress?

What areas of expertise within crisis, trauma, or disaster counseling would I like to develop?

Exercise 2

The Spectrum of Crisis, Trauma, and Disaster

Consider the spectrum of crisis, trauma, and disaster presented in Chapter 1. Next, ask yourself two questions: (1) What are the

primary differences between these constructs? and (2) What are the primary similarities between these three constructs? As you reflect on the similarities and differences, we invite you to list the distinguishing factors, boundaries, and intersections of crisis, trauma, and disaster, identify the pros and cons of each factor and intersection, and describe the potential client impact of each pro or con.

Additional Resources

Helpful Links

American Psychological Association: <https://www.apa.org/ed/accreditation>

Council for Accreditation of Counseling and Related Educational Programs: <http://www.cacrep.org/>

Council on Social Work Education: <http://www.cswe.org/accreditation.aspx>

EMDR Institute Inc: <http://www.emdr.com/distance-learning/>

International Society for Traumatic Stress Society: <http://www.istss.org/education-research/online-learning/advanced-training-certificate-program.aspx>

Office of Program Consultation and Accreditation: <http://www.apa.org/ed/accreditation/>

Substance Abuse and Mental Health Services Administration (SAMHSA): <http://www.samhsa.gov/>

Training Standards: professional counselors at www.cacrep.org; psychologist at www.apa.org; and social workers at www.cswe.org/getattachment/Accreditation/Accreditation-Process/2015-EPAS/2015EPAS_Web_FINAL.pdf.aspx

Vista Continuing Education: <http://www.vistaceus.com/Default.aspx>

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