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MOOC 2
Learning Unit 4
Group Training

Psychological Early Intervention

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Chapter 3 – Group Supervision

- Introduction

Effective supervision practices can facilitate the professional development of the supervisee, the continued growth of the supervisor, and the overall development of our field and its practice. In addition to individual supervision, many aspiring certificants also participate in group supervision experiences either as part of their academic practicum or as part of a supervised independent fieldwork experience. Group supervision can provide unique opportunities to establish critical professional repertoires, such as peer feedback skills and public speaking skills. However, the quality of the group supervision experience is impacted by the supervisor's arrangement of the components of the experience in order to maximize the effectiveness of these learning opportunities.

Since the successful professional's repertoire extends well beyond knowledge of the research and conceptual understanding, the effective professional requires a high level of intellectual and interpersonal skills, and accordingly, frequent peer and supervisor feedback. A group supervision format represents an excellent forum for this type of feedback and the development of these advanced skill sets that cannot be accomplished in the individual supervision format alone, because the supervisor cannot observe interactions with colleagues.

This chapter distinquishigly focuses on the formats of (1) Reflective Practice, (2) Group Supervision: led and peer, (3) Trauma-Informed (IT) Supervision and (4) Trauma-Informed Principles and the Discrimination Model of Supervision.

3.1. Reflective Practice

Introduction

Reflective practice can be considered the key component for achieving critical thinking, self-awareness, and a deeper meaning and understanding in active professional life. Also, a way for integrating theory and practice, for achieving critical control of our personal experience when working with patients. The domain for self-awareness and self-understanding is a major component of effective reflective practice.

Working in traumatized context and/or organization involves distressing dynamics that can lead to more traumatic situations for each individual worker and for the organization itself.

In order to maintain the capacity of working in a context imbued with disappointing dynamics, staff members must develop the ability to tolerate the anxiety of 'not knowing' and create an organizational culture *to be with* the disappointment problem and *carry on*.

Supporting staff at work in difficult places is a crucial starting point in empowering front line practitioners/workers. Regular meeting of the members of multidisciplinary team is needed for co-operative problem solving. Reflective Practice Group can be used in clinical, practicum and supervision setting.

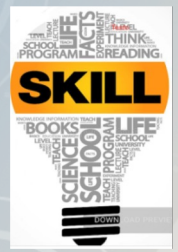
The term 'reflective practice' was coined by Schön in 1983, emphasizing "knowing in action" and since then it was employed in a wider meaning. Dewey (1933) first described reflection in terms of 'thinking about thinking', encouraging professionals to examine the underlying reasons for their choices and actions, as Reflective Practice is a reciprocal process in which experience is the trigger for reflection and a mindful practice for practitioners.

3.1. Reflective Practice

Reflective practice was born as a process in which practitioners gain skills to identify, and change various assumptions to increase awareness, effectiveness, and competency. It constitutes a form of experiential learning which enables professionals to move from their own concrete experiences, to abstract conceptualization of an idea to act upon the new idea and to step to further experience. RP can provide a common training setting in which reflective practice skills can be taught and developed. Early thoughts involve description while deeper levels of reflection involve greater examination of premises and critical synthesis.

Reflective practice is effectively learned:

1. within a small group setting
2. through narrative methods
3. with structured supervision that promotes safety and trust
4. in a guided and mentored experience
5. in a 'learning-by-doing' structured approach in which reflecting can motivate learning and facilitate the assimilation of experience with knowledge and skills
6. critical awareness is achieved by reflecting about what has been done during an intervention (reflection-in-action), by starting analysis after the fact (reflection-on action) and by planning for future interventions (reflection for- action)



3.1. Reflective Practice

- **Gibbs' s model (1988) is an experiential learning cycle model including:**

· 1. Identification and selection of the issue or situation requiring reflection and description of the events

· 2. Discussion of the practitioner's thoughts and feelings

· 3. Evaluation by the practitioner of what was evaluated positive or negative about the event

· 4. Analysis of the event, in order to increase awareness of one's experiences, knowledge, models, skills, values, biases, theories assumptions, and whatever may have played a role in the situation

· 5. Awareness of alternative options and what could be done in the future if the same event occurred

- **Senediak' s (2014) supervision model:**
- Reflective practice focuses on interpersonal patterns between the client and trainee
- The trainee reviews a set of reflective questions to help identify and change clinical interpersonal patterns
- The trainee can develop clinical competence within this therapeutic context that supports reflectivity focused on interactions
- Cooper et al. (2017) using a combination of the two models found that some open questions are very important in enhancing the reflective practice process in a practicum setting

3.1. Reflective Practice

Reflective practice is an iterative process, in which experience is the trigger for reflection. Surface reflection involves description, while deeper levels of reflection involve greater examination of premises and critical synthesis. The capacity for reflective practice is a domain of competency requirements for workers across healthcare domains. Reflective Practice can take the following three formats:

1. **Reflective supervision group** refers to the phenomenon in which an unconscious dynamic from the therapeutic context is 'enacted' in the group, and is called **"parallel process"**. The group, including the supervisor, is mirroring the unconscious dynamics highlighted by the supervisee' s presentation. In this case, the supervisor helps group members to use their experience in the supervision group to reach insight into the therapeutic relationship.

2. **Reflective counselling practice** is a mindful practice for practitioners. In this case, awareness of own strengths or/and limitations, levels of stress and mindfulness of personal matters is fundamental because personal matters can affect performance. After each counselling session, the professional evaluates her/his performance. As learning strategy it allows professionals to become aware of their theoretical base and learn from their experience. Reflective counselling practice with practitioners, or staff in hospitals, is a method to enhance awareness of own strengths or/and limitations. Levels of stress and mindfulness of personal matters constitute key-points as personal matters can affect performance.

3. **Practicum** involves primarily experiential learning (learning-by-doing) in which trainees or professionals reflect on their experiences to continually learn and reapply their learning to a new experience.

3.1. Tips

- Initial worksheet

1. Describe the interaction:
2. What was my question for supervision?
3. What were my thoughts, assumptions, and expectations about the interaction at that time?
4. What was the emotion of the interaction? Similar or different from my usual experience with this client?
5. To what degree do I understand this interaction as similar to the client's interactions in other relationships?
6. What did I want or hope to happen?
7. What assumptions, models, or theories do I now use to understand what is going on?
8. What past professional or personal experiences may have affected my understanding?
9. How else may I describe and interpret this interaction in the session?
10. How might I test out alternatives?
11. How will the clients' responses inform what I do next?

- Post worksheet

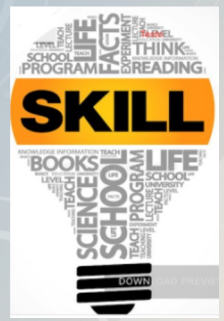
1. Briefly describe the initial interaction along with your initial assumptions, beliefs, models, and/or skills.
2. Describe the supervisory feedback subsequent to the initial interaction.
3. Describe what you did differently based on the feedback and your processing of it.
4. Describe your impressions of the outcome(s) related to your subsequent interactions.
5. What did you learn, if anything, about your initial assumptions, beliefs, models, and/or skills?
6. What, if any, assumptions, beliefs, models, and/or skills do you now use to understand what is going on?
7. What, if anything, will you do differently when faced with a similar client, interaction, and/or issue?
8. Comments

Cooper, L. D., Wieckowski, A. T. (2017). A Structured Approach to Reflective Practice Training in a Clinical Practicum. *Training and Education in Professional Psychology*. Advance online publication. http://dx.doi.org/10.1037/tep0000170

3.2. Group Supervision

When choosing a supervision model, therapists need to match their professional development plan with the model's goals, theoretical orientation, member roles and relationship (leader-led/leader-less), the degree of structure in the procedure, members' roles and feedback focus, and stages in group development.

There are two types of group supervision: vertical and horizontal. Vertical supervision is a hierarchical relationship, with the supervisor as an identified expert in the process and includes tutorial supervision, training supervision, managerial and consultancy supervision. Horizontal supervision is a non-hierarchical relationship, commonly referred to as peer supervision, and supervision is at the same level in a form of consultancy. Peer supervision differs from more traditional forms of supervision in that it does not require the presence of a more qualified, identified expert in the process; the supervisor, and in that the peer supervision process emphasizes developmental, critical and supportive feedback and encourages self-directed learning, while deemphasizes evaluation.



3.2. Group Supervision

- The group supervision experience can help establish very specific professional repertoires that can only be accomplished in a group setting, such as actively listening to others, refraining from engaging in competing activities and contributing in a way that keeps the group moving along in a positive and productive manner. The benefits to the group setting are plentiful, alongside with the skills required.

- <u>For the group supervision leader</u>:
- It is important to structure the experience in a way that will maximize the potential benefits, so you: 1. create a schedule and a standardized format, 2. use group supervision for generalization of skills from individual supervision, 3. incorporate public presentation opportunities, 4. plan for specific behaviours to ensure productivity and positivity and 5. manage interpersonal dynamics.

- <u>For peer group supervision (leaderless supervision)</u>:
- Peer supervision provides therapists with a different learning experience to that in leader-led supervision. The principles of the relationship include: 1. free choice of partner, 2. non-hierarchical relationship, 3. no formal evaluation, 4. recipricity and mutuality, 5. equal commitment to structured sessions and 6. reflective learning.

3.2. Group Supervision

Through group supervision, either led or peer, and independently of the supervision model applied for specific reasons, **professionals, trainees, supervisors, participants can achieve:**

- ongoing professional development
- greater (social) networking
- observational learning
- having multiple listeners for the same event
- decreased dependency on authority
- increased reflectivity and options from different frameworks
- reducing limitations of work, autonomy and conflict resolution when needed
- developing empathy
- peer feedback
- coping with isolation of private practice
- gaining and providing support, encouragement and practical ideas
- modeling and rehearsing positive and productive discussion
- practising public speaking and presenting
- developing professional repertoires
- meeting individual goals relating to difficult cases, ethical and professional issues
- developing a greater awareness of counter-transference and parallel processes
- feeling safe to present, gained community, collegiality
- continuing education and reassurance, validation and belonging

3.2. Tips

There are several models of group supervision, either leader-led or leader-less/peer, applied in clinical and therapeutic fields, indicatively mentioned the following:

1. The Personal Construction Models of Group Supervision: Led and Peer

2. The Group Reflection Model

3. Role-playing

4. The Structured Peer Group Supervision

5. The Group Supervision Alliance Model

6. The “Plunket Model” of peer reciprocal supervision

7. A Greek model of supervision: the matrix as supervisor – a version of peer supervision developed at IGA (Athens)

3.3. Trauma-Informed (TI) Supervision

- **Introduction**

Trauma-informed (TI) supervision is a fundamental element of trauma-informed care, a supportive supervision based on the five core tenets of TI approach that enables therapists to operate from a trauma-informed perspective. Trauma-informed (TI) perspective underlines the interaction between the social, personal and biological realms and recognizes the cumulative effects of trauma. This approach rephrases 'What is wrong with you?' into 'What happened to you?'.

Sweeney, A., Filson, B., Kennedy, A., Collinson, L., Gillard,S. (2018). A paradigm shift: relationships in trauma-informed mental health services. British Journal of Psychiatry Advances. Vol. 24;319–333.

The term "trauma-informed" was introduced in 2001 by Harris and Fallot and refers to social and mental health services that receive people affected by some trauma. The core of trauma-informed perspective is defined by 5 principles: **trust, safety, choice, collaboration, and empowerment**. This perspective endorses that "any person seeking services or support might be a trauma survivor… [Treatment must] recognize, understand, and counter the sequelae of trauma to facilitate recovery".

Goodman, L. A., Sullivan, C. M., Serrata, J., Perilla, J., Wilson, J. M., Fauci, J. E., & Di Giovanni, C. D. (2016). Development and validation of the Trauma-Informed Practice Scales. Journal of Community Psychology. Vol. 44; 747–764. pp. 748.

In the immediate aftermath of trauma exposure setting, a trauma specific, focused, or centered service promotes resilience and mitigation of long-term negative effect. Trauma-Informed practice recognizes the interpersonal and sociopolitical frame of trauma.

Berger, R., Quiros, L. (2016). Best practices for training trauma-informed practitioners: Supervisors' voice. Traumatology. Vol. 22(2). 145–154.

3.3.1. Trauma-Informed (TI) Perspective

Introduction

Trauma-Informed Care is not "trauma therapy", but it recognizes the multifaceted treatment needs of the victims and the connection between past traumatic experience and present-day challenges.

Trauma-Informed Practice addresses the different contexts, in which traumatic experience may surface. People who had experienced a traumatic event seek assistance to address their responses to it. Others seek help to cope with problems in current life that reflect and stem from past traumatic event.

A T**rauma-Informed organizational culture** is built on the five core principles of a trauma-informed perspective: **safety, trust worthiness, choice, collaboration, and empowerment**. These principles represent the opposite conditions experienced by the victims during the traumatic event.
Dill, K. (2019). Trauma-Informed Field Instruction and Models of Practice. *Field Finds*. Vol. 9(2). fieldeducator.simmons.edu

Trauma-informed care and supervision are necessary in any practice setting.

Trauma-informed supervision requires the same five elements that comprise trauma-informed practice and care. Berger, R., & Quiros, L. (2016). Best practices for training trauma-informed practitioners: Supervisors' voice. *Traumatology*. Vol. 22(2), 145–154.

3.3.1. Trauma-Informed (TI) Perspective (i)

Indirect trauma is a consequence of working with survivors of trauma, it is different from burnout syndrome and countertransference, though it may lead to these phenomena. **Secondary traumatic stress, vicarious trauma, and compassion fatigue** are the three distinct and interrelated manifestations of it. The risk of indirect trauma is higher among newer professionals in the job, among the ones with less experience at work, among the ones with long lasting experience working with trauma survivors, and the ones with less education.

Secondary traumatic stress, as a form of indirect trauma, is included in the PTSD diagnosis of DSM-V (APA, 2013), where the health professional mirrors and presents symptoms similar to those of the trauma survivors. The cluster of symptoms includes intrusive and persistent thoughts/images of the victims, hypervigilance, hyperarousal, reexperiencing the client's trauma in recollections and dreams. Professionals, in order to react to the persistence of these symptoms, adopt strategies such as emotional insulation, denial, detachment, and disbelief.

The term **vicarious trauma** often refers to an extended range of professionals' reactions. More specifically, it is a specific manifestation of distortions in thinking among personnel working with people exposed to trauma. Health personnel develop a worldview, as their clients', characterized by suspicion, pessimism, and powerlessness.

3.3.1. Trauma-Informed (TI) Perspective (ii)

Compassion fatigue is particularly common among personnel, who work with trauma survivors, but also in other therapeutic settings, such as Intensive Care Units. After long period of personnel's exposure to trauma, while being very empathetic to survivors' stories of trauma, witnessing and participating in their distress, personnel presents an inability to empathize with clients. This phenomenon is more intense in cases where survivors/victims faced difficulties to engage or displayed hostility toward staff.

"Vicarious resilience" or "vicarious post-traumatic growth" has been observed among therapists working in a variety of health services. The term refers to therapists' personal growth and positive impact, due to the exposure to their patients' resilience. In other words, the concept of vicarious resilience refers to the positive effects on therapists by witnessing their patients working through their traumatic experiences.

3.3.1. Trauma-Informed (TI) Perspective (iii)

The five Core Principles of Trauma-Informed Perspective (TIP)

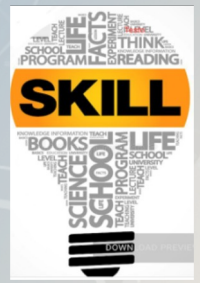
Safety includes physical and emotional safety. Trauma survivors may experience other people and the world as unsafe. The assurances of privacy, appropriate physical space and office furnishings contribute to sense physical safety. Emotional safety develops through the experience of a supportive, validating, and understanding relationship between victims and staff members. Safety is, also, interdependent with trust.

Trust depends on the establishment of open and honest communication, and clear boundaries by the clinician. Confidentiality is protected, but if there is a need to break it you should explain that in advance. Cultural awareness sustains trust worthiness, since individuals' experience of trauma is influenced by cultural identity. Trust involves helping clients trust themselves, developing self-capacities to cope with feelings.

Empowerment refers to the working relationship which, in turn, will reinforce victims' capability to achieve their goals and get more control on their lives.

Choice refers to the concept that victims are the experts in their lives, following victims' empowerment.

Collaboration between health staff and victims reinforces victims' choice and empowerment.



3.3.1. Trauma-Informed (TI) Perspective

In order to decrease the risk for Indirect Trauma

Ensure an organizational culture that normalizes and validates professionals' psychological reactions

Assure a supportive organizational atmosphere

Self-care proaction is a basic activity in managing the effects of indirect trauma

Sustain and develop organizational and supervisory environments that promote self-care activities

Convey to the staff the notion that responsibility for mediating the impact of indirect trauma is both organizational and individual

3.3.1. Trauma-Informed (TI) Perspective

Positive outcomes include:

- increased appreciation for opportunities in life
- rearrangement of personal goals and priorities
- enhanced sense of professional competence and inventiveness
- intensified attitude for compassion and empathy
- for those therapists with a history in trauma exposure, affirmation of their strengths and resilience

3.3.2. Three Types of Trauma-Informed Supervision

Introduction

Besides a general difficulty in the provision of clinical supervision, providing trauma-informed supervision challenges supervisors' knowledge of trauma-informed practice and care, and also their understanding of the nature of trauma and its sequelae.

Many models of clinical supervision have been developed during the last 25 years, but an integration of trauma-informed principles within these models is lacking. A critical task also for trauma-informed supervision is how to address therapists' reactions to working with trauma survivors.

It is important to help students/supervisees/trainees understand and recognize their own resilience when confronted with the trauma history of their patients and to enable them to integrate it into practice.
Trauma history may affect therapists' own lives and their relationships with patients. Peer support and open dialogue during supervision promote insight in their experience as therapist.

The three types of TI Supervision are distinguished and described, as above:

1. **Trauma-informed supervision**
2. **Trauma-Informed field instruction**
3. **Trauma-informed field supervision**

Knight, C. (2019). Trauma Informed Practice and Care: Implications for Field Instruction. Clinical Social Work Journal. Vol. 47:79–89.

3.3.2. Trauma-Informed (TI) Supervision

With Trauma-Informed supervision, in individual or group setting, the supervisees become able to respond in a more appropriate and not-traumatizing manner to trauma survivors' histories.

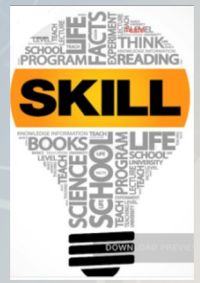
The supervisor should possess knowledge not only about psychological trauma and its effects on victims, but also about basic skills in clinical supervision, indirect trauma, and core concepts of trauma-informed practice and care.

Researches demonstrated that clinicians avoid bringing into discussion those topics that most need supervision. For a therapist who is working with trauma survivors, it is very possible these omitted topics refer to indirect trauma.

Furlonger, B., Taylor, W. (2013). Supervision and the Management of Vicarious Traumatization Among Australian Telephone and Online Counsellors. *Australian Journal of Guidance and Counselling*. pp 1-13 doi 10.1017/jgc.2013.3

The supervisor should not pay too much attention to supervisees' personal reactions, exclusively referring to a personal level, during the referred session. Excessive concentration on personal experiences may conclude in a quasi-therapy, leading to boundary violations and weakened guidance and self-efficacy.

On the other side, ignoring or minimizing the supervisees' reactions may intensify the impact of indirect trauma.



3.3.2. Trauma-Informed (TI) Supervision

You, as trauma-informed supervisor should:

- promote secure attachment

- promote safety and trust, which enable the exploration of supervisees' experiences with indirect trauma

- make simple and intentional self-disclosures, when needed to validate and normalize supervisees' reactions

- maintain boundaries

- make use of parallel process: interactions between supervisors and their supervisees mirror reactions to and interactions with victims. Parallel process is an inevitable and bidirectional component of practice and supervision. This dynamic is not only a manifestation of transference or countertransference. It, also, represents the interplay between the supervisor and supervisees, as they engage with one another and with clients.

- maintain power balance relating to culture, gender, sexual orientation, class and race issues

- promote authentic and non-judgmental conversations

3.3.2. Trauma-Informed (TI) Supervision

Through trauma-informed supervision, supervisors and supervisees achieve:

- secure attachment, that promotes learning, self-reflection, independent thought and action

- the exploration of supervisees' experiences with indirect trauma, that promotes safety and trust

- validation and normalization of supervisees' reactions

- understanding of their affective reactions during their sessions with clients, discussing them with the supervisor

- supervisees' willingness to acknowledge and availability to discuss their affective reactions, fostered by the supervisors' self-disclosures

- supervisor's self-disclosure sustains supervisees' willingness to disclose and discuss difficult arguments

- during parallel process, supervisees reenact difficult dynamics from their practice

3.3.3. Trauma-Informed (TI) Field Instruction

- Trauma-informed field instruction cannot exist without organizational support and trauma-informed care

- Both must adhere to and promote the five trauma-informed principles not only in the treatment of survivors/victims but also between staff

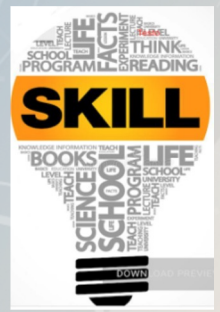
- Trauma-informed field instruction is built upon three basic interdependent responsibilities:

a) educating the student,

b) creating a learning, effective environment, and

c) attending to students' personal and affective reactions to their work/client and the supervisory relationship.

In the field instruction relationship, the contents of the instruction are delivered within a climate of safety, trust, empowerment, choice, and collaboration (the five core principals of Trauma-Informed Perspective).



3.3.3. Trauma-Informed (TI) Field Instruction

You, as a trauma-informed field instructor should:

- Frame the field instructor–student relationship as a reciprocal one

- Facilitate collaborative relationship

- Take into account the interpersonal relation with the student, and affective reactions between one another, especially when working with trauma survivors

-Normalize students' reactions, by disclosing and discussing their emotional reactions to victims

- Explore in advance possible feelings that the student may face during the next session with the survivor/victim

-Directly address transference phenomena

-Try to integrate the five trauma-informed principles into supervision

-Fit in the trauma-informed context any supervisory skills you already use

-Offer continuing education workshops on trauma

3.3.3. Trauma-Informed Field Instruction

Through trauma-informed field instruction, instructors and students achieve:

- Safety and trust, framing the field instructor–student relationship as a reciprocal one

- Improved feelings of self-efficacy and mastery, by a collaborative field instructor-student relationship

- Sustainment of students' self-directive, identifying learning needs

- Promotion of students' reflection of the TI principle of choice

- Normalization of students' reactions

- Reducing the impact of negative students' reactions

3.3.4. Trauma-Informed (TI) Field Supervision

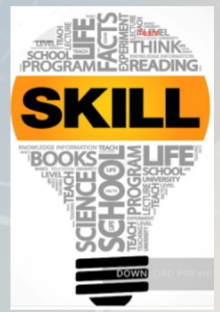
The integration of trauma-informed principles in supervision practice, help normalizing supervisees' experiences. Accomplishment of learning needs and deeper understanding of trauma survivors' narratives are also acquired.

Carolyn Knight is a pioneer for the subject of trauma-informed care within the context of field instruction. Her analysis explores the specific realities of integrating a trauma-informed perspective, when supervising students.

Knight, C. (2018). Trauma-informed supervision: Historical antecedents, current practice, and future directions. *The Clinical Supervisor*, 37(1), 7–37. doi:10.1080/07325223.2017.1413607

"Supervision relationships [in trauma work] are most meaningful, when co-created, and where supervisor and supervisee anticipate a reciprocal process that may reflect enactments of treatment scenarios that surface in the supervisory relationship".

Miehls, D. (2010). Contemporary Trends in Supervision Theory: A Shift from Parallel Process to Relational and Trauma Theory. *Clinical Social Work Journal*. Vol. 38:370–378 p.377.



3.3.4. Trauma-Informed (TI) Field Supervision

You, in the role of field supervisor should promote the following core principles:

1) knowledge about trauma

2) safe and supportive relationships

3) an atmosphere that respects the five tenets of a trauma-informed perspective

- in the case of development of parallel process, you frankly discuss this phenomenon, opening, this way, the space for more insight and acknowledgment of the dynamics in the session that were mirroring in the supervision

- in your role of supervisor, keep in mind that you are looked at as a good model of professional behavior

3.3.4. Trauma-Informed (TI) Field Supervision

Through trauma-informed field supervision, supervisors and supervisees achieve:

- Deeper understanding of the dynamics during the session with the survivors, and during the supervision session

- Improvement of the relationship between supervisee(s) and supervisors

- Amelioration of supervisees' and supervisor's self-understanding and understanding one another

- How to handle similar situation in their work with survivors/victims

- Sustained and enhanced collaboration and empowerment TI principles

3.4. Trauma-Informed Principles and the Discrimination Model of Supervision

Introduction (i)

Bernard's Discrimination Model is one of the most utilized and widely known model of supervision. This model conceptualizes supervision as an educational and relational process.

The supervisor's role addresses **three different dimensions concerning supervisees' skills**:

-**intervention** refers to skills and interventions of the supervisee adopted during the session with the client

-**conceptualization** concerns the ability to recognize patterns, themes and levels of understanding of the ongoing process during the supervised therapeutic session

-**personalization**, meaning the supervisees' ability to adapt their personal style, maintaining self-awareness and awareness of countertransference

3.4. Trauma-Informed Principles and the Discrimination Model of Supervision

Introduction (ii)

In a trauma-informed context, the implementation of the three **discrimination model roles of the supervisor (those of teacher, counselor, and consultant)**, supervisees receive guidance, education, and suport:

- In the **teaching role**, the supervisor has primary responsibility for supervisees' learning, also enhancing a more active learning attitude. This role is critical with inexperienced supervisees, or when they are facing an unfamiliar to them clinical situation.

- The **consultant role** is more advisable and eligible with supervisees, who are more confident in their abilities and receptive to learning. The supervisor increases their ability to think more critically and analytically.

- The **counselor role** includes helping supervisees recognize, examine and handle their feelings and reactions towards the client, in order to meliorate the therapeutic process. This role doesn't mean providing therapy to the supervisees.

Furthermore, the 5 principles of trauma-informed approach underline the importance to deal with the relational aspects of the supervisory relationship

Berger, R., & Quiros, L. (2016). Best practices for training trauma-informed practitioners: Supervisors' voice. *Traumatology*, 22(2), 145–154. doi:10.1037/trm0000076

3.4.1. Trauma-Informed Principles and the Discrimination Model of Supervision

Safety Principle

Supervisees working with trauma survivors/victims, experience their clients' trauma narratives in a way based upon their (i.e. supervisees's) personal history, background, professional training and job experience.

Supervisors should assist clinicians/trainees/supervisees in minimizing the negative impacts of their work and their psychological burden.

Supervisors should promote supervisees' self-care.

Indirect trauma is not countertransference, but these two processes are often co-occurring and, also, reinforce one another

Berger, R., & Quiros, L. (2014). Supervision for trauma-informed practice. *Traumatology*. Vol. 20:296–301. doi:10.1037/h0099835

3.4.1. Trauma-Informed Principles and the Discrimination Model of Supervision

Safety Principle /Supervision work and supervisors' skills include:

- Attempting to identify strategies in order to prevent indirect trauma
- Acting in teacher and consultant role, which promotes supervisees' understanding of their affective reactions during work
- Helping supervisees' understand the countertransference process and develop strategies to elaborate it
- Modeling supervisees' vulnerability and helping them elaborate their feelings about clients' trauma

-Modeling transparency and vulnerability is essential for acknowledging, and elaborating countertransference and indirect trauma

-Engaging in tuning emotionally in each supervisory session

-Promoting reflections on any noteworthy changes in supervisees' reactions during a therapy session, and trying to understand, if their reactions are related or not to personal or professional experiences

-Normalizing supervisees' personal reactions

-Promoting supervisees' self-care

-Maintaining the boundaries in the supervisory relation

-Defining and clarifying supervisees' expectations from both supervision and/or their clients

-Encouraging supervisees to undertake an active role in learning

-Promoting open discussion

3.4.1. Trauma-Informed Principles and the Discrimination Model of Supervision

Safety Principle

- Supervisees feel accepted and understood
- Normalization and validation of manifestations of indirect trauma
- Minimization of indirect trauma impact
- Easier managing of supervisees' affective and/or behavioral reactions
- Fostering professional growth and responsibility in the supervision context, as a 'safe place'
- Decrement of indirect trauma effects by working together
- Strengthening supervisees to engage in self-care
- Containing the pain of working with survivors/victims

3.4.2. Trauma-Informed Principles and the Discrimination Model of Supervision

Trust Principle

Trust and safety are interdependent principles of trauma-informed approach.

The supervisor should recognize the possibility for supervisees' re-traumatization, in case the supervisory session focuses too much on client's disclosures.

In settings where survivors' present-day problems are foreground, staff members may have a tendency to ignore or avoid exploration of the trauma, hindering survivors' trust development.

In the supervisory relationship the issue of mandatory reporting, and its impact on the therapeutic relationship, is also discussed. Sometimes, making a report can be perceived as breaking client's trust.

3.4.2. Trauma-Informed Principles and the Discrimination Model of Supervision

Trust Principle

Trust is facilitated when supervisors help supervisees in understanding:

- how survivors/victims relate to the external world after the traumatic event
- survivors'/victims' core beliefs about themselves and others
- how these beliefs influence the therapeutic relationship

Assist supervisees in understanding:

- manifestation of transference and how these dynamics may deepen or impede therapeutic alliance and, consequently, clients' insight
- how to help their clients' managing present-day problems

The counselor role incorporates addressing supervisees' affective reaction, while maintaining clear boundaries.

Verify and control that the main focus remains on the supervisees' reactions, and not on the traumatic event itself.

Discuss requirements of mandatory reporting, how to meet their legal obligations, and how to reduce the impact on the therapeutic relationship, preserving client's trust.

3.4.2. Trauma-Informed Principles and the Discrimination Model of Supervision

Trust Principle

Trust will be fostered when the supervisees view the supervisor as:

- knowledgeable about trauma and its impact on both survivors and therapists
- suitable and sufficient in teaching appropriate interventions and techniques

Avoidance of re-traumatization, by focusing on supervisees' reactions and not on the traumatic event itself

Maintenance of boundaries protects the supervisory relationship from shifting into a therapeutic one

Enhancement of self-awareness, that is obtained by the supervisors' intentional and designed exploration of supervisees' personal reactions

3.4.3. Trauma-Informed Principles and the Discrimination Model of Supervision

Choice, Collaboration and Empowerment Principles

In trauma-informed supervision, the mutual developing relationship makes recognizable the equal value of both supervisees' and supervisor's previous knowledge and contribution.

The supervisor should be available in undertaking the teacher role, especially when supervisees exercise their first trauma-informed practice.

Fontes (1995) first described the so-called "share vision approach". In this model, the supervisor facilitates the development of an egalitarian relationship that allows open and authentic discussion with the supervisees, reducing power differences.

The concept of a more egalitarian relationship focuses the attention on both parties, including their in-between relationship, as the relational model of supervision indicates.

Peled-Avram, M. (2017). The Role of Relational-Oriented Supervision and Personal and Work-Related Factors in the Development of Vicarious Traumatization. *Clinical Social Work Journal*. Vol. 45:22-32.

3.4.3. Trauma-Informed Principles and the Discrimination Model of Supervision

Choice, Collaboration and Empowerment Principles

- As a trauma-informed supervisor you should balance your roles between the expert-teaching and the consultant one. Consultant's role focuses more on increasing supervisees' autonomy, empowerment and independence. Help supervisees in understanding the situation, where clients need assistance in managing present-day challenges.

- The egalitarian approach is effective in working through the manifestations of parallel proces.
Miehls, D. (2010). Contemporary Trends in Supervision Theory: A Shift from Parallel Process to Relational and Trauma Theory. *Clinical Social Work Journal*. Vol. 38:370–378 p.377.

- Address supervisees' personal issues when they surface in supervisory relationship. Display authenticity and transparency.

- Promote honest discussion about the supervisee-supervisor relationship. Relational theory considers parallel process as a reflection of transference from both parties, in the supervisee-supervisor relationship.

- As a supervisor, you should accomplish organizational requirements, while maintaining personal responsibility for both supervisees and clients. Trauma-informed orientation helps in finding a non-conflictual position between organizational demands and responsibility.
Becker-Blease, K. A. (2017). As the world becomes trauma-informed, work to do. *Journal of Trauma & Dissociation*. Vol. 18; 131–138.

3.4.3. Trauma-Informed Principles and the Discrimination Model of Supervision

Choice, Collaboration and Empowerment Principles

Supervisees achieve:

- Supervisees learn how to recognize and address countertransference in the therapeutic relationship
- Supervisees, through understanding their reactions during supervision, learn about their clients' reaction towards them
- Amelioration of the supervisory relationship, by working through transference processes, that, in turn, improves clinical practice
- Exploration of mutual transference during supervision with an open and honest disclosure
- Encouragement of both personal and professional growth
- Sharing their progress and professional achievements, not only difficulties or challenges
- Modeling the conversation for the next therapeutic session with clients
- Mutual respect deriving from the displayed genuineness and transparency on behalf of the supervisor, from clarification of expectations, and by fostering supervisees' feedback
- Minimization of the negative effects resulting from power relations in supervisory processes

3.3. Trauma-Informed (TI) Supervision

- **Conclusion**

All of the above characteristics, inherent in trauma-informed supervision, can only occur in a specific organizational context, that is trauma-informed.

Trauma-informed supervision should be available to the clinicians and should have duration and continuation in time.

Trauma-informed supervisors should have access to specialized support and guidance, as their supervisees have.

In trauma-informed practice and care, usually faced within an organizational context, mirroring processes between clients and therapists, and between supervisors and supervisees are already difficult. In case, though, of a private practice setting, these mirroring phenomena are amplified.

The application of trauma-informed practice and care in peer supervision is still a pioneering practice.