Clinical
Supervisor Training

Class One,
Part One

Foundations of Trauma-Informed Therapy and Supervision

An Introduction

Our Class One Roadmap

1. Holding and performing clinical supervision foundations and tasks while viewing our supervisees and their client cases through trauma-educated (trauma-sensitive) lens – on a micro and macro level.

2. The 10 core foundations of trauma-informed therapy and supervision.

What Is *Super-vision*?

Seeing things from a full and comprehensive perspective of two people in the room.

- A faraway look at the **big picture** of the client, the supervisee, and what is happening in the supervision session.
- A **close-up look**: at a particular aspect of something being brought up (or is showing up) in a supervision session.

What Is Super-vision?

- Supervision is **more than case discussion or consultation**:
  - It includes routine invitations for reflection by both parties in a collaborative way.
  - It makes space for exploration, reflection, and feedback on different levels: situational, cognitive, emotional, and nervous system levels.
  - It is interactive - growth happens within the supervisory **relationship.**
  - It supports supervisee **growth** while **protecting clients** and the **public.**

What Is Super-vision?

Sometimes **Evaluative** and, Therefore, **Hierarchical** — Yet Also **Developmental**:

- Supervision includes evaluation and authority.
- Evaluation protects clients, the supervisee, and the profession.
- Promotes accountability, integrity, and encouragement.
- The purpose of the evaluation is developmental — not control or shaming.
- There is a power difference that must be used ethically.

What Is Super-vision?

Structured, Contracted, and **Accountable:**

- Supervision is intentional and organized.
- Clear agreements outline the roles and expectations in the supervision relationship/dynamic/process.
- Things like: frequency, documentation, goals, and specific evaluation tools/goals are well-defined ahead of time.
- Transparency creates safety and clarity – it sets the tone for honest introspection and growth.
- Because client welfare is involved, supervision carries real responsibility.

What Is Super-vision?

Embedded Within Ethical, Cultural, and Regulatory Systems:

- Supervision exists within well-defined ethical codes and standards that are understood and/or taught.
- It operates inside regulatory and professional frameworks.
- Supervisors must consider culture, diversity, and power.
- Clinical work isn't just on the client level; it is also shaped by broader social systems. **These are always being considered together** (macro and micro levels).
- Super-vision means seeing the client, therapist, system, and profession together.

Super-Vision is Relational So We Can Support:

- Multiple viewpoints - in a safe space/process to explore these.
- The complexity of the client's world as it intersects with the therapist's world, and how this then shows up in the supervisory relationship / experience.
- Collaborative conversations.
- Goodwill and respect.
- It 'interrupts' our typical practice. It wakes us up to what we are doing. Supervisors are a gentle and respectful 'agitator' of multiple and intersecting functions (both seen and unseen).

Super-Vision is Relational So We Can Support:

Hawkins and McMahon (2020):

- A joint endeavor in which a therapist, through the help of a supervisor, attends to his clients, himself, the client-therapist relationship, and the wider system and cultural contexts.

- Here, she improve the quality of her work, herself as a tool in this, the client's life, and the wider profession, all while staying open to their continuous learning, evolution, and development.

Core Mandate of Super-Vision: Clinical Competence and Client Growth and Welfare

Client welfare anchors supervision:

- Ensure supervisee skills, knowledge, and competence
- Safeguard client welfare
- Provide ongoing evaluation and feedback
- Protect the public
- Act as gatekeepers of the profession
- Help supervisees grow and develop their own ‘inner supervisor’

Three Interwoven Functions

Effective supervision integrates all three (Hawkins & Smith, 2013; Milne, 2009):

- *Normative*: standards and accountability
- *Formative*: teaching and development
- *Restorative*: support and reflection

On both micro and macro task levels.

Self Reflection: Which of the three is your default? And which one goes missing when you're stressed or rushed? What's your prediction about this if supervising a therapist?

The Concept of Super-Vision

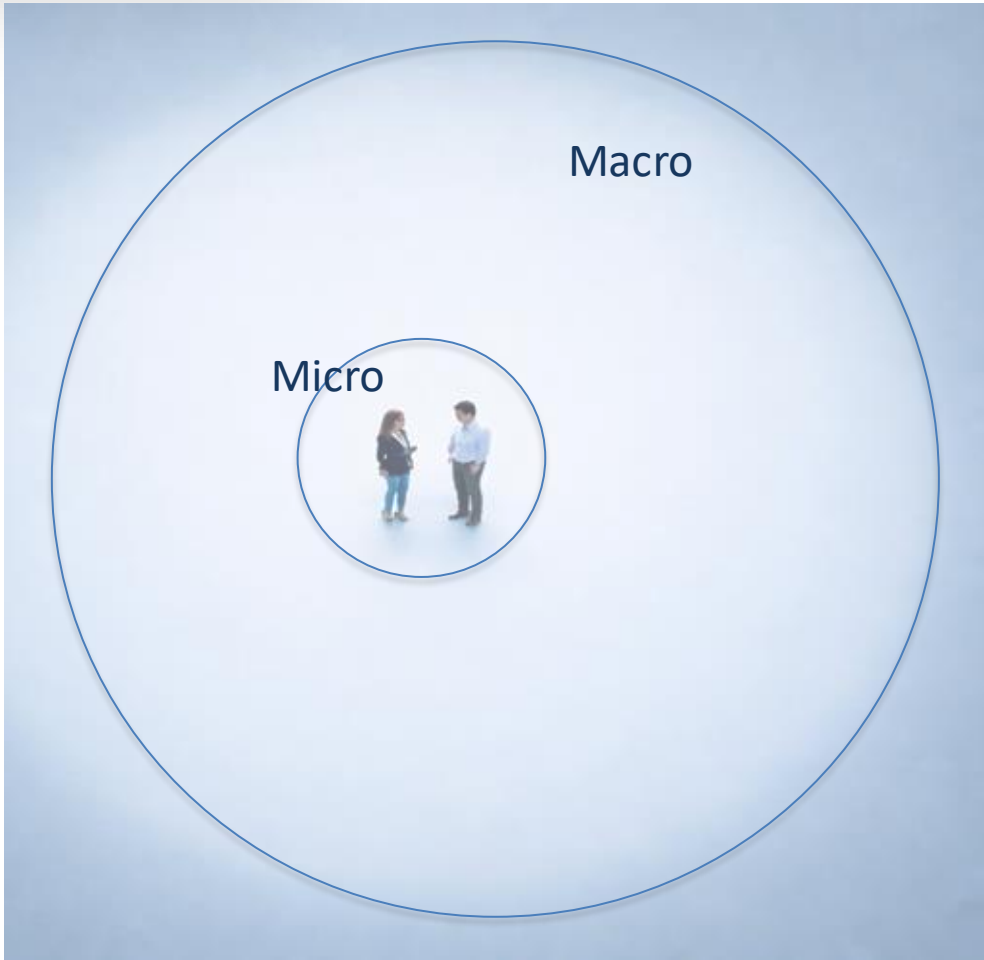
(And, What This Means…)

Micro — Person-Level Considerations

- Emotional & Psychological Health
- Developmental Lags and Needs
- Relationships and Attachment
- The nervous system injuries from trauma
- Identity and Meaning-Making
- Physical and Functional Well-Being
- Practical Life Stressors

Macro — System-Level Considerations

- Social and Cultural Context
- Economic Environment
- Legal and Institutional Systems
- Health Care & Service Structures
- Societal Stressors



Super-Vision Tasks on the Micro Level

What the Supervisor Is Doing in the Room and Supervisory Relationship:

- Building a respectful alliance where learning and honest dialogue can happen
- Being clear about roles, expectations, and the supervision contract
- Slowing down to deepen case conceptualization
- Helping the supervisee connect theory, intervention, and clinical judgment
- Exploring supervisee reactions, including transference and countertransference
- Noticing blind spots and defensive patterns in a supportive way
- Giving clear, balanced, evaluative feedback
- Supporting ethical considerations and boundary awareness
- Challenging gently to expand clinical thinking
- Helping tolerate ambiguity instead of rushing to fix
- Tracking growth and clinical competence over time
- Supporting the development of reflective practice and “internal self-supervisor”

Super-Vision Tasks on the Macro Level

What the Supervisor Is Doing in the Room and Supervisory Relationship:

- Keeping client welfare and public protection at the center
- Ensuring adherence to ethical codes and regulatory standards
- Using structured supervision agreements and documentation
- Evaluating competence and readiness for increased responsibility
- Acting as a professional gatekeeper when needed
- Monitoring scope of practice and professional boundaries
- Modeling professionalism, integrity, and accountability
- Attending to cultural context and social influences in cases
- Recognizing power and hierarchy within supervision
- Preparing supervisees for organizational and institutional realities
- Transmitting professional identity and standards of practice
- Supporting long-term competence within complex systems.

Super-Vision Outcomes for the Supervisee

Outcomes for the Supervisee (Because of Micro Level Supervisory Foundations)

- Increased psychological safety and confidence in learning
- Stronger emotional regulation under clinical stress
- Greater self-awareness of triggers, blind spots, and reactions
- Improved case conceptualization and clinical reasoning
- Ability to tolerate ambiguity without rushing to fix
- Reduced shame around mistakes and performance anxiety
- Stronger ethical judgment in real time
- Increased capacity to self-reflect mid-session
- More thoughtful intervention pacing
- Clearer boundaries and professional decision-making
- Ownership of clinical choices
- Development of an internal reflective supervisory voice

Super-Vision Outcomes for the Supervisee

Outcomes for the Supervisee (Because of Macro Level Supervisory Foundations)

- Clear understanding of ethical and regulatory responsibilities
- Stronger professional identity and sense of role
- Greater awareness of power, hierarchy, and authority
- Ability to recognize (even insidious) systemic trauma and structural stressors
- Increased cultural humility and bias awareness
- Reduced tendency to over-pathologize survival adaptations
- Confidence navigating institutional pressures
- Clearer understanding of scope of practice
- Competence in documentation and accountability practices
- Feel more resilience and confidence/self-trust in high-stress environments
- Stronger systems-level thinking beyond the therapy room or your own experience

Foundations of Providing *Highly Trauma-Informed* Clinical Supervision

Ten *Trauma-Informed* Super-Vision Foundations

1. Safety as a Primary Goal
2. Pacing, Titration, and Timing
3. "Symptoms" as adaptations that are 'normal' given the trauma context
4. Attachment, Power, and Authority issues
5. Transference and Countertransference
6. Rupture and Repair
7. Vicarious Trauma and Sustainability
8. Shame-Sensitive Languaging
9. Dissociation Awareness
10. Nervous system literacy

One:

Safety as the Primary Clinical Goal

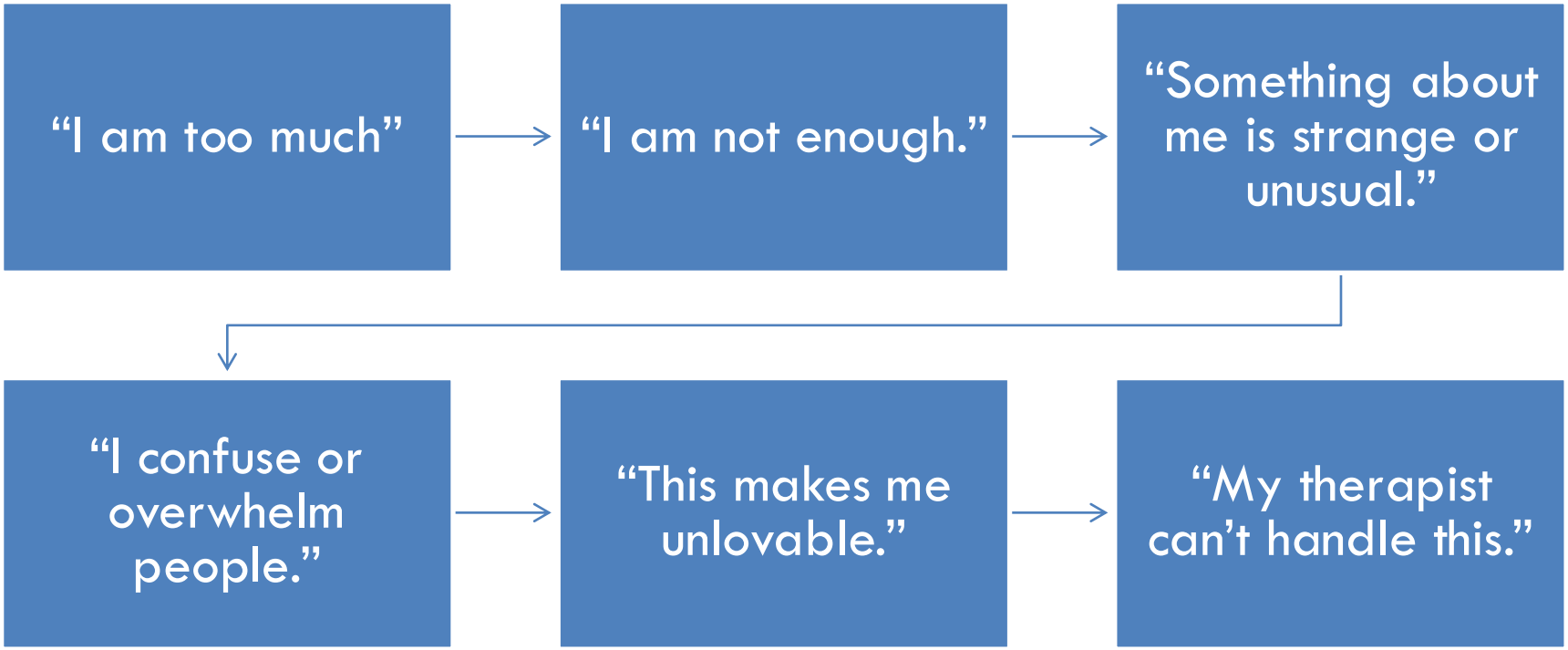
- Pacing the Client
  - Regulation
  - Timing
  - Developmental Issues
  - Boundaries
- Knowledge and Skill
- Therapist Attunement and Authenticity (Use of Self)
- Therapist Curiosity
- Therapist Self-Trust
- Therapist Trusting Client

Safety as the Primary Clinical Goal in Trauma Therapy

Why New Therapists Often Move Too Fast Impacting Safety

- Pressure to help quickly (from client)
- Desire to reduce distress immediately
- Need to demonstrate competence
- Rigid use of therapy techniques
- Lack of self-trust
- Lack of training
- Client's defenses are 'running the session'
- Triggered by the client
- Still developing their own inner safety

Core Shame Impacting Safety for Client



Always Assessing Safety:

- Is the client able to stay present and engaged?
- Is the client becoming more open and curious or more guarded?
- Is the nervous system moving toward regulation or (old) self-protection?

- Is a part of the client feeling unsafe even if cognitively safety is understood?

- Is this a safety issue we can process in the session with pacing?
- How is my sense of safety with this client?

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Overt Indicators of Lack of Safety for Clients

- **Talking quickly or filling space with words**
  A flight response that prevents slowing down into emotional experience.
- **Interrupting or talking over the therapist**
  Can reflect nervous-system urgency rather than intentional disrespect.
- **Restless body movement**
  Foot tapping, shifting posture, adjusting clothing repeatedly.
- **Sudden changes in breathing**
  Breath becomes shallow, held, or irregular when certain topics arise.
- **Urgency to "solve" the problem immediately**
  The client pushes toward solutions to escape emotional discomfort.
- **Abrupt topic redirection**
  Quickly steering the conversation away from vulnerable material.
- **Overly intense eye contact**
  Sometimes a hypervigilant monitoring of the therapist's reactions.
- **Sudden shifts in energy or tone**
  Becoming animated, joking, or overly lively when difficult topics arise.

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Subtle Indicators of Lack of Safety for Clients

- **Over-compliance or "good client" behavior**
  Agreeing quickly with interpretations or suggestions.
- **Excessive intellectualizing**
  Analyzing experiences instead of feeling them.
- **Detached storytelling**
  Describing trauma events without emotional engagement.
- **Minimizing distress**
  "It wasn't that bad," or "Other people had it worse."
- **Rigid politeness**
  Avoiding disagreement or expression of discomfort.
- **Nervous laughter** or smiles around painful material
- **Vague or short answers** to meaningful questions
- **Difficulty identifying emotions or body sensations**
  "I don't know what I feel."

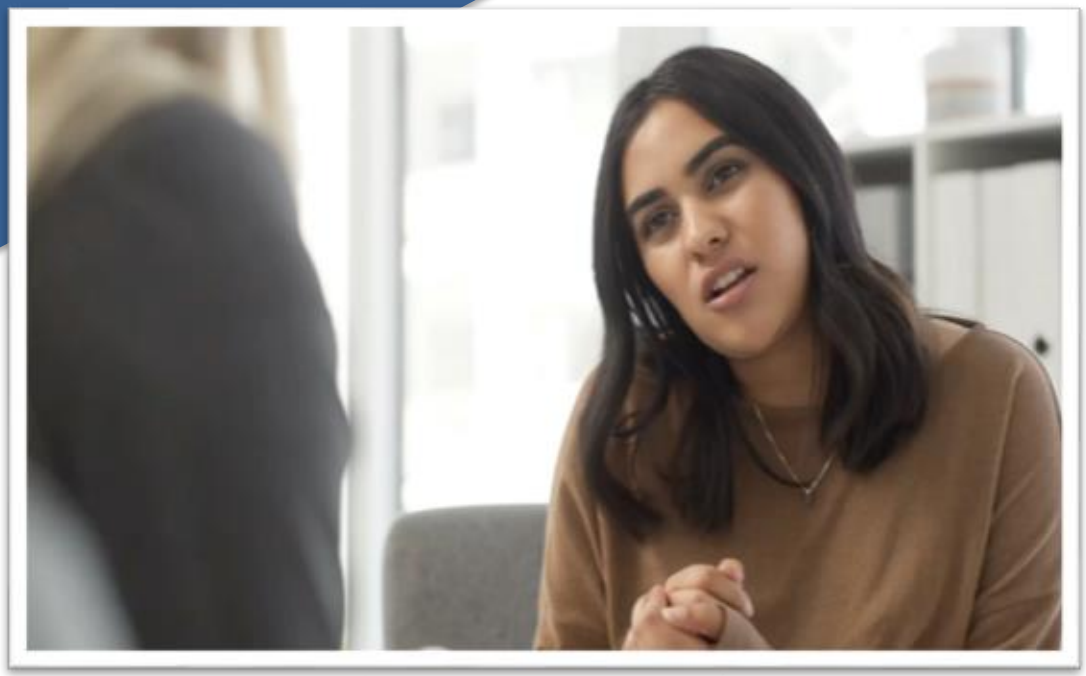
Asking Supervisee, "Is There…"

- Predictable structure and pacing?
- Gentle but open curiosity?
- Expressing non-judgement?
- Trauma psychoeducation to the client?
- Regulation skills and window of tolerance building?
- Tracking of protective parts of client in therapy?
- Tracking nervous system reactions/states?
- Providing lots of choice and control?
- Repairing relational ruptures properly?
- Sensitive and non-shaming language?

How Safety Issues Can Show Up in the Supervisee

- Agreeing quickly with supervisor feedback without discussion
- Presenting cases in overly polished or simplified ways
- Avoiding bringing difficult or confusing sessions to supervision
- Speaking cautiously or choosing words very carefully
- Asking fewer questions than expected for their level of training
- Shifting discussion quickly away from their own reactions in sessions
- Deflecting attention toward techniques or theory rather than their experience
- Being frequently challenging or begging to differ
- Seeking answers over being curious
- Appearing hesitant to challenge or clarify

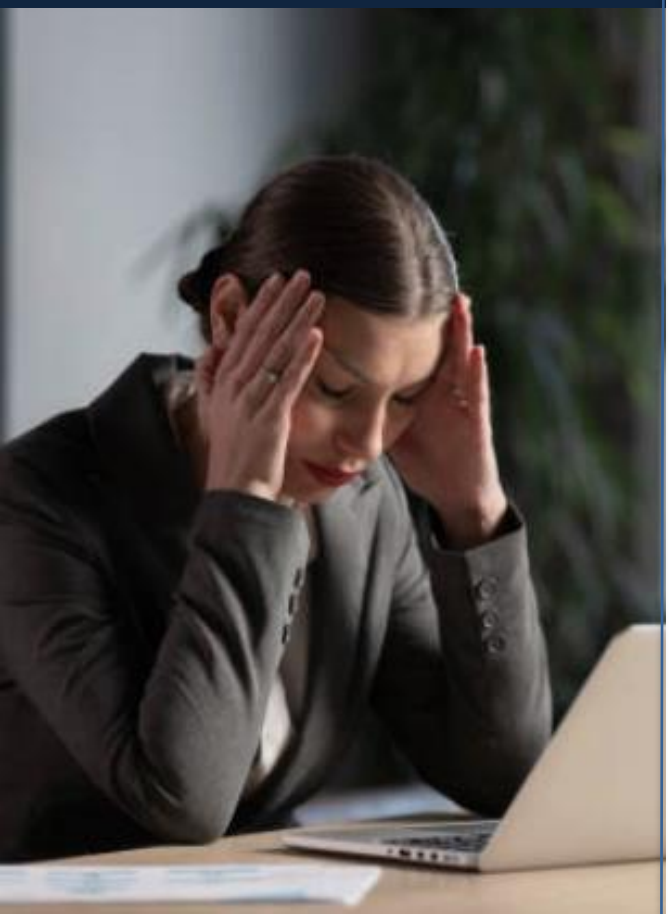
Clinical Supervisor Task

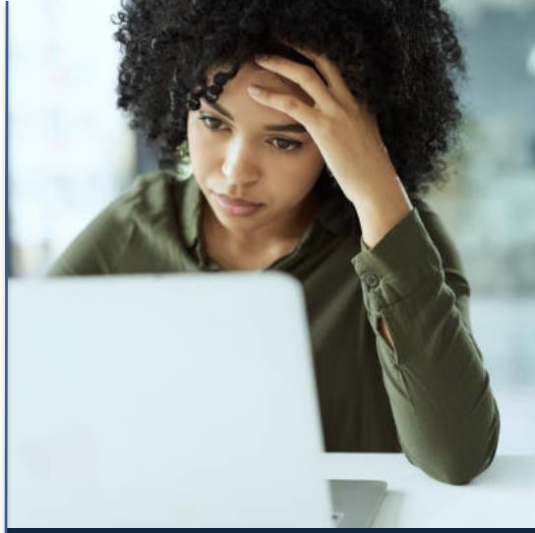


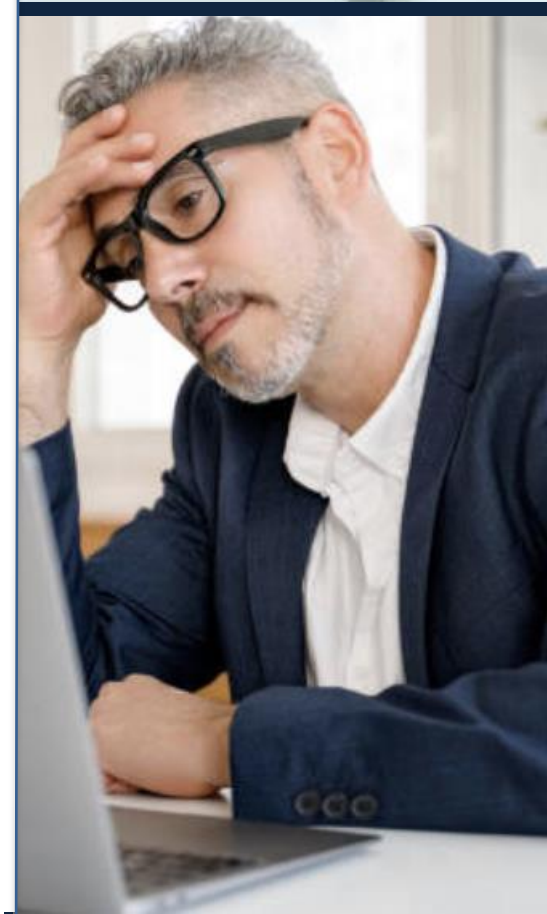
- Normalize uncertainty and learning
- Inquire
- Normalize protection activation in client and supervisee
- Emphasize/model curiosity rather than judgment
- Slow the pace of supervision
- Invite honest discussion of difficult moments
- Be transparent about the supervisory process
- Balance support with guidance
- Acknowledge the emotional impact of the work
- Listen and repair ruptures in supervision

Safety Issues Can Also Occur in the Supervisee

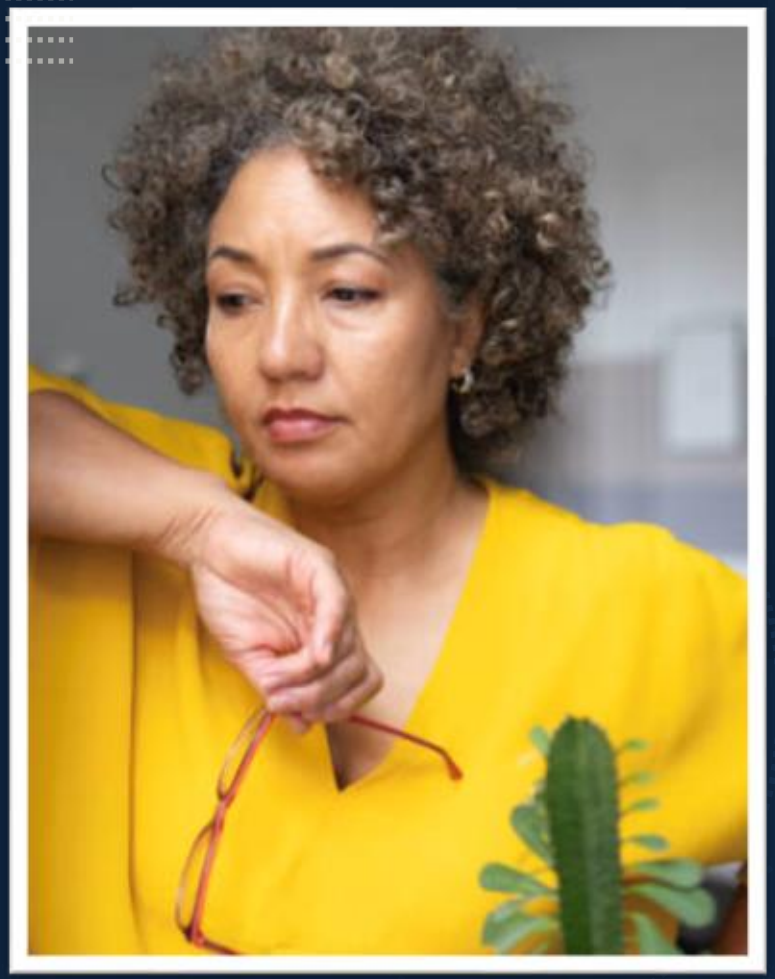
- Client emotions may feel overwhelming
- Fear of making mistakes
- Sessions feel unpredictable
- Session content may feel concerning, overwhelming and/or urgent
- Uncertain what to do
- Uncertain of their skill / pressure to know quickly
- Personal triggers
- Fearing a 'version' of the client
- Fearing client's Protector Parts
- Client inviting 'old dynamic' in therapist that challenges collaboration / safety







How Unsafety May Show Up During Supervision (For Both the Supervisee and the Supervisor)




Two:
Pacing, Titration, and Timing

Pacing Supervision for the Supervisee

- “Slower is faster.”
- As supervisors, we’re not only encouraging a slower clinical pace — we’re modelling it in the supervision room.
- Slowing down creates room for:
- Curiosity — rather than rushing to answers
- Not knowing — without shame or pressure
- Playing with ideas and different clinical perspectives
- Reflection, integration, and growth
- Noticing what may be missing clinically
- Learning that “not knowing yet” can be okay

Of course, the goal is not to fill every silence or solve every problem. It’s to

Signs Therapy May Be Moving Too Fast

Supervisors may notice the following indicators in supervisee Case discussions:

- Sudden emotional flooding in the client
- Dissociation, spacing out, or loss of focus
- Difficulty describing experience or finding words
- The client becomes overly intellectual or disconnected
- Increased avoidance between sessions
- Worsening symptoms after trauma discussions
- The client becomes withdrawn or shuts down during session
- Increased panic, agitation, or distress in session
- The client appears confused, foggy, or disorganized

When these signs appear, supervision tasks:

- Grounding and orientation
- Regulation of the nervous system
- Strengthening internal and external resources
- Re-establishing present safety before continuing trauma exploration.
- Checking the safety in the therapy relationship

Signs Therapy May Be Moving Too Slow

Supervisors may notice the following indicators in supervisee Case discussions:

- Sessions stay focused on education or coping skills with little movement toward deeper material
- Prolonged stabilization without gradual entry into processing
- Client shows readiness to explore more, but the clinician hesitates
- Conversations remain intellectual rather than emotional
- Repeated use of the same safety exercises without progression
- The client reports feeling stuck or not moving forward
- Subtle avoidance of trauma material by the client or clinician
- Clinician expresses fear of dysregulating the client despite adequate stability

When this occurs, supervisors may guide clinicians to:

- Identify small, titrated entry points into trauma material
- Explore protector part concerns about moving forward
- Support manageable emotional engagement
- Move toward gradual processing while maintaining regulation
- Note situational issues that need support first

Supervising Pacing in (Trauma) Therapy Work

Trauma processing must occur at a speed the client's nervous system can tolerate (not just cognitive assessment of this).

Noticing the Window of Tolerance 'Width'

Effective trauma therapy requires clinicians to track:

- nervous system regulation
- emotional intensity
- cognitive processing capacity
- relational safety
- inner and external resources

Supervisors help supervisees evaluate and slow down the work when needed.

Three:

Trauma "Symptoms" as Adaptations

(Not Pathology)

Trauma responses are adaptive survival strategies. So, what if:

- Symptoms reflect nervous-system learning, not disorder or something needing urgent 'fixing'
- Behaviors often labeled 'resistance' are protective
- Supervisors reframe pathology into adaptation and use these to teach supervisees to generate curiosity within themselves, and their clients.

Why This Reframing Is Essential in *Trauma-Informed* Supervision

Pathology-based framing increases shame, defensiveness, and urgency:

- Clinicians may become directive, corrective, too 'evaluative' or confrontational
- Clients' protective nervous-system responses escalate or shut down, and deeply impact therapy (impasses arise)
- Therapy (or supervision) that (even inadvertently) reinforces pathology often recreates trauma dynamics and impasses / stuck points in the work.

Supervisory Task:

Shift Supervisee Languaging and Mindset

"What's wrong?" to "What is (has) this been protecting the client from?"

- Help clinicians identify the *threat* (old/current/real/imaged) the ***nervous system and resulting behavior is organized around***
- Teach supervisees to slow down and be curious… rather than quickly confront and 'fix' protective strategies
- This reframing reduces shame, increases curiosity, and supports ethical trauma care
- Keeps the client's nervous system in the room, not just thoughts and behaviors

What Changes When We Reframe Behavior as Adaptation

Curiosity replaces judgment
(and fear) in both therapist and client:

- Protective behaviors are understood (and even respected) *before* change i attempted
- Understanding 'stuck' or 'resistance' makes so much more sense here.
- The nervous system feels safer, allowing *connection, curiosity, learning and integration*
- Supervisee learns to work with protection rather than against it – more flow, less 'stuck' ("resistance"). Prevents cognitive mind vs. nervous system fears.

The Supervisor's Task:

Modeling the Reframe

Supervisors teach trauma-informed care through how they conceptualize cases.

How supervisors think becomes how clinicians practice:

- Reframing in supervision teaches clinicians how to reframe with clients.
- This stance reduces re-traumatization and ethical drift.
- Works with 'stuckness'
- Helps de-shame the client, while building safety, understanding, and relational alliance.

Four:

Attachment, Power, and Authority

Trauma sensitizes clients to authority and control, which then can impact and ‘heat up’ attachment issues.

What Is Attachment?

Attachment is the biological and relational system that helps humans seek safety, comfort, and connection.

Early relationships shape how people experience:

- Safety and trust
- Closeness and distance
- Boundaries and authority
- Support during distress

Attachment patterns are adaptive strategies learned in early relationships and often become more visible under stress.

The Four Attachment Patterns

Secure Attachment

- Comfort with closeness and independence
- Able to ask for support while maintaining autonomy

Anxious Attachment

- Strong need for reassurance
- Fear of abandonment or rejection

Avoidant Attachment

- Discomfort with emotional dependence and need/vulnerability
- Preference for self-reliance and distance

Disorganized Attachment

- Desire for connection mixed with fear of closeness
- Often linked with early trauma or relational instability

Secure Attachment in Therapy

Characteristics:

- Closeness and autonomy can coexist
- Needs and limits expressed directly
- Therapist used as a resource rather than regulator
- Rupture and repair occur with relative ease
- Comfortable with boundaries
- Consistency in behaviour
- Good internal and external resources

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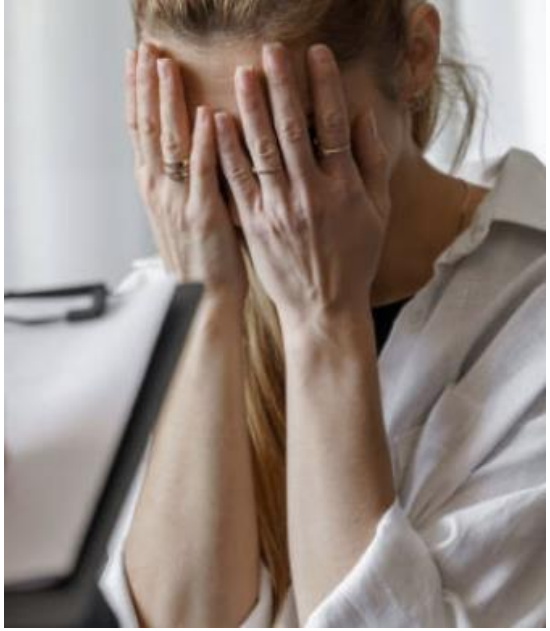


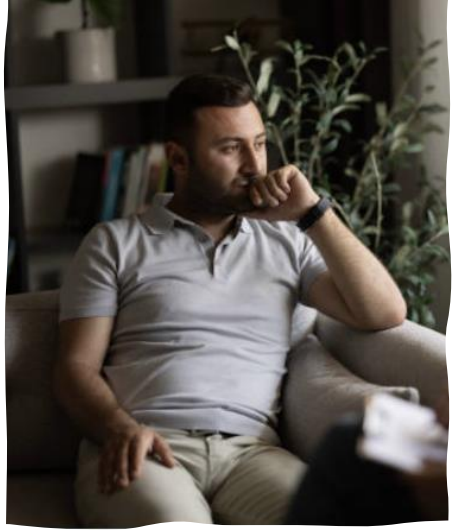
Anxious Attachment in Therapy

Common Patterns:

- Reassurance seeking
- Fear of abandonment
- Sensitivity to therapist tone or availability

Supervisory Tasks:

- Maintain consistent boundaries
- Avoid over-functioning or rescuing
- Identify protector parts



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Avoidant Attachment in Therapy

Common Patterns:

- Discomfort with emotional dependence
- Intellectualizing or minimizing distress
- Withdrawal when emotional closeness increases

Supervisory Task:

- Tolerate distance
- Support gradual engagement
- Identify protector parts

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Disorganized Attachment

Relational Patterns May Include:

- Push–pull dynamics
- Emotional unpredictability
- Therapist confusion or dysregulation

Supervisory Tasks - Guiding:

- Structure and Consistent Boundaries
- Pacing and Time
- Nervous-system Regulation
- Trauma Processing

Attachment Dynamics in Therapy

Trauma therapy activates attachment systems.

As safety grows in treatment:

- Attachment needs become more visible
- Relational sensitivities increase
- Emotional intensity may rise

This is engagement in the therapeutic relationship, not regression.

Supervisor Tasks:

- Teaching about attachment-based issues
- Normalize therapist attachment activation
- Notice urges to rescue, withdraw, or over-control: always tracing countertransference reactions
- Link activation to protective self-parts
- Differentiate therapist protector parts and client's different self-parts
- Reframe reactions as attachment (pain and protection) processes
- Teaching how to track nervous system shifts in the client and the supervisee
- Model curiosity rather than judgment
- Model secure attachment through supervision
- Teach secure attachment therapy with insecure clients
- Continue to monitor pacing and regulation

Attachment: Power, and Authority

Trauma can sensitize people to authority and control.

Supervisors help supervisees understand:

- How power dynamics influence therapy
- How consistent boundaries can both regulate and confuse the nervous system
- How therapist authority can feel stabilizing when held safely.

Five:
Transference and Countertransference

The Relational Triangles in Sessions

Client → Supervisee (Therapist) → Supervisor
(All intertwining and can show up in supervision)

1. Client → (Therapist) Supervisee
   (Therapist) Supervisee → Client

2. Supervisee → Supervisor
   Supervisor → Supervisee

3. Supervisor → Supervisee's Client

The supervisor's task is to step back and observe these relational patterns, helping the supervisee understand what belongs to the client, the therapist, and the supervisory relationship – all while keeping the focus on thoughtful, ethical, and regulated clinical work.

Parallel Process in Supervision

- Parallel process is happening when a relational pattern in therapy begins to show up again in supervision.
- What the **client evokes in the therapist** may be recreated between the **supervisee and supervisor**.
- A therapist who feels **helpless, pressured, criticized, shut out, or overly responsible** may leave the supervisor feeling something similar.
- The supervisor's reactions can therefore become **useful clinical information** rather than something to act on.
- The goal is to **notice, slow down, and sort out** what may belong to the client, the therapist, the supervisor, and the relationship itself.
- We remain curious without **blaming, over-interpreting,** or reacting too quickly.
- **Key supervisory question: *"Whose is this, where is it moving, and what might it be telling us?"***

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Common indicators include:

- Reacting strongly to small misunderstandings or scheduling changes
- Assuming the therapist or supervisor is disappointed or angry
- Feeling unusually eager to impress or gain approval
- Frequently apologizing or worrying about “doing something wrong”
- Becoming discouraged or ashamed after normal feedback or guidance
- Expecting the therapist or supervisor to solve problems quickly
- Hesitating to share struggles for fear of judgment
- Becoming unusually quiet, withdrawn, or guarded in the relationship
- Seeking special attention, reassurance, or extra time
- Testing boundaries to see if the relationship is reliable
- Interpreting neutral tone or brief responses as rejection
- Feeling unusually attached to the therapist or supervisor
- Becoming upset when the therapist or supervisor sets limits
- Reacting strongly to perceived distance, disagreement, or correction
- Comparing themselves negatively to what they imagine the therapist or supervisor expects
- Appointment and scheduling issues that become frequent

Client Transference

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Supervisee Countertransference With Client

Common indicators include:

- Feeling unusually protective or wanting to rescue
- Feeling irritated, frustrated, or impatient
- Feeling overly responsible for progress or outcomes
- Wanting to push the work faster than client's pace
- Avoiding certain topics because they feel uncomfortable
- Feeling unusually tired, drained, or emotionally overwhelmed after sessions
- Feeling the need for the client to like or approve
- Judging the client's choices or behavior harshly
- Feeling discouraged or helpless about the work
- Thinking about the client frequently outside of sessions
- Pressure to give advice or solve issues quickly
- Noticing strong emotions during or after sessions

Supervisor Task:

Questions to Help Supervisees Explore This (Using Supervision Foundations)

Supervisor Counter-Transference with Supervisee

- Feeling unusually protective of the supervisee
- Rescuing the supervisee by stepping in too quickly to solve problems
- Avoiding difficult feedback in order to prevent discomfort or conflict
- Becoming overly critical or impatient with the supervisee's learning pace
- Feeling unusually proud of or invested in the supervisee's success
- Overidentifying with the supervisee in some way
- Feeling competitive or threatened by a highly capable supervisee
- Expecting the supervisee to work in ways that mirror the supervisor's own style
- Becoming directive instead of encouraging supervisee's independent thinking
- Feeling frustrated when the supervisee repeats mistakes
- Dismissing or minimizing the supervisee's concerns
- Feeling inordinately anxious about the supervisee's clinical work
- Spending disproportionate time thinking about the supervisee's cases
- Feeling the need to prove expertise or authority in supervision
- Withdrawing emotionally from a supervisee who is struggling

Two Indicators for Supervisors:

1. **Different Standards for Different Supervisees**
   Are you responding differently to the same behaviour depending on the supervisee? For example, does one person's late documentation get a gentle reminder while another's results in a serious conversation? **Pause and ask:** *What might be shaping my reaction to this person?*

2. **Avoiding Important Feedback**
   Are you repeatedly putting off a conversation a supervisee needs to have? Sometimes what looks like protecting the supervisee may actually be protecting **ourselves** from conflict, disappointment, tension, or being disliked.

Supervisor Countertransference with Supervisee's Client

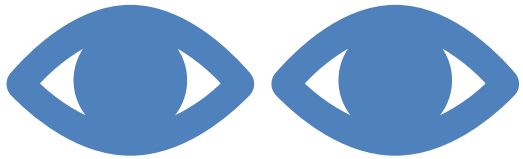
- Feeling unusually protective of the client
- Feeling strong sympathy that may limit clinical curiosity
- Feeling unusually critical or judgmental toward the client
- Experiencing anger toward people in the client's story
- Quickly siding with the client without exploring the full clinical picture
- Minimizing or dismissing the client's struggles
- Pushing the supervisee to confront the client more strongly than needed
- Encouraging the supervisee to rescue or protect the client
- Feeling frustrated or impatient with the client's pace of change
- Feeling emotionally overwhelmed by the client's trauma history
- Assuming the client is resistant or difficult without deeper exploration
- Identifying strongly with the client's life situation or story
- Feeling unusually invested in the outcome of the case
- Directing treatment strongly based on personal reactions
- Reacting strongly to the client's moral choices or life decisions

A Good Question…

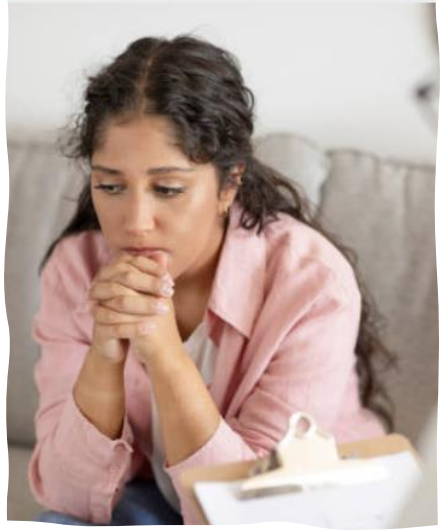
One particularly useful check is:

“Am I more worried about this client than my supervisee is?” And if the answer is yes, the next question is: “Is that because I’m noticing something clinically important — or is some of this mine?”

That’s the work here: take the reaction seriously, but hold it lightly enough to examine it before acting on it.



6.
Rupture and Repair as Core Skills



Mis-attunement or ‘empathic failure’ is inevitable in therapy, trauma work, and supervision.

- Avoidance of rupture increases harm
- Repair restores safety more than perfection
- Impact matters more than intent

Examples of Ruptures in Therapy and Supervision

Subtle ruptures / misattunements:

- Therapist changes the subject just as the client becomes vulnerable.
- Supervisor gives advice before fully understanding the supervisee's concern.
- Therapist responds with reassurance when the client needed their pain acknowledged.
- Supervisor's tone becomes slightly impatient or dismissive.
- Therapist assumes what the client is feeling instead of checking.
- Supervisor overlooks a supervisee's uncertainty and moves straight into teaching.

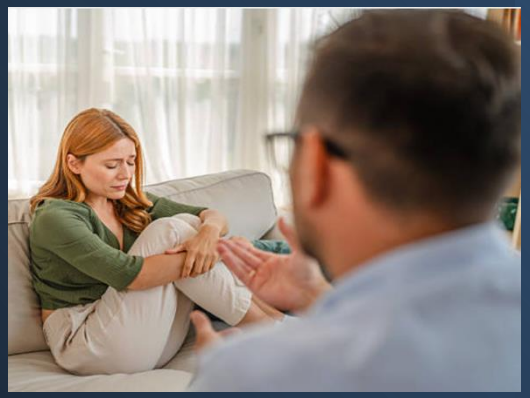
Examples of (Even Subtle) Ruptures in Therapy and Supervision Con't

- Therapist pushes the pace a little faster than the client can tolerate.
- Supervisor focuses on technique while missing that the supervisee feels overwhelmed.
- Therapist forgets an important detail the client previously shared.
- Supervisor gives feedback that is technically accurate but poorly timed or lacking warmth.

- **More overt ruptures / misattunements**
- Therapist directly challenges a client in a way that feels shaming or critical.
- Supervisor sharply criticizes a supervisee's clinical decision.
- Therapist pressures a client to discuss trauma they have clearly said they aren't ready to discuss.
- Supervisor dismisses or minimizes a supervisee's concern.
- Therapist or supervisor becomes defensive when the other person says they felt hurt, misunderstood, or judged.

Some Signs of Rupture in Session
(Client or Supervisee)

- Becoming quieter or more withdrawn than usual during sessions
- Giving shorter answers and sharing less personal material
- Shifting from emotional discussion to more intellectual conversation
- Avoiding topics that were previously explored
- Appearing polite or agreeable but less engaged in the work
- Showing subtle irritation, tension, or defensiveness
- Missing sessions or beginning to arrive late more frequently
- Expressing doubt about whether sessions are helping
- A noticeable drop in warmth, eye contact, or emotional connection, or change in body language
- A sense of distance, awkwardness, or disconnection in the room
- Agreeing quickly without real reflection or discussion
- Changing the subject when certain feelings or topics arise
- Less spontaneity, curiosity, or emotional presence in the conversation



Supervisor Task: Supervisee Has a Client Rupture

- Encourage slowing down and reflecting on what may have happened in the interaction
- Help explore what the experience may have been like from the client's perspective
- Normalize that ruptures are common and repair can strengthen the relationship
- Support the supervisee in noticing their own emotional reactions or defensiveness
- Encourage curiosity rather than self-blame or avoidance
- Help identify the moment when the disconnection may have started
- Guide the supervisee in gently naming the rupture in the next session
- Practice language that acknowledges misunderstanding or mis-attunement
- Encourage listening carefully to the client's experience without becoming defensive
- Reinforce that repair often builds greater trust and safety in the therapeutic relationship
- Is any of this a replay from the client's past? What might this teach us/guide us to explore?

B

Supervisor Task: When We Have a Rupture With Our Supervisee

- Pause and acknowledge the moment rather than moving past it.
- Name the mis-attunement openly and take responsibility for your part.
- Invite the supervisee to share how the moment affected them.
- Listen without defensiveness or explaining your intention too quickly.
- Validate the supervisee's experience, even if it was not your intention.
- Differentiate intention from impact.
- Slow the conversation and re-establish psychological safety.
- Model humility and accountability in the supervisory role.
- Repair the relationship before returning to the clinical material.
- Reflect together on what the moment might teach both of you.
- Where might a replay for either of you be happening?

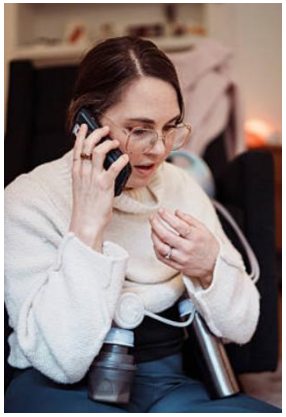
B

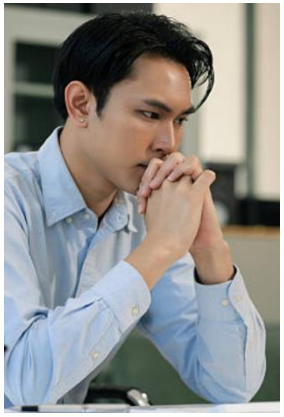
Personal Task: When We Have a Rupture With our Supervisee

Supervisor's Person Reflection Tasks After the Rupture

- Consider what internal reactions contributed to the mis-attunement.
- Reflect on possible countertransference or supervisory stress.
- Notice whether authority, evaluation, or power dynamics played a role.
- Ask whether the supervisee may have experienced shame or threat.
- Revisit the supervisory alliance and clarify safety and expectations.
- Explore what the supervisee may need going forward.
- Use the moment as a learning model for client rupture and repair.
- Ensure the supervisee leaves feeling supported and respected.
- Was this a true rupture, or something triggering my supervisee that we can visit as a part of the discussion, when the timing is right, and when the supervisee's sense of rupture has been respectfully addressed?

7. Burnout, Vicarious Trauma, Secondary Traumatic Stress, and Sustainability





This is predictable:

- Burnout increases ethical risk.
- Regulation is a professional responsibility.
- Sustainability protects clients.
- Vicarious trauma can affect emotional wellbeing and clinical judgment.
- Burnout may reduce patience, focus, and empathy in clinical work.
- Supervision helps notice early signs of emotional exhaustion.
- Open discussion reduces shame and isolation for therapists.
- Supervisors can support healthy pacing and boundaries.
- Processing difficult cases protects therapist wellbeing.
- Attention to these issues protects client care.
- Addressing them supports long-term sustainability in practice.

8. Shame-Sensitive Language During Growth

Avoiding Shaming Language in Therapy and Supervision

- Avoid statements that imply blame or personal failure
- Avoid language that suggests someone "should have known better"
- Frame mistakes as opportunities for reflection and learning
- Acknowledge the difficulty of therapy work and personal growth
- Maintain a tone of respect, safety, and openness in both therapy and supervision
- Intention over behavior when the goal is understanding and learning
- Behavior over intention when the goal is safety, responsibility, and repair
- This can be tricky so specific language choices must be emphasized

Continued…

Avoiding Shaming Language in Therapy and Supervision

- Focus on understanding intention before judging behavior
- Recognize that behavior may reflect stress, fear, or limited options
- When behavior causes harm, address the behavior while still respecting the person's intention
- Avoid assuming negative motives without exploration
- Use **curiosity** and questions rather than criticism

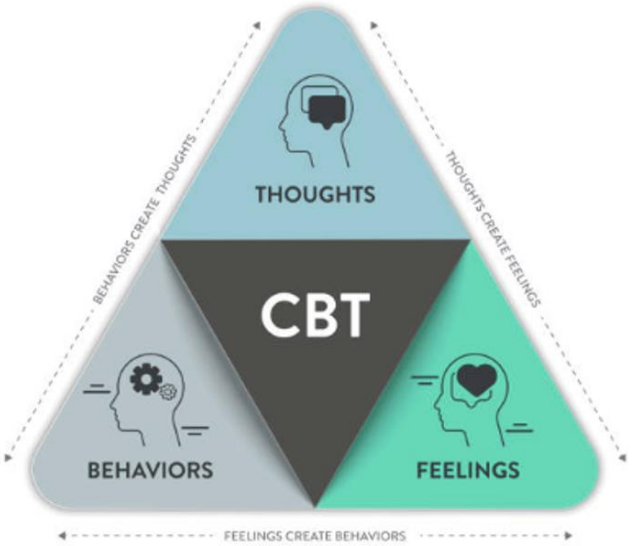
9. Dissociation Awareness and Response

Dissociation is protective, not resistance

- Flat affect is not calm
- Can show up in different ways
- Impacts certain tasks of therapy
- Cognitive clarity can mask disconnection
- Addressing this must be an important part of therapy
- Re-orientation and learning to stay more present must precede exploration and deeper therapy

10.
Why Nervous System Understanding Must Be Part of Supervision

- Helps supervisees recognize different arousal levels in clients
- Explains how different parts of the brain become active at different arousal states
- Helps clinicians see when the thinking brain is less accessible
- Shows why talk therapy or CBT may not reach trauma responses
- Supports better pacing when clients become overwhelmed or shut down
- Builds greater understanding and compassion for client reactions
- Helps clinicians explain these responses so clients can understand themselves better

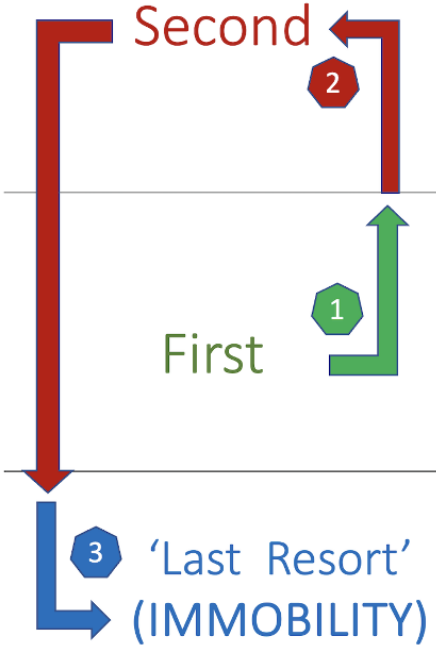


But We Now Know…
Post-Traumatic Issues, and Healing, is a ‘Square’

Traditional trauma models focus on thoughts, feelings, and behaviors. However, a 'square' model includes:

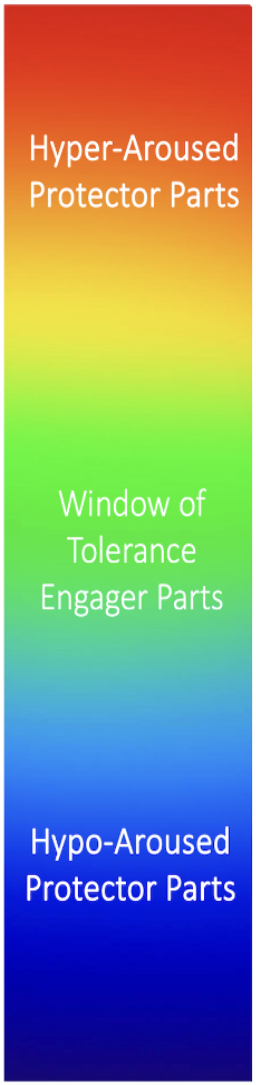
- Autonomic Nervous System (ANS): Physical responses, often involuntary, related to trauma triggering and automatic self-protection (SIBAMs).

PVT: The Order of Defenses During Threat



	Sympathetic Nervous System	**Fight-Flight** Yell, scream, rage, intimidate, scratch, spit, kick, punch, use a weapon, run.
	Parasympathetic Nervous System (Ventral Vagal Branch)	**Social Engagement** Appeal to the threat, talk it down, attempt to negotiate, call for help, and seek support after the event is over.
	Parasympathetic Nervous System (Dorsal Vagal Branch)	**Freeze-Shutdown** Stiffen, go still, numb, dissociate, paralysis, unconsciousness, leave your body.

My Protector and Enager Parts



Fight Protector:
- Intense
- Tight / Braced
- Anxiety / Panic
- Needing Control
- Anger / Rage
- Rigidity / Perfection
- Aggressive Reactions

Flight Protector:
- Intense
- Tight / Braced
- Anxiety / Panic
- Wanting Escape
- Avoidance Reactions
- Fleeing Behaviors

Adult Part:
- Daily life management
- Good judgment
- Problem-Solving
- Connecting Well

Core Self Part:
- Authentic
- Wisdom
- Deeper Connections
- Intuition and Knowing

Freeze Protector:
- Numbing • Zoning • Disconnecting
- Dissociating • Shutting Down • Collapsed
- Unconscious

Submit Protector:
- Pleaser
- Rescuer / Fixer
- Keeps Peace
- Dismisses Needs
- High Empathy
- 'Doormat'
- Over-responsible
- Irrational Guilt and Shame
- Self-Blaming

Please-See-Me Protector:
- Needs Attention
- Fears Abandonment
- Dependency Reactions
- High Self-Focus
- Desperation
- Rescue Fantasies
- Child-Like Reactions
- Easily Hurt

Based on the work of Janina Fisher 2017 and Jenifer Freedy 2025

Core Supervisory Principle

Super-vision is itself a nervous-system experience

- How we supervise teaches how clinicians treat clients
- Enhances complex and critical, nuanced thinking and curiosity
- Trauma-informed supervision must be comprehensive and include the body and nervous system
- Promotes safety and growth

Trauma-Informed Super-Vision Tasks

Mico-Level Trauma-Informed Supervisor Tasks (with Supervisee)

- Creating psychological safety while being clear about authority and roles
- Slowing down conversations when activation rises
- Helping supervisees notice nervous system responses (themselves and clients)
- Exploring transference and countertransference through a trauma lens
- Normalizing trauma responses as adaptive survival strategies
- Reducing shame around mistakes and learning edges
- Supporting client regulation before problem-solving
- Encouraging pacing and titration in trauma work
- Noticing attachment dynamics that show up in supervision
- Repairing ruptures in the supervisory alliance
- Modeling steady, calm presence during intense case discussion
- Helping supervisees build an internal trauma-informed reflective voice

S

Trauma-Informed Super-Vision Outcomes for the Supervisee

- Feels safer bringing up mistakes and uncertainty
- Has stronger nervous system awareness in sessions
- Can regulate themselves during intense trauma disclosures
- Recognizes transference and countertransference more clearly
- Understands trauma responses as survival strategies
- Feels less shame about learning edges
- Paces trauma work more thoughtfully
- Notices attachment patterns in therapy relationships
- Repairs ruptures with more confidence
- Tolerates strong emotions without rushing to fix
- Reflects before reacting in clinical moments
- Develops an internal calm, trauma-informed supervisory voice

S

Trauma-Informed Super-Vision Outcomes for the Supervisee

- Keeps client safety and stabilization at the center of care
- Understands trauma as both personal and systemic
- Avoids labeling survival adaptations as “disorders” too quickly
- Recognizes power and hierarchy in therapy and institutions
- Practices with greater cultural humility
- Notices bias and works to reduce its impact
- Navigates workplace stress without reenacting trauma dynamics
- Understands scope of practice in trauma treatment
- Documents cases with trauma sensitivity
- Recognizes signs of vicarious trauma in themselves
- Builds resilience for long-term trauma work
- Develops a sustainable, (truly) trauma-informed professional identity

Trauma-Informed
Super-Vision Tasks

Maco-Level Trauma-Informed Supervisor Tasks (with Supervisee)

- Keeping client safety and stabilization at the center
- Recognizing systemic and historical trauma impacting clients
- Avoiding over-pathologizing survival adaptations
- Attending to power, hierarchy, and authority in supervision
- Supporting culturally responsive and equity-aware practice
- Exploring bias and privilege in case conceptualization
- Preparing supervisees for high-stress institutional settings
- Addressing scope of practice in trauma treatment
- Encouraging documentation that reflects trauma sensitivity
- Supporting awareness of vicarious trauma and burnout
- Modeling accountability without intimidation
- Promoting sustainable, trauma-informed professional identity

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Clinical
Supervisor Training

Class 1

Let's Continue…

I'll see you in
Part Two