Clinical
Supervisor Training

Session 1

Welcome to Part Two

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.

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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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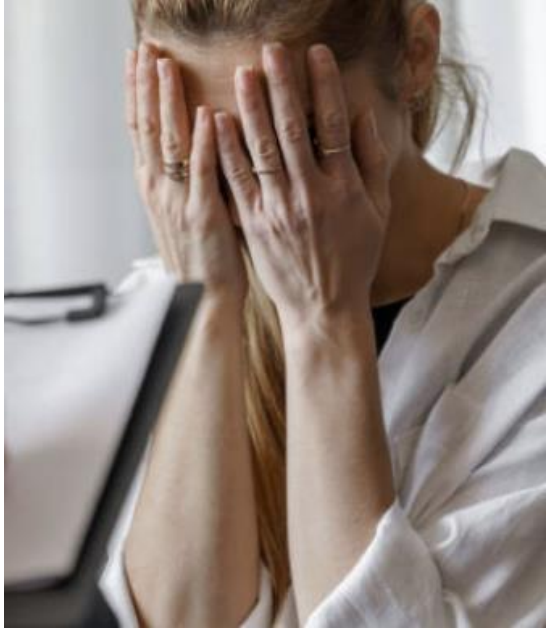


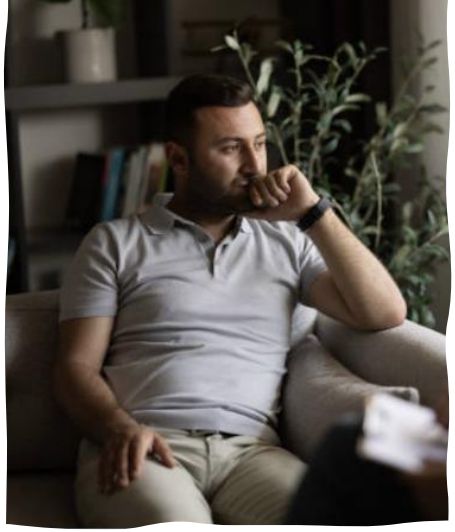
Anxious Attachment in Therapy

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

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.

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.

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

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.

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Client Transference

Supervisee Transference

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

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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 Super-vision Foundations)

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

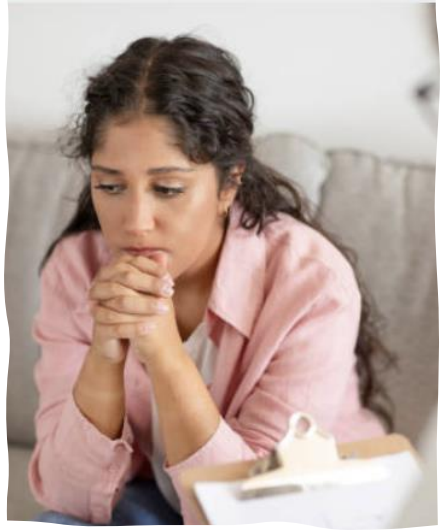
Withdrawing emotionally from a supervisee who is struggling

Supervisor Counter-Transference with Supervisee

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

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.

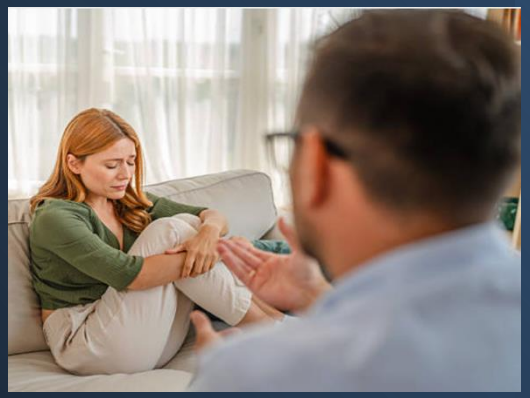
Examples of (Even Subtle) Ruptures in Therapy and Supervision Con't

- 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?

Supervisor Task: When We Have a Rupture With Our Supervisee

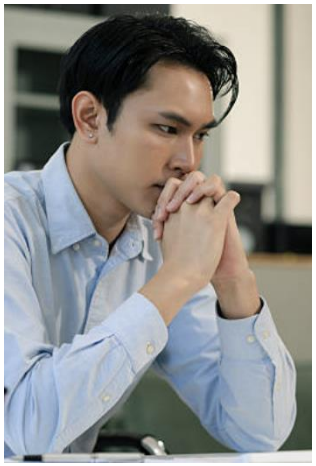
- Pause and acknowledge the moment rather than moving past it.
- Name the mis-attunement openly and take responsibility for your part.
- Invite the supervisee to share how the moment affected them.
- Listen without defensiveness or explaining your intention too quickly.
- Validate the supervisee's experience, 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?

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

- 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

Continued…

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

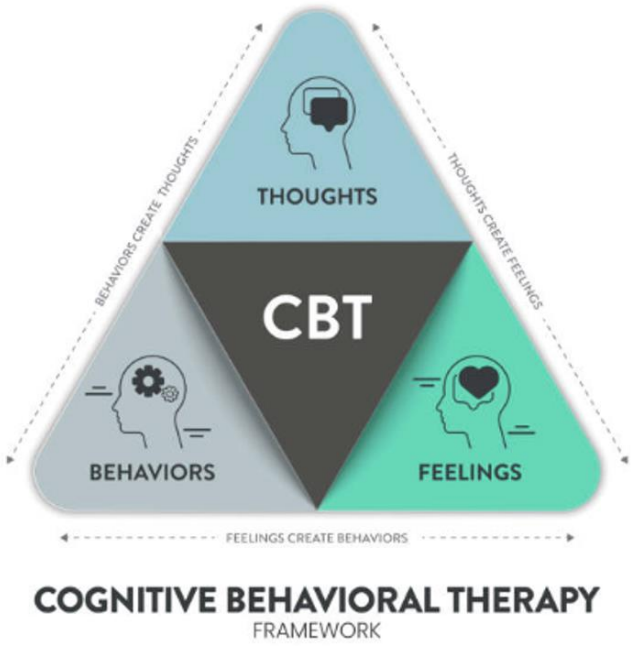
9. Dissociation Awareness and Response

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

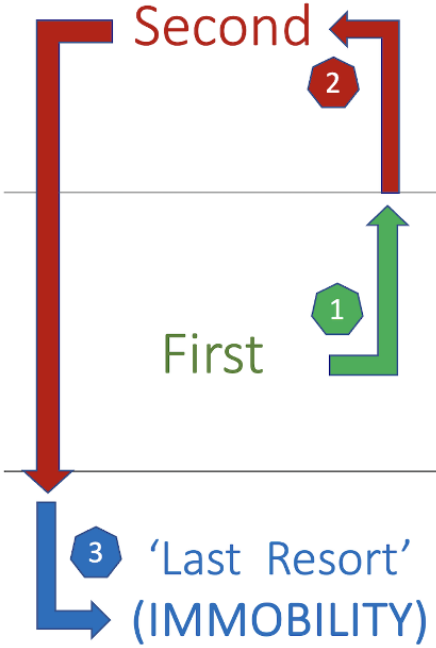


But We Now Know…
Post-Traumatic Issues, and Healing, is a ‘Square’

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

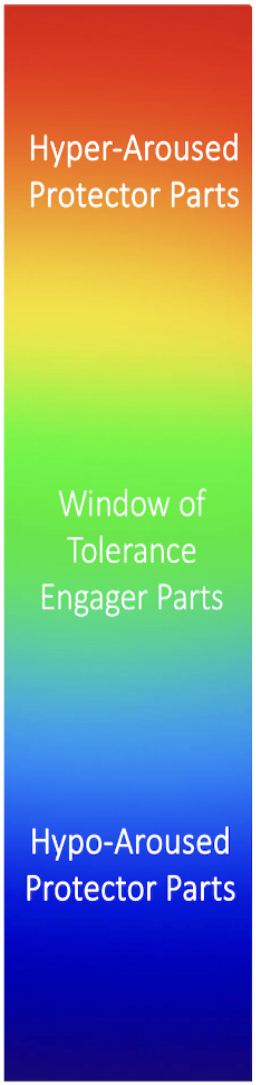
- Autonomic Nervous System (ANS): Physical responses, often involuntary, related to trauma triggering and automatic self-protection (SIBAMs).

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

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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

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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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