Reflective Practice in Trauma-Informed Supervision

Building Reflective Capacity, Relational Depth, and Trauma Awareness in Clinical Supervisors

Class 4

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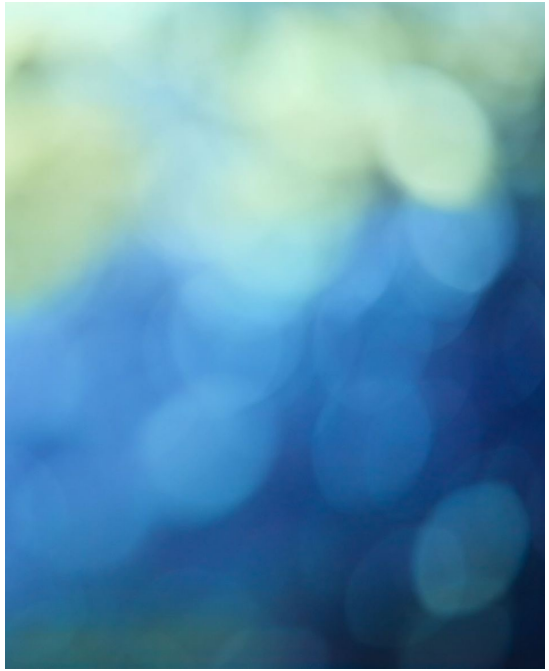
Presentation Overview

- Reflective Practice as Essential in Supervision
- Trauma-Informed Reflective Supervision
- The Reflective Supervisory Relationship
- Reflective Tools and Methods
- Developing Reflective Capacity
- Ethics, Evaluation, and Implementation



SECTION I

Reflective Practice - Essential in Supervision

How is Reflective Practice Different from Self-Assessment

Self-Assessment

- Evaluates performance against set criteria or standards
- Focuses on outcomes: "How well did I do?"
- Often a one-time, structured exercise (e.g., rating scales, checklists)
- *Goal: identify competency gaps and measure progress*

Reflective Practice

- Explores the meaning behind actions, emotions, and assumptions
- Focuses on process: "Why did I respond that way?"
- Ongoing, relational, and embedded in daily practice
- *Goal: deepen self-awareness and sustain professional growth*

What is Reflective Practice?

Reflective practice is the disciplined capacity to examine one's own professional actions, emotional responses, assumptions, and values, to deepen understanding, improve practice, and foster ongoing learning.

Intentional

Reflection is a deliberate, structured process — not incidental self-criticism or spontaneous rumination about clinical work.

Relational

In supervision, reflection is co-constructed within a relational context, shaped by the supervisory alliance and trust.

Recursive

Effective reflection cycles between experience, analysis, and changed action — it is not a single event but an ongoing spiral.

Transformative

Deep reflective practice transforms professional identity, clinical assumptions, and therapeutic relationship quality over time.

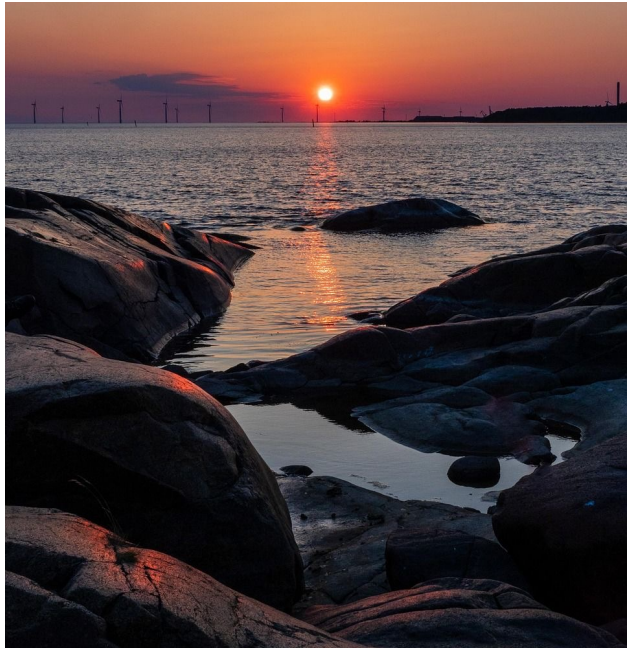
Why Self-Reflection Matters

Self reflection:

- brings important information about ourselves into awareness – patterns, triggers, intuition, and blind spots.
- turns awareness into insight so future actions are intentional, not automatic.
- reveals strengths and growth areas, building resilience and supporting ongoing learning.
- improves emotional regulation, learning, decision-making, and our ability to be present in session

Approaching Self-Reflection in Supervision

- Reflective practice is grounded in several core principles: **intentionality, honesty, openness**, and **commitment to growth.**
- Practitioners are encouraged to approach reflection with **curiosity** and a willingness to challenge assumptions.
- **Consistency is key**—regular reflection builds self-awareness and fosters continuous improvement.
- Reflective practice should be **holistic**, considering emotional, somatic, cognitive, and behavioral dimensions.



SECTION II

Trauma-Informed Reflective Supervision

Integrating trauma awareness into the supervisory process and reflective stance

Trauma-Informed Supervision: Core Framework

SAMHSA (2014): Trauma-informed supervision realizes, recognizes, and responds to the impact of trauma on supervisees, clients, and organizations — and actively resists re-traumatization (the four Rs) — integrating trauma awareness into every supervisory interaction.

The Supervisory Relationship as Microcosm

The supervisory relationship mirrors the therapeutic relationship. How the supervisor treats the supervisee models how the supervisee may treat clients — especially in trauma-laden work.

Reflective Stance as Core Competency

Trauma-informed supervision requires supervisors to maintain a reflective stance — curious, non-judgmental, and aware of their own emotional activation — throughout the supervisory process.

Attending to the Whole Supervisee

Trauma-informed supervision addresses the supervisee as a whole person: their trauma history, cultural identity, emotional state, and professional development simultaneously and with integration.

Hawkins & Shohet (2012): Trauma-conscious supervision creates the same conditions for the supervisee as good therapy creates for the client.

The Parallel Process in Supervision

Parallel process occurs when dynamics from the client-therapist relationship are unconsciously replicated in the therapist-supervisor relationship. Reflective supervision makes this visible and useable.

Client–Therapist Relationship	Therapist–Supervisor Relationship	Supervisor Reflection
Trauma material, attachment patterns, and relational dynamics originate here	The supervisee unconsciously brings client dynamics into the supervisory space	The supervisor notices the parallel and uses it reflectively for supervisory and clinical insight

Frawley-O'Dea & Sarnat (2001): Recognizing parallel process is one of the most powerful reflective interventions available to the clinical supervisor.

Vicarious Traumatization & Reflective Practice

Pearlman & Saakvitne (1995): Vicarious traumatization (VT) is the cumulative transformation of the therapist's inner world through engagement with traumatized clients — altering beliefs, assumptions, memory, and identity.

Warning Signs of VT in Supervisees

- Intrusive imagery or nightmares from client material
- Cynicism, hopelessness, or loss of meaning in work
- Over-identification or enmeshment with trauma survivors
- Disrupted sense of safety, trust, or personal invulnerability
- Emotional numbing or detachment in supervision
- Avoidance of traumatic case material in case presentations

Reflective Supervisory Responses

- Create explicit space for VT discussion in every supervisory cycle
- Normalize VT as an occupational reality, not personal weakness
- Use reflective journaling to track cumulative exposure over time
- Examine the supervisee's somatic cues as VT indicators
- Collaboratively develop individualized restorative self-care plans
- Refer to personal therapy when VT disrupts professional functioning

Figley (1995): Supervisors themselves are vulnerable to secondary traumatic stress — reflective self-supervision is essential.

The Costs of Caring: Four Distinct Constructs

Vicarious traumatization, secondary traumatic stress, compassion fatigue, and burnout are distinct — each calls for a different supervisory response. The ProQOL (Stamm, 2010) supports routine monitoring.

Vicarious Traumatization

Pearlman & Saakvitne (1995): Cumulative transformation of the clinician's inner world — beliefs, worldview, identity — through empathic engagement with trauma. Response: meaning-focused reflection.

Compassion Fatigue

The broader erosion of empathy and the capacity to care — the 'cost of caring' — combining secondary traumatic stress with cumulative emotional depletion. Calls for restoration and workload review.

Secondary Traumatic Stress

Figley (1995): PTSD-like symptomatology — intrusion, avoidance, arousal — arising from indirect exposure to trauma. Can emerge suddenly, even after a single case. Calls for stabilization and support.

Burnout

Maslach & Leiter (2016): Emotional exhaustion, depersonalization, and reduced accomplishment from chronic occupational stress. Not trauma-specific — often organizational, requiring systemic response.

Accurate differentiation guides the response: meaning-making for VT, stabilization for STS, systemic change for burnout.

Vicarious Resilience & Vicarious Posttraumatic Growth

Hernández, Gangsei & Engstrom (2007): Trauma work does not only deplete — witnessing survivors' resilience can transform the clinician positively. Reflective supervision attends to growth, not only harm.

Signs of Vicarious Resilience

1. Renewed appreciation of clients' resourcefulness and strength
2. Deepened sense of meaning, purpose, and hope in the work
3. Reassessment of one's own problems and priorities
4. Expanded capacity for empathy and connection
5. Growing confidence in the possibility of healing

Supervisory Practices That Cultivate Growth

1. Ask explicitly: what is this work giving you, as well as costing you?
2. Reflect on client resilience, not only client suffering
3. Track growth themes in reflective journals over time
4. Balance VT monitoring with strengths-based inquiry
5. Name and celebrate clinical moments of witnessed healing

A trauma-informed supervisory frame holds both realities: the costs of caring, and the growth that caring makes possible.

SECTION III

The Reflective Supervisory Relationship

Alliance, power, countertransference, and relational repair in supervision

Encouraging Reflection in Supervisees

- Provide safety – to allow for admitting mistakes and learning
- Model vulnerability
- Ask reflective questions
- Validate and normalize

The Reflective Supervisory Alliance

The supervisory alliance — the quality of the bond, agreement on goals, and agreed tasks between supervisor and supervisee (Bordin, 1983) — is among the most powerful predictors of effective supervision outcomes.

Bond

The emotional quality of the supervisory relationship: trust, warmth, respect, and a sense of being genuinely known and cared for as a professional and a person.

Goals

Mutual agreement on the aims of supervision: clinical skill development, professional identity formation, self-awareness, cultural competence, and ethical practice.

Tasks

Agreed methods for achieving supervision goals: case presentation, reflective journaling, role play, direct observation, Gibbs cycle debriefs, written reflection.

Building a Reflective Alliance — Practical Practices:

- Establish a supervision contract that explicitly names reflective practice as a core supervisory activity
- Begin each session by checking in about the supervisee's state
- Create ritual moments for reflective pausing within supervisory sessions
- Invite supervisees to bring wonder, confusion, and uncertainty — not only polished competence
- Regularly elicit feedback on the supervisory relationship itself — meta-reflection on supervision

Falender & Shafranske (2004): The supervisory alliance is not incidental to competency-based supervision — it is the medium through which competence develops.

Rupture & Repair in the Supervisory Alliance

Watkins (2021): Ruptures — strains or breakdowns in the supervisory alliance — are inevitable. Unaddressed, they drive nondisclosure; repaired well, they become powerful models of relational accountability.

Recognizing Rupture

Withdrawal ruptures (compliance, minimal disclosure, avoidance) and confrontation ruptures (criticism, defensiveness) — adapted from Safran & Muran's (2000) alliance research.

The Supervisor Initiates

The power differential means the supervisor carries primary responsibility for noticing strain and opening the conversation — promptly, and without requiring the supervisee to raise it first.

The Repair Sequence

Name the strain, invite the supervisee's experience non-defensively, own the supervisor's contribution, and renegotiate goals, tasks, or relational expectations.

Repair as Parallel Process Teaching

A well-repaired supervisory rupture models exactly what trauma survivors need from their therapists: rupture acknowledged, responsibility taken, and trust rebuilt.

Watkins (2021): How supervisors handle rupture may teach more about relational practice than anything they say about it.

Supervisee Nondisclosure & Shame in Supervision

Ladany, Hill, Corbett & Nutt (1996): Most trainees withhold important information from supervisors. Safety to disclose is the precondition of reflection — what cannot be spoken cannot be reflected upon.

What Supervisees Commonly Withhold

1. Negative reactions to the supervisor or to supervision itself
2. Clinical errors and perceived failures
3. Countertransference reactions, including attraction to clients
4. Personal issues affecting clinical work
5. Doubts about their own competence and fit for the profession

What Reduces Nondisclosure

1. A strong supervisory alliance and consistent relational safety
2. Supervisor openness about their own errors and uncertainties
3. Normalizing mistakes as the raw material of learning
4. Transparent, predictable evaluation processes
5. Directly and compassionately addressing shame when it enters the room

Shame is the enemy of reflection: attending to shame protects the conditions that make reflective supervision possible.

Power, Reflexivity & the Supervisory Relationship

Reflexivity — the capacity to examine how one's own position, identity, and power shape professional practice. It is distinct from, but foundational to, reflective practice.

Power Dynamics in Supervision

Evaluative Power
Supervisors gatekeep professional entry — this creates power that cannot and should not be ignored in reflective work.

Epistemic Power
Which knowledge counts? Whose frameworks dominate? Western clinical epistemology can marginalize other ways of knowing.

Identity Power
Race, gender, class, age, and ability create intersecting power differentials that operate in the supervisory dyad.

Relational Power
Supervisees may self-censor, please, or defer to the supervisor — active reflexivity is needed to interrupt this pattern.

Practicing Reflexivity

1. Name power dynamics directly in supervision
2. Solicit ongoing feedback from supervisees
3. Examine your assumptions about supervisee progress
4. Monitor for self-silencing in the supervisory dyad
5. Engage in anti-oppressive consultative supervision

Anti-Oppressive Consultative Supervision

Supervision itself is a site of power. Anti-oppressive practice requires us to examine and interrupt that power actively.

What It Means

Decentre Western clinical frameworks
Dominant knowledge systems can reproduce oppression within supervision itself.

Seek consultation across difference
Actively consult with peers whose identities and lived experiences differ from your own.

Name and interrupt oppressive dynamics
When bias or marginalization surfaces in the case or in the room, name it rather than bypass it.

Hold space for the political dimension
Situate client distress within structural conditions, not only individual psychology.

Reflective Practice Prompts

- Whose frameworks am I centering when I evaluate this supervisee's clinical reasoning?
- Am I consulting with someone who can challenge my blind spots around race, class, gender, or ability?
- Have I examined how systemic oppression may be shaping this presenting problem beyond individual pathology?
- Is my use of supervisory authority replicating the very dynamics I am trying to challenge?

Anti-oppressive supervision is not a technique — it is an ethical orientation that makes power visible and accountability possible.

Multicultural Orientation & Broaching in Supervision

Davis et al. (2018): The multicultural orientation (MCO) framework — cultural humility, cultural opportunities, cultural comfort — grounds the reflexive commitments of trauma-informed supervision in evidence.

Cultural Humility

- An other-oriented stance: curious, open, aware of the limits of one's own cultural lens
- Ongoing self-examination — a way of being, not an achieved competence
- Modelled by the supervisor before it is asked of supervisees
- Counters epistemic power in the supervisory dyad
- Linked to stronger alliances and outcomes in research

Cultural Opportunities

- Noticing and taking up moments to explore cultural identity in clinical material
- Broaching: deliberately inviting conversation about race and culture
- Missed opportunities examined reflectively, not punitively
- Applies to the supervisory relationship itself, not only to cases

Cultural Comfort

- The felt ease to remain present and engaged in cultural conversations
- Discomfort tracked somatically and brought into reflection
- Grows through practice, consultation, and supervisor modelling
- Discomfort avoided becomes culture unexamined
- Day-Vines et al. (2007): a continuing disposition, not a one-time event

MCO reframes cultural work in supervision as a relational way of being, not a set of techniques.

Countertransference as Reflective Data in Supervision

Countertransference — the therapist's emotional, somatic, and relational responses to the client — is not an obstacle to good therapy. It is rich clinical data requiring reflective supervision.

Complementary CT

The therapist responds as significant others in the client's life typically have — unconsciously enacting the client's relational template. A supervisor spots this from case descriptions.

Concordant CT

The therapist identifies with and feels what the client feels — empathic resonance that can be therapeutic when well-regulated and consciously used.

Somatic CT

Van der Kolk (2014): The body keeps the score. Somatic responses in the therapist (tightening, numbness, restlessness) carry valuable information about the client's unspoken trauma – and possibly the supervisee’s own unfinished work.

Supervisory question: 'What are you noticing somatically as you talk about this client?' opens somatic reflective territory.

SECTION IV

Reflective Tools & Models in Supervision

Practical approaches for cultivating structured reflection in the supervisory space

Self-Reflection in Supervision - Somatic

- Somatic responses can reveal countertransference to a client, empathizing with a client, or indicate that one's own unresolved issues are being triggered.
- Supervisees with high empathic attunement may need to learn how to discern whether a somatic response is their own or their client's... And how to protect themselves from being overwhelmed by somatic empathy.
- Mindful body scans can provide important awareness if a supervisee is feeling overwhelmed, confused, or conflicted when discussing a case in session.

Supervision Prompts

- *Notice what happens in your body right now as you describe that moment.*
- *Were there physical sensations during the session that you noticed and set aside?*
- *I notice that your (posture has shifted...breathing seems to have become shallow...face has a pained expression, etc.) as you talk about this session. What is happening for you?*

REFLECTIVE PRACTICE EXERCISE

Somatic Check-In with a Case Moment

Building somatic awareness & mindsight through embodied self-reflection

10-12 min

1 Recall

1 min

Silently recall a recent client interaction that left you unsettled, confused, or unexpectedly moved.

2 Body Scan

3 min

Guided body scan: notice where you hold the memory. Ask: Is this response mine, or am I carrying something from the client?

3 Reflective Journal

4 min

Write freely: What did my body tell me that my words didn't? What belief or assumption might this connect to?

4 Pair Share

3 min

Share one insight with a partner — not the case details, but what the body scan revealed about your countertransference.

Self-Reflection: Emotional

- Recognizing countertransference
- Recognizing supervisee emotions as information which can reflect:
  - Picking up client emotions – some of which the client might not feel safe expressing
  - Conflict between client's values and beliefs with one's own values or beliefs
  - Perception that a boundary is threatened or has been crossed
  - One's own wounded parts that need attention

Supervision Prompts

- *What feelings came up for you in session? How did that impact you?*
- *What did you feel when (the client) disclosed that?*
- *Is there anything you're still carrying from that session right now?*

Self-Reflection: Cognitions

Supervisee thoughts about a session can provide helpful information about:

- Internal conflicts
- Confusion or uncertainty
- Judgements or biases
- Their own cultural perspectives

Supervision Prompts

- *What were your thoughts when the client said that?*
- *How did your conceptualization shift over the course of the session?*
- *What theoretical lens were you using, and did it feel like a good fit?*

Self-Reflection: Behaviour

Some aspects of supervisee behaviours that might come up in supervision and could benefit from reflection might include:

- Consistently going over time with some clients
- Struggling to sit in silence with clients
- Trying to convince a client – through logic - as to why they should try an intervention or consider a different decision.

Supervision Prompts

- *Walk me through what you did in that moment. What led you to that choice?*
- *Were there things you wanted to say but didn't? What stopped you?*
- *If you could rewind and sit in that silence a little longer, what do you imagine might have happened?*

Reflective Journals & Narrative Writing in Supervision

Moon (2004): Reflective writing externalizes thought, creates distance from experience, and generates new perspectives not available through verbal reflection alone.

Unstructured Journals

Free-writing about clinical experiences, emotional responses, and emerging questions — giving form to inchoate professional experience.

Structured Reflection Prompts

Guided questions using Gibbs or Schön frames: 'Describe a moment of clinical discomfort and what it revealed.'

Process Notes

Narrative accounts of sessions focusing on the therapist's internal process — what was felt, avoided, and noticed — rather than client content.

Dialogue Journals

Written exchanges between supervisee and supervisor — creating a reflective text that spans sessions and tracks growth over time.

Supervisory Writing Prompts

- When was I most present/least present this week?
- What did I notice in my body during this session?
- What am I avoiding bringing to supervision?
- What does this client evoke in me — and why?
- How did my cultural position shape this interaction?

Boud, Keogh & Walker (1985): Writing creates a 'third space' for reflection that both internalizes and externalizes the learning process.

Interpersonal Process Recall (IPR) in Supervision

Kagan & Kagan (1990): IPR is a classic reflective method using session recordings. The supervisee — not the supervisor — controls playback, pausing to recall internal experience that went unspoken in session.

The IPR Protocol in Supervision:

1. **Record**
   With the client's informed consent, record a session (video or audio) for supervisory review.
2. **Select**
   The supervisee chooses a segment that felt significant, confusing, or emotionally charged.
3. **Replay**
   The supervisee controls the playback, pausing wherever something internal was happening.
4. **Recall**
   The supervisor takes an 'inquirer' stance: What were you feeling? What did you want to say? What held you back?
5. **Explore**
   Unspoken thoughts, feelings, body sensations, and images are examined without judgment or evaluation.
6. **Integrate**
   Insights are linked to countertransference, parallel process, and future clinical choices.

Kagan's inquirer role is deliberately non-evaluative — IPR assumes the supervisee is the best authority on their own internal experience.

Additional Self-Reflection Catalysts:

- Meditation or Prayer
- Peer feedback
- Personal Therapy

Case Example

Client Background:

Maya, a 34-year-old woman, has been in weekly individual therapy for eight months, presenting with complex trauma, attachment difficulties, and a history of unstable relationships. The therapeutic relationship has been warm and productive, with significant progress made around self-worth and emotional regulation.

The Incident

- During a session in late autumn, Maya arrives visibly distressed. She discloses that she is facing eviction and has nowhere to go over the coming weekend. She becomes tearful and says, *"You're the only person who really understands me. I don't know what I'd do without you."*

- As the session draws to a close, she asks whether she can text the therapist over the weekend — *"just to know someone is there."* The therapist, feeling caught off guard and moved by Maya's distress, hesitates — and in that pause, says: *"Let me think about that."* Maya visibly brightens, interpreting this as a tentative yes.

- The therapist leaves the session feeling unsettled, aware that a boundary may have shifted — and that Maya is now holding an expectation that was never clearly declined.

Self-Reflection Exercise

- What specifically, about this scenario that leaves you feeling unsettled?
- What emotions are coming up for you?
- Do a body scan and notice any body sensations... Where are they located? What do these sensations feel like (e.g., weight, tension, nausea, sharp pain, achiness)? Move your awareness from your mind into the area holding the physical sensations. Curiously notice any thoughts, memories, emotions, or other physical sensations that come up.
- How do you make sense of the situation with the client?
- What do you think you could have done differently?

One Case, Three Lenses

Why we will analyze the same case three times

- The sections that follow apply three foundational reflective models — Gibbs' reflective cycle, Schön's reflection-in and on-action, and Kolb's experiential learning cycle — to the same supervisory case. The repetition is deliberate: watching one clinical moment refracted through **three different frames** reveals what each model illuminates, what each leaves in shadow, and when a supervisor might reach for each. A synthesis slide follows the third analysis.

Gibbs' Reflective Cycle (1988)

Gibbs' six-stage cycle offers a structured, accessible protocol for systematic reflection on clinical experiences in supervision.

1

Description

What happened? Describe the clinical event, supervisory interaction, or critical incident without analysis or judgment.

2

Feelings

What were you thinking and feeling? Honest exploration of cognitive, emotional, and somatic responses during the experience.

3

Evaluation

What went well, and what was challenging about the experience? Move toward a more balanced, less emotionally driven appraisal.

4

Analysis

What sense can you make of the situation? Draw on theory, supervision, and evidence-based frameworks to understand what occurred.

5

Conclusion

What else could you have done? Identify alternative responses, different interventions, or other ways of being present.

6

Action Plan

If this arose again, what would you do? Commit to specific, observable changes in future clinical practice.

Gibbs (1988): The cycle is designed to be used with colleagues in supervision, not in isolation — reflection is inherently relational.

Applying Gibbs' Reflective Cycle

1. Description – *What happened?*

The therapist was presented with a request to extend contact outside of scheduled sessions from a client with known attachment difficulties. Under emotional pressure, the therapist gave an ambiguous response rather than responding with a clear boundary. The client interpreted ambiguity as permission.

2. Feelings - *What were you thinking and feeling?*

Some possible feelings that supervisee could explore in supervision:

- A pull toward rescuing or soothing — *"She looked so alone."*
- Discomfort with being perceived as cold or withholding
- Guilt about the asymmetry of the therapeutic relationship
- Anxiety in the aftermath about having created a false hope
- Possibly some countertransference rooted in the therapist's own experiences of abandonment or caretaking

* *While not part of this approach, we could add somatic reflections.*

3. Evaluation - *What was good and bad about the experience?*

What went well:

- The therapist noticed the discomfort quickly
- The issue was brought promptly to supervision
- The therapeutic relationship remained intact

What was difficult:

- The response was ambiguous rather than clear
- Maya was left holding an unresolved expectation
- The boundary was momentarily destabilized

4. Analysis - *What sense can you make of the situation?*

This is where the richest clinical and reflective work happens.

Questions for supervision might include:

- **Countertransference:** What personal material was activated in the therapist? Why was "no" so difficult to say in this moment?
- **Power and care:** Is the impulse to extend availability genuinely therapeutic, or does it risk reinforcing dependency?
- **Risk:** What safety planning and practical supports does Maya's imminent eviction require — before, or alongside, processing the boundary?
- **Theoretical lenses: (e.g.,)**
  - From a trauma-informed lens, is the client's request related to enmeshed boundaries in important relationships? Is the therapist's hesitation a re-enactment of self-sacrifice of one's boundaries for another?
  - From a person-centred lens, it might reflect an internal conflict between unconditional positive regard and professional boundary.

5. Conclusion -*What else could you have done?*

- The therapist might reflect on alternative responses:
- A warm but firm refusal: *"I can hear how frightened you are right now. Texting outside our sessions isn't something I'm able to offer — but let's use the rest of our time today to make sure you feel as resourced as possible going into the weekend."*
- Redirecting to crisis supports and safety planning

6. Action Plan - If this situation arose again, what would you do?

- Identify personal triggers around saying "no" in therapeutic relationships — potentially as a thread in personal therapy or supervision
- Develop a clear internal protocol for out-of-hours contact requests before they arise
- In the next session with Maya, address the ambiguity directly and compassionately, using it as clinical material
- Explore with the supervisor how this moment reflects wider patterns in the therapeutic relationship

Schön's Two Modes of Professional Reflection

Schön (1983, 1987) identified two distinct modes of reflection essential to expert clinical practice:

Reflection-in-Action

"Thinking on one's feet"

- Occurs during the therapeutic moment, in real time
- Noticing unexpected client responses and adjusting
- Accessing intuition grounded in embodied professional knowledge
- Allows the practitioner to experiment within the session itself
- Supervisors cultivate this through live observation and in-the-moment reflection

Reflection-on-Action

"Looking back to move forward"

- Retrospective examination of clinical events after sessions
- Creating distance to examine what occurred and why
- Reviewing journal entries, session recordings, or case notes
- Identifying assumptions, biases, and emotional reactions
- Primary mode in formal supervision — structured and intentional

A third mode — reflection-for-action — prepares practitioners through anticipatory reflection before clinical encounters: pre-session preparation, anticipating likely triggers, and rehearsing boundaried responses in supervision.

Part One: Reflection-in-Action

Thinking in the moment — the live, improvisational intelligence of the practitioner

- Schön argued that skilled practitioners are constantly making micro-adjustments during practice — reading the situation, drawing on tacit knowledge, and responding in ways that are neither purely instinctive nor fully conscious. This is *knowing-in-action*: the embodied professional expertise that largely operates below the level of articulation.
- In this moment, the therapist's knowing-in-action was already signalling something:
  - A physical sense of discomfort — perhaps a tightening, a hesitation in the body before the words came
  - An awareness, however fleeting, that the request was clinically significant
  - An implicit recognition that something in the room had shifted

- But here is where Schön's concept becomes most useful: **the therapist's reflection-in-action was interrupted.** The emotional charge of Maya's distress — her tearfulness, her words *"you're the only person who really understands me"* — created what Schön might call a **surprise**, a moment where the situation talked back in a way the practitioner's frame could not immediately accommodate.
- Rather than pausing to reframe in real time, the therapist gave ground. The words *"let me think about that"* were not a clinical intervention — they were a deferral. They represent a moment where reflection-in-action was available but not fully deployed.

Supervision Prompts

- What did your body tell you in that moment, before you spoke?
- What were you trying to manage — Maya's distress, your own discomfort, or both?
- At what point did you notice things slipping? What stopped you from naming what was happening in the moment?
- Schön talks about practitioners reframing problems as they arise. What reframe might have been available to you in that moment?

Part Two: Reflection-on-Action

Deliberate retrospective sense-making — what supervision is largely built for

- After the session, the therapist carries the discomfort into the following days and brings it to supervision. This is reflection-on-action: the conscious, analytical revisiting of an experience with enough distance to examine it more fully.
- Schön distinguishes this from mere rumination. Genuine reflection-on-action involves:
  - **Examining the frame** — What assumptions, beliefs, or habitual responses shaped the therapist's reaction?
  - **Naming the knowing** — What did the therapist already know, professionally and intuitively, that their in-the-moment response failed to honour?
  - **Testing hypotheses** — What theories of practice — attachment, trauma-focused, countertransference, relational dynamics — help make sense of what happened?
  - **Identifying repertoire** — What past experiences, clinical knowledge, or supervisory learning might be brought to bear next time?

Supervision Prompts

- When you revisit the session now, what do you understand that you didn't understand then?
- What personal or professional frame was operating that made "no" difficult to access?
- How does this moment connect to broader patterns in your work — with Maya specifically, or with clients who present in acute distress?
- What would it mean to bring this learning back into the room with Maya?

Kolb's Experiential Learning Cycle (1984)

Kolb's cycle provides a structured framework for transforming clinical experience into professional learning through four sequential, recursive phases.

1 Concrete Experience

The actual clinical event — a session, a supervision interaction, or a difficult therapeutic moment that serves as the raw material for learning.

2 Reflective Observation

Stepping back to observe the experience from multiple perspectives — What happened? How did it feel? What did I notice in myself and the client?

3 Abstract Conceptualization

Drawing on theory, clinical literature, and supervision input to make meaning of the experience — integrating new insights into clinical frameworks.

4 Active Experimentation

Applying new conceptualizations to future practice — trying different interventions, relational approaches, or ways of being with clients.

Kolb (1984): Learning is not the result of experience per se, but rather the transformation of experience through structured reflection.

Stage One: Concrete Experience

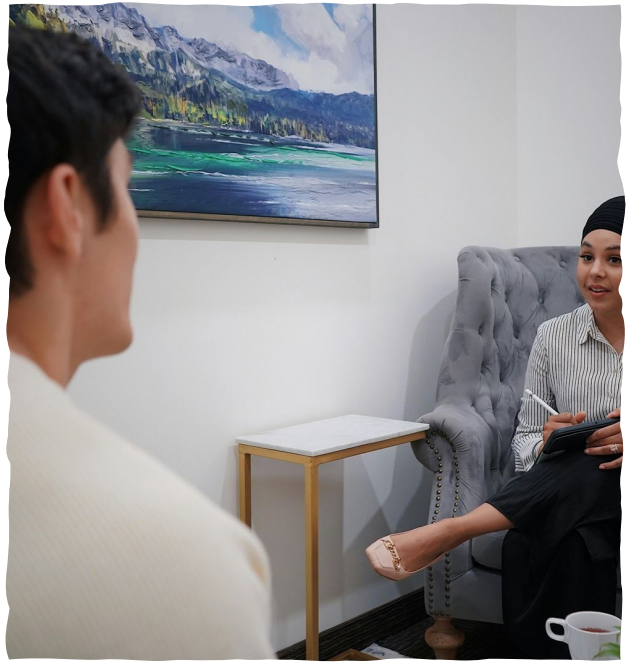
What actually happened? — the raw, unprocessed event

- Kolb's cycle begins not with analysis but with the thing itself: the lived, embodied, felt experience of being in the room. Before any reflection or theorising is possible, the practitioner must first be able to simply **describe and own** what occurred — without judgment, justification, or premature interpretation.

For this therapist, the concrete experience encompasses:

- Sitting across from Maya as she described her crisis, watching her distress build
- Hearing the words *"you're the only person who really understands me"* — and feeling their weight
- Experiencing the internal pull toward comfort and rescue as the session drew to a close
- The moment of hesitation before speaking — and the choice, however unconscious, to offer ambiguity rather than clarity
- Maya's visible brightening in response
- The walk to the car afterward, carrying a feeling the therapist might struggle at first to name — unease, guilt, a low-level professional alarm

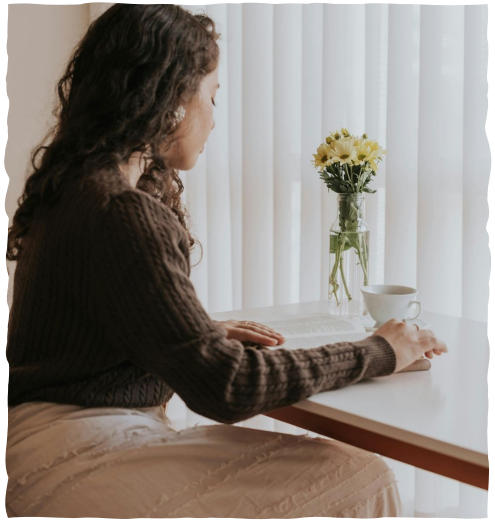
Supervision Prompts



- Take me back into the room. What do you remember first — the image, the feeling, the words?
- Where did you feel this in your body, and when did that feeling begin?
- What was the moment the session shifted for you?
- Can you describe what happened without yet trying to make sense of it?

Stage Two: Reflective Observation

Stepping back — looking at the experience from multiple angles



In this stage, the therapist might notice:

- **From their own perspective:** The discomfort with Maya's dependency, the difficulty of holding a boundary when a client's distress was so raw and immediate
- **From Maya's perspective:** How the request itself might be understood as an attachment behaviour — a reaching out that was simultaneously a test of the therapist's constancy and availability
- **From an observer's perspective:** What a supervisor watching through a one-way screen might have seen — a practitioner momentarily overwhelmed by the relational field, making a decision from emotion rather than from clinical grounding
- **From a temporal perspective:** How the same moment might look different with a week's distance compared to the hour immediately after the session
- **What was not done:** The clear, warm, boundaried response that was available but not accessed — noticed in service of learning, not shame

Supervision Prompts:

- If you were watching this session from outside the room, what would you have seen?
- How do you imagine Maya experienced your hesitation?
- What do you notice now that you couldn't see clearly in the moment?
- What were you most trying to avoid — and what did that avoidance cost?

Stage Three: Abstract Conceptualization

Making meaning — bringing theory, knowledge, and frameworks to bear

This is the stage where experience is transformed into understanding. Kolb argues that genuine learning requires practitioners to move beyond personal reflection and connect their experience to **broader frameworks, concepts, and professional knowledge.** In clinical supervision, this is the natural home of theory.

Examples of Interpretations

Attachment Theory:

- Maya's request maps clearly onto anxious attachment behaviour — the reaching toward the attachment figure at moments of threat, testing availability, and seeking proximity as a regulatory strategy.
- The therapist's hesitation, seen through this lens, was a moment in which the therapeutic frame — itself a secure base — momentarily wobbled.
- Understanding this theoretically allows the therapist to return to the clinical relationship with greater intentionality.

Countertransference:

- The therapist's pull toward saying yes warrants serious conceptual attention. Whose need was being served in that moment? The compulsion to rescue, to soothe, to be experienced as available and good — these are countertransferential currents that, left unexamined, can quietly erode the therapeutic frame over time.

- Kolb's model creates space to ask: what does theory tell us about why this happened, not just what happened?

Professional Ethics and Power:

- Kolb's abstract conceptualization stage also invites engagement with the ethical dimension. Codes of practice around out-of-hours contact exist not as bureaucratic constraints but as protections — for the client, the therapist, and the integrity of the work.
- Bringing this layer into supervision helps the therapist reconnect their lived experience with the professional and ethical structures that hold it.

Trauma-Informed:

- The client is expressing vulnerability and trust in the therapist. This might be the first time she has experienced one or both. This is an important moment and needs to be acknowledged.
- At the same time, boundaries are important to protect the integrity of the therapeutic relationship. It's important explore this in supervision to identify other ways this could have been handled in the moment to support the therapeutic alliance, while maintaining essential boundaries, and reminding the client of other resources/supports and their own resiliency.

Supervision Prompts

- What theoretical frameworks help you make sense of what happened in this session?
- How does attachment theory illuminate Maya's request and your response to it?
- What does the literature on countertransference tell you about the pull you felt?
- How does your professional and ethical framework speak to this moment?

Stage Four:
Active Experimentation

Planning forward — taking learning back into practice

- Kolb's final stage closes the loop between reflection and action. Learning that does not change practice is, in his framework, incomplete. Active experimentation asks the practitioner: **given everything you now understand, what will you do differently — and how will you know if it works?**

In the immediate clinical relationship with Maya:

- The ambiguity created in the session needs to be addressed directly and compassionately in the next meeting. This is not damage limitation — it is an opportunity. The therapist might say something like: *"I want to come back to something from last week. I didn't respond as clearly as I should have when you asked about texting over the weekend, and I want to be honest with you about that. I'm not able to offer contact outside of our sessions — and I think it's important that we understand together what that brought up for you."*

Used well, this moment of repair can itself deepen the therapeutic alliance and model honest, accountable relating.

- **In personal reflective practice:** Supervisee might choose to commit to keeping a reflective journal specifically oriented around moments of hesitation or emotional pull in sessions — not to catalogue failures, but to identify patterns in their own knowing-in-practice. Over time, this journal becomes a record of professional learning.

- **In future clinical situations:** The therapist rehearses — mentally and, if useful, with the supervisor through role-play — a clear, warm, boundaried response to out-of-hours contact requests. The goal is not a script but an internalised clinical position: one that can be accessed even under emotional pressure.

Supervision Prompts:

- What specifically will you do differently the next time a request like this arises?
- How will you address the ambiguity with Maya in your next session?
- What support or practice do you need to be able to access a boundaried response when you are emotionally activated?
- How will you know, over time, that this learning has genuinely changed your practice?

Group Supervision as a Reflective Space

Group supervision creates a uniquely powerful reflective environment: multiple perspectives, peer accountability, shared affect, and the social nature of reflection are all mobilized simultaneously.

Multiple Perspectives

Group members bring diverse clinical, cultural, and theoretical lenses to each case — generating richer reflection than any single supervisor-supervisee dyad.

Social Accountability

The group provides gentle accountability for reflective commitments made between sessions — a socially regulated learning environment.

Normalization & Validation

Hearing that peers share similar feelings — confusion, fear, countertransference — reduces shame and isolation, freeing supervisees to reflect more honestly.

Peer-to-Peer Learning

Supervisees learn from each other's reflective processes, not only from the supervisor's expertise — modeling lateral learning and collaborative knowledge generation.

Inskipp & Proctor (1993): The group supervision matrix holds what no individual dyad can — the full complexity of the clinical field.

SECTION V

Developing Reflective Capacity

Supervisee developmental stages, critical reflection, and transformative learning

Developmental Stages of Reflective Practice

Stoltenberg & McNeill's Integrated Developmental Model (IDM, 2010) identifies three supervisee levels, each requiring a distinct reflective supervisory approach.

Level 1

Beginning Practitioner

Reflective Stance:
Highly self-focused; anxious about evaluation; reflection tends to be self-critical and technical. Supervisor provides structure, reassurance, and explicit reflective frameworks.
Key methods: Structured prompts, Gibbs cycle, journaling scaffolds, normalization of uncertainty

Level 2

Intermediate Practitioner

Reflective Stance:
Oscillating between over-confidence and self-doubt; beginning to notice countertransference; reflection is deepening but inconsistent. Supervisor offers challenge and support in balance.
Key methods: Critical incident analysis, countertransference exploration, beginning use of parallel process

Level 3

Advanced Practitioner

Reflective Stance:
Stable professional identity; consistent self-aware reflection; able to hold complexity and ambiguity. Supervisor moves to consultation and collaborative reflection.
Key methods: Reflexivity work, transformative reflection, philosophical inquiry, supervisor self-disclosure

Stoltenberg & McNeill (2010): Supervisor flexibility — matching reflective methods to supervisee developmental level — is a core supervisory competency.

Synthesis: What Each Model Offers the Supervisor

No model is superior — each foregrounds something different. Skilled supervisors match the model to the supervisee's developmental level, the clinical moment, and the purpose of the reflection.

Gibbs (1988) Structured Debriefing

- Best for step-wise processing of a discrete critical incident
- Explicitly includes feelings and balanced evaluation
- Ideal scaffolding for Level 1 supervisees (IDM)
- Ends in a concrete, accountable action plan
- Limit: can become mechanical if used ritually

Schön (1983) Practice Epistemology

- Best for examining in-the-moment judgment and tacit knowing
- Illuminates why skilled responses fail under emotional pressure
- Develops reflection-in-action for advanced practice
- Limit: offers less step-by-step structure for novices

Kolb (1984) Experiential Learning

- Best for transforming experience into theory-linked learning
- Strong bridge between practice and the clinical literature
- Closes the loop through active experimentation
- Suits Level 2–3 supervisees ready for conceptual work
- Limit: underweights emotion unless deliberately added

In practice they nest: Gibbs structures the debrief, Schön deepens the judgment analysis, Kolb carries learning into experimentation.

Technical Reflection vs. Critical Reflection

Not all reflection is equally transformative. Taylor (2010) distinguishes between levels of reflection — from surface-level technical problem-solving to deep critical examination of assumptions and power.

Technical Reflection	Solving practical problems within existing clinical frameworks. 'How do I apply this intervention more effectively?' Necessary but insufficient for professional transformation. Does not examine the assumptions behind the technique itself.
Practical Reflection	Examining the values and goals embedded in clinical actions. 'Why did I choose this approach? What does it assume about the client and the therapeutic relationship?' Begins to surface implicit clinical commitments.
Critical Reflection	Mezirow (1991): Interrogating taken-for-granted assumptions about power, knowledge, culture, and professional identity. 'Whose interests does this intervention serve? What does my theoretical model silence or exclude?' Enables transformative learning.

Increasing depth of reflection → → → → Increasing capacity for transformation

REFLECTIVE PRACTICE EXERCISE

Escalate the Question

Moving from technical to practical to critical reflection (Taylor, 2010; Mezirow, 1991)

10-12 min

1

Technical

2 min

Write down a real technical question you brought to supervision recently — a How do I? question about method or intervention.

2

Practical

2 min

Rewrite it as a Why did I? question. What values, goals, or assumptions about this client sit underneath your original question?

3

Critical

3 min

Rewrite it once more: Whose interests does this approach serve? What does my model silence, exclude, or fail to see here?

4

Pair Share

4 min

Read all three versions to a partner. Which one would you actually be willing to bring to your own supervisor, and why?

Self-of-the-Therapist Work in Supervision

Self-of-the-therapist (SOT) work examines how the therapist's own personal history, family of origin, cultural identity, and unresolved trauma shape clinical presence and relational choices.

Personal History as Clinical Resource

The therapist's own experiences of loss, trauma, attachment disruption, and healing are not liabilities — they are the empathic substrate of clinical wisdom when well-reflected.

Cultural Identity & the Therapeutic Self

Ryde (2009): The therapist's racial, ethnic, gender, class, and spiritual identity are not peripheral — they are central to the relational field of therapy and must be consciously examined in supervision.

Family-of-Origin Inquiry

Supervisees examine how family roles, emotional rules, conflict styles, and attachment patterns are reenacted in the therapy room — often unconsciously and without reflective supervision.

Personal Therapy as Reflective Practice

Personal therapy for supervisees is not remedial — it is a form of deep reflective practice that cultivates the self-awareness essential to effective trauma-informed clinical work.

Pearlman & Saakvitne (1995): Unexamined therapist history is not neutral — it is active in the clinical encounter, for better or for worse.

REFLECTIVE PRACTICE EXERCISE

Family-of-Origin Echo

Private self-of-the-therapist reflection — no disclosure required

8-10 min

1 Notice
2 min

Bring to mind one client presentation that reliably pulls you out of neutrality — anger, withdrawal, over-helping, or rescue.

2 Trace
3 min

Write privately: what familiar role does this pull you into? Where in your own history was that role learned and rewarded?

3 Reframe
2 min

How is this same history also a clinical resource? Name the specific empathy or attunement it gives you access to.

4 Choose
2 min

Decide what — if anything — you would bring to supervision, and what belongs in personal therapy. Sharing is optional throughout.

Transformative Learning in Supervision

(Mezirow, 1991)

Mezirow's transformative learning theory holds that deep professional development requires a disorienting dilemma — a moment that cannot be resolved within existing frames of reference — followed by critical reflection and frame transformation.

1	**Disorienting Dilemma**	A clinical experience that cannot be explained or resolved by the supervisee's existing frameworks — creates productive cognitive and emotional tension that opens space for growth.
2	**Critical Self-Examination**	Exploring assumptions, emotions, and identity responses to the dilemma — supported by the supervisor's curious and non-assumptive questioning stance.
3	**Recognition of Shared Experience**	Discovering that others (peers, supervisors) have experienced similar disorientation — normalizes and socially validates the learning struggle.
4	**Exploration of New Roles**	Experimenting with different clinical stances, theoretical frameworks, and relational approaches — testing new professional identities in a safe supervisory space.
5	**Building Competence & Reintegration**	Integrating the new frame into professional identity and practice — transformative learning becomes the new baseline for clinical work.

Mezirow (1991): Transformative learning requires more than information — it requires the safe crisis of challenged assumptions within a holding environment.

REFLECTIVE PRACTICE EXERCISE

Your Disorienting Dilemma

Tracing your own transformative learning sequence (Mezirow, 1991)

12-15 min

1

Recall

2 min

Identify a case your existing frameworks could not hold — where the theory you trusted stopped explaining what was happening.

2

Locate

3 min

Map yourself onto Mezirow's five phases. How far did you get, and at which phase did the process stall or get shut down?

3

Name It

3 min

Which assumption was actually being challenged? About the client, about therapy, or about yourself as a clinician?

4

Small Group

5 min

In threes, share what the holding environment did or did not provide. What would have helped you move to the next phase?

SECTION VI

Ethics, Evaluation & Implementation

The ethical dimensions of reflective supervision, and institutional embedding

Ethical Dimensions of Reflective Supervision

Reflective supervision is not value-neutral. It is grounded in ethical commitments to honesty, beneficence, accountability, and the professional wellbeing of supervisees and the clients they serve.

Confidentiality & Disclosure

Supervisees must feel safe to bring their doubts, errors, and vulnerabilities to supervision. Supervisors have an ethical responsibility to protect what is shared while fulfilling their gatekeeping obligations transparently.

The Ethics of the Reflective Demand

Supervisors must not demand levels of self-disclosure or personal reflection that exceed the supervisory role. Reflective depth must be calibrated to safety and professional relevance — not personal curiosity.

Informed Consent for Supervision

Supervisees deserve to know: How will our supervisory work be conducted? How will I be evaluated? What is the scope and limit of confidentiality? What are my rights if I experience harm in supervision?

Accountability to Client Welfare

All reflective supervisory practice is ultimately in service of client welfare. Supervisors must maintain sight of this primary obligation, ensuring reflective work enhances — not displaces — clinical responsibility.

Bernard & Goodyear (2019): The ethics of supervision includes the obligation to actively cultivate a reflective climate — not merely to allow it to emerge.

REFLECTIVE PRACTICE EXERCISE

Where Is the Line?

Calibrating the ethics of the reflective demand (Bernard & Goodyear, 2019)

10-12 min

1

Prompt A

2 min

A supervisor asks: What was happening in your body when the client described the assault? Supervisory, or over the line?

2

Prompt B

2 min

Does this client remind you of anyone in your own family? Decide as a group where this sits, and what makes the difference.

3

Prompt C

3 min

Have you resolved your own trauma history enough to hold this case? Legitimate gatekeeping, or an unethical demand?

4

Principle

4 min

Draft one sentence your group could put in a supervision contract that names the limit of reflective self-disclosure.

Telesupervision, Recordings & Technology

Rousmaniere & Renfro-Michel (2016): Technology shapes how supervision happens — videoconference supervision, routine session recording. Each brings reflective opportunities and distinct ethical obligations.

Reflective Opportunities

1. Session recordings enable access to valuable information about what happened, and allow for reflection.
2. Access to specialized trauma supervision across distance
4. Recorded supervision sessions for supervisee development
5. Continuity of supervision through disruption or relocation

Ethical & Practical Considerations

1. Privacy, informed consent, and secure storage for recordings and platforms
2. Jurisdictional and regulatory requirements for remote supervision
3. Attending deliberately to somatic and relational cues on screen
4. Contracting explicitly for technology use and its limits
5. Guarding the reflective space from distraction and interruption

The medium changes; the supervisory obligations — safety, confidentiality, presence, and reflective depth — do not.

Organizational Culture & Reflective Supervision

Individual reflective practice cannot be sustained without organizational cultures that value, protect, and resource reflective supervision. Organizational and systemic factors are decisive.

Organizational Barriers to Reflection

1. Time pressure and caseload demands leaving no space for deep reflection
2. Performance cultures that value productivity over reflective depth
3. Trauma-saturated systems that have normalized distress and suppressed disclosure
4. Hierarchical structures that inhibit honest supervisee vulnerability
5. Absence of supervisor training in reflective facilitation methods

Organizational Enablers of Reflection

1. Protected, regular supervision time written into organizational policy
2. Senior leadership who model and participate in reflective practice
3. Peer consultation groups as a normalized organizational resource
4. Training in reflective methods for all clinical supervisors
5. Trauma-informed organizational cultures that value staff wellbeing

SAMHSA (2014): Trauma-informed organizations create conditions for sustained reflective practice — it cannot rest on individual commitment alone.

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