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Clinical Supervision and the Trauma Therapist

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November 6, 2005

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Within the four walls of my office, on the phone or in a group treatment room, I have listened to – and witnessed the re-telling of molestation by fathers, brothers, teachers, priests, doctors, police officers, and uncles. The impact of hearing these stories in the privacy of my office, isolated from the rest of the world, has transformed me, and I am no longer the person I was before I started working with survivors of sexual violence.

Since childhood sexual abuse occurs in the context of a trusted relationship, the same issues of trust, safety, power, and control can find their way into the therapy relationship, which can become both complicated and compelling (Baker Miller & Pierce Stiver, 1997; Courtois, 1988; Dolan, 1991). Clinical supervision facilitates an examination of the process of therapy, allowing the trauma therapist to share thoughts, feelings, struggles, and fantasies with the expressed purpose of creating healing connections for survivors (Courtois, 1988; Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996).

Despite its potential benefits, the reality is that most trauma therapists do not receive regular clinical supervision, mainly due to a lack of understanding in the process combined with reluctance, on the part of designated supervisors, to obtain adequate training. Additionally, some trauma therapists may be resistant if a previous attempt with supervision was ineffective (Hewson, 2001). Other complications with safety and trust might include a supervisor who holds multiple roles in relation to the trauma therapist or a lack of choice in supervisors, which is a reality in most hierarchical organizations (Hewson, 2001).

The mental health profession itself holds the unrealistic notion that competent trauma therapist never allow themselves to be impacted by their work, and that they are always aware of what is occurring within the therapy relationship (Pearlman & Saakvitne, 1995). The profession's denial of the humanity of the therapist does a disservice by confusing "not knowing", being moved, and feeling with a client, with ignorance and incompetence, thus equating clinical supervision with weakness (Herman, 1997; Pearlman & Saakvitne, 1995).

As funding becomes increasingly tied to hours of service to clients, it becomes easy for staff and agency administration to focus solely on the provision of service as opposed to providing clinical supervision to its staff (Richardson, 2001). Similarly, therapists in private practice and/or trauma therapists who are not provided supervision in their workplace would have to choose to spend their own time and money on private clinical supervision, a choice that might not be feasible given other financial, family, and personal commitments.

The purpose of this chapter is to highlight the myriad benefits of clinical supervision for the trauma therapist, and the trauma client, by discussing (a) the nature and purpose of supervision (b) common issues in trauma therapy supervision, (c) popular models of supervision, and (d) characteristics of effective supervisors and supervisees, and finding the right supervisor.

The Nature and Purpose of Supervision

Thankfully my first experience with clinical supervision was a positive one. It began in the second semester of my master of social work internship at a local women's shelter. Like most shelters there was little funding to provide residents with "on-the-spot"

immediate and/or long-term therapy. To help meet the needs of the residents, the university I attended agreed to provide a clinical social work intern (me), and a faculty member who would provide me with 1.5 hours of weekly clinical supervision.

I was worried and confused, and had no idea what clinical supervision entailed until my supervisor provided me with an article explaining the process. I was relieved to discover that rather than a weekly evaluation of my work, the relationship was intended as more of a mentorship. Throughout the duration of our meetings, my supervisor showed increasing curiosity about my interest in working with women; my beliefs about power and control; how I planned to take care of myself; how I felt before, during and after each meeting with a client; and how my view of the world might be changing as I listened to the women's stories of abuse, poverty, and racism.

My clinical supervisor was respectful and encouraging of my choice to pursue my own personal therapy. When I felt I had made a "mistake" with a client, she helped me to process it and to see how I might use this new learning in my next therapy session. She created an interpersonal container where it was safe for me to discuss transference, counter-transference, and vicarious trauma (see appendix A for definitions). The relationship that emerged was based on mutual respect and empowerment, curiosity, education, personal growth, support and confrontation. We were both willing to be challenged and transformed. Through this first supervisory relationship, my love for learning and reading evolved into a passion for therapy.

Unfortunately this type of growth fostering supervisory relationship is not the norm. I myself have worked in environments that have ranged from no supervision at all or worse yet, bad supervision, to environments where training, education and quality

supervision were embraced and encouraged. The inconsistencies with how support, education, and training are viewed in the field of trauma work seem to point to a general lack of understanding of clinical supervision by both supervisees and supervisors (Mathews, 1995; Richardson, 2001).

To begin with, clinical supervision is not, nor should it ever be, linked to performance management, whereby the supervisee might fear the content of supervision making its way into a performance review (Richardson, 2001). The purpose of clinical supervision is to provide a safe space for supervisees to debrief, share difficult experiences, relax, promote self-care, be affirmed, and have energy restored (Richardson, 2001). More like an apprenticeship than counseling, the supervisor must still use therapy skills to create the trust and safety necessary for the supervisee to feel free enough to explore difficult feelings and experiences, while creating a process that is both “stretching and fluid” (Hewson, 2001).

Common Issues for Trauma Therapy Supervision

Ideally, the space of supervision serves as a refuge between sessions with clients, and used for education, consultation, analysis, personal growth, and introspection. Over the lifetime of the therapist, regular on-going clinical supervision can help ward off boredom and mediocrity, by encouraging the creation of a new therapy with each new client (Baker Miller & Pierce Stiver, 1997; Hewson, 2001; Pearlman & Saakvitne, 1995; Yalom, 2002). The following section will explore the various issues for trauma supervision.

Mastery of Theory and Skill. Pearlman and Saakvitne (1995) claim, that the supervisor has the task of holding a theoretical container, to provide the therapist with a

sense of context and meaning. The theoretical container would include knowledge about normal responses to childhood sexual abuse, child development, feminist theory, self-care as well as various approaches to therapy.

Expressive Arts Applications and Repertoire. An art-centered approach to supervision ensures a central role for art making, and helps the expressive arts therapist remain connected to their creative community (Baratta et al., 2001). Ensuring that the required competencies are met, the supervision process would include making art and bringing in the artwork of clients to ensure that art is the primary form of clinical analysis and expression (Knill, Levine, & Levine, 2005). Finding an expressive arts supervisor who also specializes in trauma therapy might not be possible and may necessitate having two supervisors, one who specializes in trauma work and another who can offer in-depth, analytically-oriented expressive arts supervision (Austin & Dvorkin, 2001).

The Therapy Relationship. Since childhood sexual abuse normally occurs within the context of an interpersonal relationship with a trusted person, the therapeutic relationship can, as previously stated, become complicated and compelling (Courtois, 1988; Pearlman & Saakvitne, 1995). The goal of therapy is to model a healthy non-exploitative relationship through therapist authenticity, empathy and openness, adding the spark of humanity that was missing in the survivor's perpetrator (Courtois, 1988; Wosket & Page, 2001). Despite good intentions, navigating through the needs and emotions of both client and therapist, can trigger certain aspects of the other's personhood or behavior that can derail the healing connection (Courtois, 1988; Wosket & Page, 2001). Given the potential stressful working conditions, and the possible harm to both client and therapist,

clinical supervision that focuses on improving the therapy relationship is essential to the success of therapy (Pearlman & Saakvitne, 1995).

Boundaries. Sexual abuse is a violation of the child's physical and emotional space, leaving the adult survivor with a potentially distorted idea of healthy and unhealthy boundaries (Dolan, 1991). Balancing empathic engagement with the negotiation of clear and safe boundaries between therapist and survivor, communicates safety, care, and respect. At times, this might be difficult faced with the intense emotions that often emerge during the re-telling of abuse (Herman, 1997; Kottler, 2003; Mathews, 1995; Saakvitne & Pearlman, 1996). Clinical supervision can provide the necessary container to examine the motives of the therapist in negotiating the conflicting requirements between flexible and rigid boundaries (Herman, 1997; Kottler, 2003).

Transference. Survivors, who report having felt confused, betrayed, humiliated, helpless, and abandoned at the time of their abuse, often report similar feelings toward people in positions of authority over them, including therapists (Herman, 1997). The dynamics this can introduce into the therapeutic process can alternate between periods of conflict, attachment, idealization, withdrawal, and hostility (Courtois, 1988). Clinical supervision can assist therapists, depersonalize transference responses, by examining how past relational images might be showing up in the present and finding ways to work towards re-connection and healing (Baker Miller & Pierce Stiver, 1997).

Counter-Transference. Experienced at various levels of awareness, counter-transference responses can be confusing, personal, and often embarrassing for the therapist. Trust and safety within the supervisory relationship can provide the space to differentiate between the personal issues of the therapist versus the issues that can be

addressed in the therapy relationship (Pearlman & Saakvitne, 1995). Shining light on the impact, therapist and client have on one another can provide an opportunity for insight, transformation, and healing.

Vicarious Trauma. The natural consequence of empathic connections with survivors can result in vicarious trauma, which is the inevitable and cumulative effect on the therapist, of hearing repeated stories of childhood sexual abuse (Dolan, 1991; Saakvitne, Gamble, Pearlman, Tabor, 2000). Vicarious trauma can impact the trauma therapist's view of herself and the world around her and, if left unchecked, can leave her feeling battered, helpless, guilty and confused (Saakvitne & Pearlman, 1996). Ultimately clinical supervision would educate, and offer suggestions for self-care, while drawing attention to the signs of vicarious trauma (Dolan, 1991; Herman, 1997, Saakvitne & Pearlman, 1996; Yalom, 2002). The latter can parallel the symptoms of traumatic stress including: anxiety; disconnection; guilt; emotional flooding; numbing; social withdrawal; hopelessness; avoidance; rage; helplessness; hypervigilance; difficulty in relationships and with sexuality; and social withdrawal (Herman, 1997; Saakvitne & Pearlman, 1996).

Self-Care. Saakvitne et al. (2000) claim that if *the self* of a therapist is the *tool of the trade*, self-care is the regular maintenance required to combat the occupational hazards of trauma work. Therapists can demonstrate a serious commitment to physical, emotional, and spiritual well being through self-care (Kottler, 2003). Sound clinical supervision, which is part of self-care, can ensure that therapists strive toward maintaining balance between work and leisure, action and reflection, and giving and receiving (Saakvitne & Pearlman, 1996). Practical self-care in the workplace would include (a) monitoring caseload (b) limiting the number of clients seen each day (c)

taking breaks, and (d) making time to nurture collegueship (Kottler, 2003; Saakvitne & Pearlman, 1996).

Community Work. Herman (1997) argues that working with survivors requires a strong committed moral stance from the therapist. This would include a well-developed critical analysis of the fundamental injustice of various forms of oppression – and how they intersect with childhood sexual abuse. Ideally, clinical supervision can help keep trauma workers grounded in the knowledge that individual acts of sexual abuse are connected to a much larger notion of the political domination of one group over another. Exploring or re-connecting with a wider feminist consciousness and joining with others to address abuse on a macro level through activism, can help trauma therapists feel connected to something larger than themselves, thus leading to transformational conversations between therapist and client (Mann, 2005).

Survivor Therapists. Despite the fact that 26 to 43 % of trauma therapists are also survivors (Elliott and Guy's study as cited in Pearlman & Saakvitne, 1995), the acknowledgment of the value, and presence of survivor therapists is almost non-existent in the literature and in the workplace (Pearlman & Saakvitne, 1995). Ideally clinical supervision would acknowledge, recognize, understand, and openly address the possible advantages and disadvantages survivor therapists can bring to their work with trauma clients (Pearlman & Saakvitne, 1995).

Models of Clinical Supervision

Current literature advocates a combination of individual, peer, and group supervision as the ideal when considering the well being of trauma therapists and the clients they work with (Herman, 1997; Richardson, 2001). Individual supervision

consists of a formal contract between a supervisee and a supervisor, who would meet on a weekly or bi-weekly basis to explore identified issues in a reflective manner (Wosket & Page, 2001). These meetings would provide a bridge between sessions with survivors, providing the supervisee with an opportunity to review the work of therapy (Wosket & Page, 2001).

Group supervision normally takes place with an internal or an external facilitator. The purpose is threefold: (a) to debrief, problem-solve, and discuss painful emotions resulting from trauma work, (b) promote organizational and individual self-care, and (c) to identify the specific effects of trauma work on the self of the therapist (Richardson, 2001; Saakvitne & Pearlman, 1996). Connecting with colleagues in group-supervision can provide the usual transformational powers of a group through cohesion, intimacy, validation, reality testing, and problem solving (Kottler, 2003; Saakvitne & Pearlman, 1996). More importantly, regularly scheduled group supervision can counteract the isolation, boredom, and despair that can be experienced when therapists lack opportunities for real connection with colleagues (Kottler, 2003).

Peer supervision occurs when at least two clinicians consult with one another (Pearlman & Saakvitne, 1995). Meetings can range from informal de-briefing to a more formal structure where each person is allotted a set amount of time to present and discuss their clinical work (Pearlman & Saakvitne, 1995). This type of meeting can help revitalize one another by focusing on encouraging each other to be more creative and innovative, while providing a special source of comfort and energy (Kottler, 2003).

Working with the issue of sexual abuse can be draining, and even with regular personal therapy, individual, group and peer supervision, trauma therapists should also

have access to a supervisor to debrief or consult with throughout the workday to ensure proper mental and emotional functioning (Kottler, 2003; Richardson, 2001). When a therapist finds herself working alone in private practice or in a workplace that does not offer effective quality supervision, she might consider creating a peer support network as well as paying for regular private clinical supervision.

Characteristics of Effective Supervisors and Supervisees

Supervisors. In my experience, the best clinical supervisors are the ones that display a deep sense of respectful curiosity within a safe yet “stretching” environment. They facilitate growth through their own commitment to ongoing training and development, as well as obtaining personal consultation for their role as supervisor. They are confident enough to be open to being changed and taught by the supervisee. Effective supervisors share a sense of reciprocal responsibility within the relationship, thus being open to evaluating the supervisory process, including any unspoken feelings between supervisor and supervisee, and subsequently taking due responsibility (Hewson, 2001).

Committed to the idea of “not knowing”, effective supervision is more of an exploration of the unknown, through which the supervisor encourages the therapist to develop the courage and the willingness to face the unknown within themselves and in the relationships, they have with their clients (Wosket & Page, 2001). By modeling this type of exploration, supervisors are empowering the supervisee to do the same with their clients, thus working towards creating a healing process based on mutual empathy, intuition, instincts, and of course “not knowing” (Wosket & Page, 2001).

With a compassionate eye, the clinical supervisor helps the supervisee to pick out details that may be out of her sight during actual therapy with clients with the purpose of

trying to make sense of patterns and outcomes (Hewson, 2001; Wosket & Page, 2001).

As mentors, supervisors must be willing and able to abandon particular styles of supervision in order to create a new supervision with each new supervisee (Wosket & Page, 2001; Yalom, 2002).

Supervisees. Clinical supervision is most effective when it is a collaborative process. It is essential that the supervisee become an active participant in developing and monitoring the supervision process (Orlans & Edwards, 2001). Characteristics of an effective supervisee would include a commitment to learning and mentorship, as well as a willingness to be stretched and transformed. Throughout this lifelong process, an effective supervisee would be able to identify and communicate priorities, areas for growth, as well as the parts of their practice that might require attention (Wosket & Page, 2001).

A major task in therapy is to pay attention to one's immediate feelings, which can be discussed or processed in supervision, with the purpose of moving the therapist toward a greater knowledge of self (Yalom, 2002). With increased self-knowledge, the therapist works toward eliminating or at least noticing the counter-transference responses that can lead to disconnection in the therapeutic process (Yalom, 2002). The supervisee's willingness to risk exploring these unconscious responses can further increase the chances of successful connections in therapy (Baker Miller & Pierce Stiver, 1997).

An effective therapist/supervisee would feel comfortable engaging in personal therapy, a process Yalom (2002) says should be as prolonged and as deep as possible. Yalom argues that the best way for therapists to learn a particular therapeutic approach is to enter into it as a client. This provides a threefold opportunity to (a) resolve personal

issues, (b) develop an awareness of inner strengths, and (c) gain a firsthand appreciation for the strengths and weaknesses of a specific approach (Yalom 2001).

Finding the Right Supervisor. The qualities listed above can assist both supervisors and supervisees develop expectations, roles, tasks, and the required training to ensure a process that is both *fluid and stretching*. When internal supervision is not available or is ineffective, therapists have the right and the ethical responsibility to obtain private supervision outside of the workplace. Finding the right match involves conducting a search of local therapists or faculty who provide private clinical supervision; asking for referrals from valued colleagues, and past mentors; and conducting interviews. Interview questions can be developed using this chapter as a guide. At times, finding the right match might necessitate long distance clinical supervision, which can be done over the telephone and/or by email.

Conclusion

Working with survivors of sexual abuse regularly offers therapists opportunities to experience hope, sisterhood, and connection. The work is intense, powerful, and rewarding, and carries with it the inevitability of vicarious trauma. Effective clinical supervision is a safeguard against injury to clients, boundary violations, and therapist burnout. Quality clinical supervision, is one of the most significant factors in the success or failure of therapy, and is an essential part of both personal and professional accountability (Courtois, 1988; Dolan, 1991; Herman, 1997; Mann, 2005, Mathews, 1995; Orlans & Edwards; Saakvitne et al. 2000; Wosket & Page, 2001). Complications in the supervisory relationship can be minimized when there is a clear understanding of the

purpose and process of supervision, a choice of supervisors, and a desire to achieve the qualities of effective supervisors and supervisees.

Appendix

Definitions

Counter-transference. Refers to the therapist's conscious and unconscious feelings about the client. It may be in part an expression of the personal issues that the therapist brings into the therapy relationship, and it may be in part a response to the client's transference reactions (Baker Miller & Pierce Stiver, 1997, p. 142).

Transference. Refers to the client's conscious and unconscious feelings about the therapist. It may be in part an expression of past experiences and relational images from the original trauma, that are brought into the therapy relationship, and it may be in part a response to the therapist's countertransference reactions (Baker Miller & Pierce Stiver, 1997).

Vicarious Trauma. The inescapable transformation of the therapist's inner experience as a result of empathic engagement with survivor clients and their stories of devastation or betrayal that, challenge our cherished values and beliefs (Saakvitne & Pearlman, 1996 p25). In the role of witness to atrocity, the therapist will at times become emotionally overwhelmed and may experience to a lesser degree, the same terror, rage and despair as the client (Herman, 1997, p.140).

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Biography

Gisèle Harrison is a registered social worker with a part-time private practice, and a full-time public practice at a rape crisis center. She provides individual, couple, and group therapy, as well as Eye Movement Desensitization and Reprocessing. Gisèle also has over 15 years of practical experience facilitating psycho-educational groups and anti-oppression workshops across Canada, in New York, and in East Africa. Much of her work and formal training has focused on learning how gender, race, sexual orientation, class, and other forms of oppression can impact individuals and communities. She is passionate about women's issues and is always honored to be part of the healing journey of survivors of sexual violence. As a sessional instructor with the University of Windsor, she has taught courses on diversity, crisis intervention, and gender. Gisèle received her master in social work from Wilfrid Laurier University and is a member of the Ontario Association of Social Workers.