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Trauma-Informed Supervision: The Supervisory Needs of Mental Health Therapists Engaged in Trauma-Related Work

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Abstract

We present the need for therapists who engage in trauma-specific work to receive trauma-informed supervision or consultation. This is based on the findings that the emotional labor required of trauma-specific work is high and increases a therapist's risk for experiencing negative impacts from their work such as vicarious trauma, compassion fatigue, unhelpful transference/countertransference, reminders of their own trauma, and burnout. Further, clients incur risks of receiving iatrogenic care when therapists engaged in trauma-related work are not given appropriate job related resources and/or receive ineffective supervision. We discuss a model for trauma-informed supervision, including supporting theory and initial guidelines for supervisors' competence and activities. Specifically, we outline the knowledge and activities necessary for trauma supervisors to engage effectively in the clinical supervision of trauma sensitive cases and as advocates for therapists who engage in trauma sensitive work. We provide specific suggestions for supervisory intervention to reduce therapists' negative experiences with trauma work and increase positive ones. Areas for future exploration conclude this initial dialogue, which is intended to be a catalyst for crafting an evolving framework for trauma-informed supervision.

Keywords

trauma-informed supervision, trauma work, vicarious trauma

Clinical supervisors are called to maintain the ethical and performance standards of the mental health field (Holloway & Neufeldt, 1995) by meeting supervisees' normative, formative, and restorative needs (Bernard & Goodyear, 2014). As psychotherapy has become driven by evidenced-based practices that require treatment fidelity, and tailored to address specific needs, supervision has become progressively specialized (e.g., Henggeler et al., 2002). The benefit of specialized supervision is the instrumental support supervisors can provide to therapists, which is linked to employee wellbeing and reduced turnover (Eisenberger et al., 2002).

Within therapeutic work with traumatized people, specialized, instrumental supervisory support is critical, as working conditions necessitate that supervision address both the therapist's unique emotional experiences (Dalenberg, 2000; Etherington, 2009) and professional needs (Sommer, 2008). Providing trauma specific services involves intense "emotional labor" (Zapf, 2002), leading therapists' to experience complex emotions (Sprang et al., 2019) as a result of working with populations in which trauma exposure is high (Lipschitz et al., 1999; Mueser et al., 1998, 2004; Triffleman et al., 1995). Trauma-specific work contexts may lead therapists to witness traumatic retelling, read documentation of abuse, witness/intervene in unpredictable client behaviors (West, 2010), provide services in high-risk environments (e.g., war zones, correctional settings) (Johnson, et al., 2011), or come into contact with traumatic material by the inherent qualities of the population they serve, such as child welfare youth, sexual assault victims, war veterans, or victims of mass tragedy (Goodman et al., 1997; Johnson et al., 2014; Johnson et al., 2011; Sommer, 2008). The cumulative emotional labor required to be exposed vicariously to trauma (McCann & Pearlman, 1990), treat or cope with clients' multiple symptoms (e.g., Abramovitz & Bloom, 2003), risk experiencing reminders of one's own trauma (CDC, 2012; Pearlman & MacIan, 1995; Miller & Sprang, 2017), and respond to intense client reactions during

intervention (Abramovitz & Bloom, 2003; Acker, 1999; Gladstein, 1983; Small et al., 1991; Ting et al., 2008) indicate that therapists would benefit from the support of TIS (e.g., Dunkley & Whelan, 2006; Pearlman & Saakvitne, 1995; Sodeke-Gregson et al., 2013; Sommer & Cox, 2005). As supervision is conceptualized to be an antidote for many difficulties related to clinical work, TIS aims to help therapists who engage in trauma specific services with work-related issues unique or more likely among trauma therapists, such as unhelpful transference/countertransference (Wilson et al., 1994), reminders of one's own trauma, vicarious trauma (Baird & Kracen, 2006), compassion fatigue (Stamm, 2010), secondary traumatic stress (Jenkins & Baird, 2002), and burnout (Schaufeli & Buunk, 2003).

Because these needs affect all trauma therapists, we believe all trauma therapists would benefit from varying levels of TIS. For example, new therapists or those new to trauma work would benefit from individual supervision by a supervisor with more trauma specific experience (Edwards et al., 2006; Pearlman & MacIan, 1995). Conversely, veteran trauma therapists who practice independently would benefit from TIS as a social support, delivered in a consultation model with a trusted colleague who is also engaged in trauma specific work (Bakker & Demerouti, 2007; Dyregrov & Mitchell, 1992; Pearlman & MacIan, 1995; Reid et al., 1999) or through a peer consultation group that meets regularly (Catherall, 1995; Lyon, 1993; O'Conner, 2001; Oliveri & Waterman, 1993; Yassen, 1995) and adheres to a TIS framework. As such, we use the terms supervisee and therapist interchangeably here to note those who may benefit from supervision or consultation that is trauma-informed.

In addition to providing a supportive, helpful atmosphere for trauma therapists, supervision specialized for trauma-specific services should reduce the risk of iatrogenic care, as this is a serious concern among trauma-exposed clients (Bloom & Farragher, 2013; McCarthy, 1997) for a variety

of reasons. Iatrogenesis may occur due to lack of appropriate knowledge, skills, or supervision that leads to harmful practices (e.g., Chaffin et al., 2006; Gillan, 2001; Mohr et al., 1998; Ray et al., 1996; Van Emmerik et al., 2002; Wadeson & Carpenter, 1976; Weiss, 1998) or incorrect treatment implementation (e.g., Foa et al., 2002; Tarrier et al., 1999; Van der Kolk & McFarlane, 1996). Further, many traumas occur within relational contexts with power differentials (e.g., rape, incest, neglect, physical abuse, intimate partner violence, etc.), which makes therapy a ready-made context for recapitulations of previous negative experiences (e.g., Dalenberg, 2000). Collectively, therapists' occupational risks and clients' clinical risks necessitate that supervisors be prepared to address issues inherent in trauma-related work. We present an initial framework for trauma-informed supervision (TIS) that identifies the necessary competencies and activities a supervisor should consider addressing regarding supervisees' trauma-related work issues.

What is Trauma-Informed Supervision?

Supervisors who oversee trauma specific work should provide supervision based in trauma knowledge in order to benefit client (Bambling et al., 2006; Bloom & Farragher, 2013) and therapist health (Knudsen et al., 2013; Leiter et al., 2010; Rosenbloom et al., 1995). As clients and therapists continue to have significant levels of trauma exposure, and therapists continue to provide trauma sensitive treatment, appropriate responses will be needed at all levels of a helping organization (e.g., client, therapist, supervisor, and agency). We believe that TIS is inclusive of the competencies and activities identified in Figure 1 as an appropriate first response. Core competencies ensure that supervisors have trauma specific knowledge, training, and experience to lend instrumental support to supervisees (Dunkley & Whelan, 2006) and to ensure quality client care (West, 2010). Core activities assure that supervisors assist therapists as they engage in trauma-related work by assisting with occupational stressors, reducing occupational risk to harmful

emotional labor (HEL) outcomes (e.g., vicarious trauma, compassion fatigue, burnout, etc.), increasing salutogenic emotional labor outcomes (e.g., vicarious resilience, vicarious posttraumatic growth, personal growth, compassion satisfaction, etc.), and increasing organizational advocacy. Figure 1 provides an overview of TIS competencies and activities.

Figure 1

Trauma Informed Supervision Core Competencies and Activities

TIS Supervisory Core Competencies

The provision of TIS, similar to other specific forms of supervision (e.g., Hinshaw-Fuselier et al., 2009), is supported by the supervisor's competence. In TIS, this includes basic supervisory competence, or the set of skills necessary for supervisory work (Bernard & Goodyear, 2014), and the possession of working trauma knowledge (West, 2010) through training/education and experience. These competencies allow trauma-informed supervisors to provide trauma therapists with practical support (Dunkley & Whelan, 2006).

Trauma Specific Knowledge

Therapists who require TIS will benefit from the supervisor's knowledge in trauma. West (2010) found that trauma therapists experienced inadequate social support from their supervisors when the supervisor's knowledge in trauma was low. This is significant, as social support affects patient care (Firth-Cozens, 2001; Rogers et al., 2004; Suzuki et al., 2004). Therefore, it is essential that trauma-informed supervisors be well-versed in trauma and its effects across human development and functioning to provide supervisees support. Courtois and Gold (2009) provide a thorough list of what basic traumatology should include, such as how trauma affects development, attachment, memory, cognition, family dynamics, psychoneuroimmunology, neurology, and physiology; trauma risk factors, protective factors, and resiliency; trauma assessment; domestic and interpersonal violence; cultural and individual differences within trauma; human trafficking; sexual slavery; trauma from disasters, war, and political torture; treatment approaches; and specific intervention skills. Traumatology should also include knowledge related to racial trauma (Pieterse, 2018), epigenetics (Heinzelmann & Gill, 2013; Ramo-Fernandez et al., 2015; Yehuda & Bierer, 2009), the importance of self-care (Sommer, 2008), and the nature of trauma work (Hayden et al., 2015). Namely, trauma work has high rates of re-traumatization (Miller & Sprang, 2017; Pearlman & MacIan, 1995) and iatrogenesis (e.g., Bloom & Farragher, 2013; Dalenberg, 2000) that affect both client care (McCarthy, 1997) and therapist self-efficacy (Herman, 1992; Trippany et al., 2004). Because trauma-specific knowledge has been shown to enhance clinical judgments for trauma-focused treatment decisions, supervisors' knowledge in these areas is critical (Layne et al., 2011).

Trauma Specific Experience

Trauma therapists have reported needing supervisors knowledgeable about trauma (West, 2010), which includes knowledge gained through experience sufficient to model effective strategies for supervisees (Hill & Lent, 2006). Trauma-experienced supervisors are able to provide more instrumental support to supervisees by role-playing to prepare for clients, consulting for a case specific issue (Dunkley & Whelan, 2006; Stinglhamber & Vandenberghe, 2003), teaching trauma-specific intervention skills, or assisting supervisees with tailoring procedures for individual client needs (West, 2010; Fox et al., 2018). In short, there are aspects to training that are best achieved through an apprenticeship model (Shahmoon-Shanok et al., 2005), which describes specialized supervision. Reflecting this value is the process in which a therapist becomes competent through ongoing work alongside supervisors and consultants to implement an empirically supported treatment (e.g., Swales, 2010), or is eligible to be a trainer (which includes providing supervision and consultation) for an empirically supported treatment by being a certified therapist in the treatment first (e.g., McNeil & Hembree-Kigin, 2010; Norona & Acker, 2016).

Supervisor Core Activities

A supervisor who uses TIS specific skills to engage in the core activities of TIS is able to provide a reflective, safe supervision space, and can facilitate an environment for supervisory advocacy at the organizational level for therapists' needs (Bell et al., 2003). The distinction between basic supervision and TIS is an important one, as the quality, not the quantity, of supervision is protective against impairing aspects of HEL (e.g., Sodeke-Gregson et al., 2013). By utilizing TIS skills, such as thorough assessment of and response to supervisee needs, supervisors are able to support their supervisees' general wellness, trauma specific practice, and growth.

TIS Skills

We identify two skill categories which are umbrellas for skill sets a supervisor would use to embody TIS. First, supervisors assess supervisee needs (see Table 1) related to their engagement in trauma specific work (see Bride, 2007; Culver et al., 2011; Dunkley & Whelan, 2006; Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996; West, 2010). Second, supervisors implement specific strategies to address supervisee needs (see Table 2).

Table 1

Measures that Have Been Used to Assess Therapists' Needs Related to Emotional Labor

Purpose	**Measure**	**Reference**	**Assesses**
Therapist wellness	Emotional Self Awareness Questionnaire	Killian, 2007	Awareness of one's emotions
	Impact of Events Scale	Weiss & Marmar, 1996	Salience of adverse/traumatic exposure
	Jefferson Scale of Physician Empathy	Hojat et al., 2001	Empathy available for human services work
	Life Events Checklist	Gray et al., 2004	Trauma history
	Posttraumatic Growth Inventory	Tedeschi & Calhoun, 1996	[Vicarious] posttraumatic growth
	Posttraumatic Symptom Scale	Foa et al., 1993	PTSD symptoms
	Sense of Coherence Scale	Antonovsky, 1993	Capacity for coping with stressors
	Trauma Attachment & Belief Scale (TABS)	Pearlman, 2003	Trauma beliefs, distorted cognitions
	Traumatic Stress Institute Belief Scale Revision L	Pearlman, 1996	Traumatic beliefs, distorted cognitions
	Vicarious Resilience Scale (VRS)	Killian et al., 2017	Vicarious resilience of trauma therapists
Occupational health	Compassion Fatigue Self-Test	Figley, 1995	Compassion fatigue symptoms
	Job Satisfaction Survey	Spector, 1985	Satisfaction, positive appraisal of job
	Maslach Burnout Inventory	Maslach et al., 1997	Human services work-related burnout

	Perceived Value of Social Work Scale	Gibbons et al., 2011	Value, meaning of social work activities/job
	Professional Quality of Life Scale-III-R	Stamm, 2010	Quality of professional life
	Secondary Traumatic Stress Scale	Bride et al., 2003	Secondary traumatic stress symptoms
	Vocational Calling Questionnaire	Dik et al., 2012	Sense of calling, purpose, meaning in work
Client care	Working Alliance Inventory	Horvath & Greenberg, 1989	Positive client alliance to therapist

Table 2

Negative Emotional Labor Outcomes for Therapists: Risk Factors, Warning Signs, and Suggested Supervisory Responses

Vicarious Trauma (VT) in Therapists: Risk Factors, Warning Signs, and Supervisory Response				
	Risk Factors	References	Warning Signs	Supervisory Response
Individual Characteristics	Therapists new to work with trauma	Pearlman & McIan, 1995	Lack of screening by supervisors or lack of specific guidelines for work	Normalizing, orientation, informed consent by supervisor and organization; peer support; education & training about skills and common experiences engaging in trauma work; education on protective factors from VT
	Therapists with a personal trauma history	Baird & Kracen, 2006	Lack of awareness about trauma or personal experiences, lack of closure from past events	Increase self-awareness of trauma; develop deeper understanding of trauma from a professional perspective, examine cultural differences regarding trauma; encourage therapist to identify degree of closure with past traumatic experiences; education on protective factors for VT
	Those with immature or maladaptive coping styles	Adams & Riggs, 2008; Harrison & Westwood, 2009	Poor coping skills, internalization of stress	Coping mechanisms such as suppression, sublimation, and humor; self-exploration of countertransference, amelioration of self-blame, and highlight the limited responsibility associated with

				the therapist role; developing/increasing mindful self-awareness; encouraging social support, challenging pessimistic thoughts, encouraging therapist to set boundaries and honor own limits
	Neuroticism	Bakker et al., 2006; Brockhouse et al., 2011	Evidence of externalizing or internalizing symptoms, stress, etc.	Include literature and measures on burnout within agency training protocols; engagement in meaning making; self-care plan creation in supervision
	Insecure attachment styles (avoidant, fearful/preoccupied interpersonal style)	Mikulincer et al., 1993; Pines, 2004; Racanelli, 2005; Rubino et al., 2000; Sauer et al., 2003	Poor coping strategies, disrupted cognitive schemas, hyperactivating coping strategies, rumination	Assistance assessing and strengthening working alliance with client and role-playing ways to make empathic responses tangible to client; referral for own therapy to increase positive coping strategies
	Therapists who are reserved or nervous	Dill, 2007	Quiet, shy, seeking affirmation or validation with questioning	Using a strength-based approach and diffusing therapist responsibility by focus on dyadic nature (within session) and team nature (with supervisor) of clinical care
	Gender differences (females generally, males working with sexual offenders)	Edwards et al., 2006; Killian, 2008; Moulden & Firestone, 2007; Sprang et al., 2007	Over-identification with clients or generalization of gender	Training in the poverty cycle, recidivism rates, abuse and maltreatment statistics, and case studies; self-care; discussion and support regarding role overload (especially for women)
	Younger therapists	Edwards et al., 2006	Disengagement and high stress levels	Supervisors should be aware of intrusion symptoms and not allow therapist to avoid or disengage from therapy work; work stress should be carefully managed including workloads, intensity of emotional labor; encourage use of distress tolerance skills; assist therapist in adopting a

				resiliency-based perspective on the client's experiences
	Therapists specifically engaged in trauma-specific work	Knight, 2013	Difficulties with emotional regulation (restrictive emotions, poorly controlled emotions)	Ask therapist about their emotional responses to emotional labor; encourage daily self-care; creation of self-care plan in supervision; address manifestations of VT directly
Systemic & Environmental Issues	Therapists with little or no trauma-specific training	Adams & Riggs, 2008; Dunkley & Whelan, 2006	Little systemic training or trauma-specific supervision	Training; case consultation, didactic portions, and skill building in supervision; several intensive workshops or full semester of coursework in trauma specific work
	Those with high VT exposure	Baird & Kracen, 2006; Howlett & Collins, 2014	High or imbalanced caseloads, withdrawal, "taking work home"	Assist therapist in having increased control over caseload; advocate for limits on number of trauma cases seen per week; assist with self-awareness of own levels of VT
	Perception of the organization or system as unfair or unjust	Knudsen et al., 2008	Withdrawal, comments about the system as a whole	Advocate for therapists to be empowered to make their own decisions; initiate organizational level reinforcement for good performance; advocate for reduced or more balanced caseloads; offer additional supervision; advocate for organization to provide benefits for personal therapy for mental health professionals; encourage self-care and use of vacation and sick leave
	Role conflict/ambiguity	Babatunde, 2013	Over-functioning or under-functioning within the system, perceived unawareness of role	Clearly define supervisor, therapist, and other salient persons roles in the organizational structure; advocate for clearer job descriptions and formal evaluations that are tightly connected to specified roles

				and their corresponding tasks/responsibilities
	Therapists who work in rural areas	Jameson et al., 2009; Rainer, 2010; Sprang et al., 2007	High caseloads, lack of personal support	Advocate and act to help manage therapist's caseload; enhance peer support; provide resources/supervision; advocate/initiate organizational initiatives to provide social support
Unhelpful Countertransference: Risk Factors, Warning Signs, and Supervisory Response				
	Risk Factors	References	Warning Signs	Supervisory Response
Individual Characteristics	Therapist unresolved conflicts, especially those that are recent or recently re-emergent/intensified	Fatter & Hayes, 2013; Gelso & Hayes, 2002; Hayes, 2004; Pearlman & Saakvitne, 1995; Wilson et al., 1994	Undue frustration or other emotional reaction to client/client material; use of client's treatment as a means of meeting therapist's own needs; inappropriate self-disclosure in session	Assist therapist in understanding countertransference reactions and managing these reactions; helping therapist re-establish or strengthen role boundaries with client; managing therapeutic relational rupture; helping therapist explore own needs to make self-care plan/therapist plan to address own emotional needs; referral to therapy when appropriate; encourage use of mindfulness
	Therapist overidentification with client	Leitner, 1995; Dalenberg, 2000; Fatter & Hayes, 2013; Wilson et al., 1994	Therapist enmeshment or avoidance, rescuer responses; feeling overwhelmed by client's pain/suffering/emotions	Explore therapist's feelings, including emotional overwhelm and their causes; Assist therapist in understanding countertransference reactions and manage these reactions; helping therapist re-establish or strengthen role boundaries with client; assist therapist with methods of using affective levels of empathic distance; assisting therapist in increasing methods of holding and maintaining own personal frame within therapeutic relationships; referral to therapy when appropriate; encourage use of distress tolerance skills; encourage use of mindfulness skills

	Distorted appraisal of clients	Fatter & Hayes, 2013; Fauth & Hayes, 2006; Hayes et al., 2018; Wilson et al., 1994; Dalenberg, 2000	Inaccurate perceptions of client as hostile, difficult, manipulative, inaccurate recall of session events or content	Assist therapist in recognizing and understanding countertransference reactions and managing them; explore ways therapist may be engaging in avoidance and how it affects the helping relationship and client care; challenge unhelpful thoughts about client; encourage therapist to conceptualize patient from a strength's based perspective in supervision session to reframe perspective on client and help therapist see the functions of the client's engagement; monitor therapist ability to engage with difficult client emotional content; encourage use of mindfulness skills
	Avoidant disengagement	Dalenberg, 2000; Fatter & Hayes, 2013; Hayes & Gelso, 1991; Shamoon et al., 2017; Wilson et al., 1994	Anxiety in session, avoidance of client/client material; distress over client's victimization; therapist self-doubt in therapeutic abilities; rigidity regarding client care or work to reduce feelings of uncertainty	Assist therapist in recognizing and understanding countertransference reactions and manage them; explore/challenge areas of therapist's self-doubt and any defensiveness; provide trauma education/training or prepare for session as needed; encourage use of distress tolerance skills; reframe client's experiences from resiliency perspective; referral to therapy as appropriate; encourage use of mindfulness skills
	Detachment from client	Fatter & Hayes, 2013; Wilson et al., 1994	Therapist denial of patient symptoms, minimization of patient difficulties, avoidance of traumatic content, withdrawal from therapeutic interchanges/situations; reluctance to utilize appropriate self-disclosure in session	Explore areas in which therapist may be experiencing overidentification, enmeshment, rescuer reactions with client; assist therapist in recognizing and understanding countertransference reactions and managing them; explore ways therapist may be engaging in avoidance and its effect on therapy; challenge unhelpful views on client,

				client contact, and/or client symptoms; explore areas where there may have been empathy ruptures in the therapeutic relationship and address ways to enhance working alliance and therapist's effectiveness; helping therapist re-establish or strengthen role boundaries with client; encourage use of appropriate self-disclosure to foster therapeutic empathy; encourage use of mindfulness skills
Systemic & Environmental Issues	Cultures that de-emphasize countertransference possibilities	Barreto et al., 2020; Gordon et al., 2016	Organizations that prefer, recruit, require theoretical orientations or treatments that do not encourage discussion or reflection of subjective mental life	Provide training directly on countertransference; explore ethical issues that may arise due to countertransference; offer continuing education training on theoretical orientations that emphasize the subjective mental life of the therapist; encourage engagement of inner experience (i.e., immersion) techniques in the beginning of clinical cases
	Organizational identity increases therapist contact with clients who are known to more frequently stimulate unhelpful countertransference	Barreto et al., 2020; Gordon et al., 2016; Marčinko et al., 2008; Sayrs & Linehan, 2019	Organizations that provide therapy to those with personality disorders, pathogenic parenting styles in child abuse cases, and chronically suicidal clients	Provide training directly on countertransference; explore ethical issues that may arise due to countertransference with specific more difficult to treat populations or those that require intense emotional labor (e.g., suicidal clients, those with personality disorders, offending parents in child abuse cases, etc.); establish and advocate for time devoted to consultation/treatment teams to provide social and instrumental support with countertransference
Unhelpful Reminders of Therapist's Own Trauma: Risk Factors, Warning Signs, and Supervisory Response				
	Risk Factors	References	Warning Signs	Supervisory Response

Individual Characteristics	Therapist similarities to client, case	Baird & Kracen, 2006; Pearlman & Saakvitne, 1995; Weatherston & Barron, 2009	Transference, countertransference in case	Reflective supervision practices, discuss supervisee reactions to case work, extend compassion and offer support, encourage self-care and monitoring of boundaries/limits; screen cases thoroughly before assigning them; discuss assignment of case proactively with therapist to determine appropriateness of assignment/referral; increase supervision/consultation for the case when helpful
Systemic & Environmental Issues	Unpredictable, unsafe work environments (e.g., crisis centers, emergency or crisis response)	Abramovitz & Bloom, 2003; Johnson et al., 2011; Montgomery et al., 2011	Likely self-evidencing based on nature or role of organization in the community (e.g., acute hospital)	Increase safety protocols, develop safety plans for therapists and staff, debrief following environmental events that destabilize therapist, advocate for organization to practice enacting safety protocols and provide emergency/crisis management or response training
Compassion Fatigue: Risk Factors, Warning Signs, and Supervisory Response				
	Risk Factors	References	Warning Signs	Supervisory Response
Individual Characteristics	Little trauma specific training	Bell et al., 2003; Sprang et al., 2007	Overwhelmed by client/case; feeling deskilled	Provide trauma specific education and training; increase supervision/consultation for the case; role play to prepare for sessions; teach specific techniques and skills
	Pessimism toward work or work-related things	Pooler et al., 2014; Stamm, 2010	Reduced empathy, low self-efficacy for work	Promote supervisee to reflect on positive moments in case; process clinical successes to help supervisee internalize them; help supervisee make connections between therapist actions and client growth; assist therapist in ability to manage therapeutic relationship and process their own emotional experiences related to the work

Systemic & Environmental Issues	Unmanageable job demands; poor balance of job control & job demands	Karasek et al., 1998; Bakker et al., 2007; Dejoy & Wilson, 2003; Bakker & Scahufeli, 2008;	Reduced empathy, early signs of burnout, exhaustion, behind in work	Advocate for reduced demands; provide job enrichment opportunities that are not client-care tasks, preferably ones that would allow therapist to make positive changes in the work environment; advocate for organizational initiated/supported wellness benefits; advocate for more specific job descriptions that limit demands to promote reasonable load and prevent job strain; increase job resources (e.g., feedback, professional development, supervisory support, peer support, education/training, social belongingness initiatives)
	Unbalanced load of complex or challenging clinical cases	Egan, 2013; Eisenberger et al., 2002; Knudsen et al., 2008; Knudsen, et al., 2013; Lawler et al., 1995, Schabracque, 2003	Low levels of sense of professional accomplishment, diminished view of agency	Provide praise/reinforcement for positive supervisee behaviors, including attention to self-care and wellness; advocate for organizational level recognition programs; assist supervisee in internalizing positive aspects of their work that are not dependent on client response to treatment; town hall or places employees can voice concerns
Secondary Traumatic Stress: Risk Factors, Warning Signs, and Supervisory Response				
	Risk Factors	References	Warning Signs	Supervisory Response
Individual Characteristics	Prolonged, multiple exposures to client's traumatic material	Jenkins & Baird, 2002	Assimilating traumatic material of clients, distress	Assisting supervisee in meaning making, shifting focus to clients' and human resilience and hope
	Insecure attachment style	Black et al., 2005; Dozier et al., 1994; Fatter & Hayes, 2013; Mikulincer et al., 1993; Marmaras et	Intrusions, hyperarousal, use of deactivating strategies to cope; minimal alliances with clients, more therapy-related problems than average; greater dependency;	Address clinical care issues as needed: strategies to increase therapeutic alliance, review intervention plan and increase supervision for cases, assess supervisee work-related anxiety; encourage use of therapeutic coping skills such

		al., 2003; Pines, 2004; Rubino et al., 2007; Shamoon et al., 2017	more intensively intervening with clients	as mindfulness and emotional regulation, referral to therapy as appropriate
	Cumulative VT exposure due to years of trauma work	Brady et al., 1999; Bober & Regehr, 2006; Linley & Joseph, 2007; Rossi et al., 2012; Schauben & Frazier, 1995	Disrupted beliefs regarding intimacy/trust to others, difficulty with close relationships (loss of intimacy, closeness, forming close relationships)	Provide updated, increased trauma education; help supervisee become aware of their own VT exposure levels, explore existential and spiritual meaning and purpose in work; encourage use of social support that promotes physical and spiritual wellbeing
	New to trauma work	Pearlman & Saakvitne, 1995; Weatherston & Barron, 2009	Higher symptoms, intrusions, avoidance, more disrupted beliefs	Advocate for gradually increasing trauma caseloads; reflective supervision practices; encourage self-reflection in supervisee to explore self-intimacy; provide reinforcement for positive work behaviors; help supervisee internalize positive feedback, successes, and effectiveness
	Poor emotional self-awareness	Harrison & Westwood, 2009; Simpson & Starkey, 2006	Avoidance of client's trauma	Education on the importance of exposure for client care; Exploring reasons for therapist avoidance; encourage/support developing/increasing mindful self-awareness;
	Unresolved personal trauma history	Baird & Kracen, 2006; Jenaro et al., 2007; Pearlman & Saakvitne, 1995	Client/self as victim perspective, clinical stuck points or isomorphism	Assess for whether personal trauma history is resolved; refer for individual therapy as appropriate; Promote positive reinterpretation and social support; help supervisee develop a personal growth plan
	Increased or repeated vicarious trauma exposure	Baird & Kracen, 2006; Bartoskova, 2015; Harrison &	Distress (anxiety, pain/suffering), exhaustion; parallel process	Assess for intactness of therapeutic integrity with client(s); promote/support holistic self-care; engage supervisee in planning ahead for active coping;

		Westwood, 2009; Jenaro et al., 2007; McCormack & Adams, 2016		promote/encourage/support supervisee maintaining clear boundaries and honoring own limits; encourage meaning making from vicarious trauma exposure experiences; encourage strengths-based or resiliency-based perspective of clients and human spirit
	Sense of powerlessness	Brockhouse et al., 2011; Harrison, 2016; Linley & Joseph, 2004; Linley et al., 2005; Wheeler & McElvaney, 2018	Negative changes in perceptions	Challenge thoughts to take strengths-based, resiliency perspective of clients' and therapist's own experiences; encourage search for meaning of being part of healing process/observing client growth; activities that increase sense of coherence; increase use of reflective supervision practices that assists therapist in releasing helpless feelings
	Symptoms parallel to client's (PTSD), including physical symptoms	Bakker et al., 2007; Norcross & Guy, 2007; Schauben & Frazier, 1995; Segerstrom & Miller, 2004; Singer et al., 2004	Reduced physical health, somatic complaints or "sympathetic pain" without medical etiology	Encourage self-care; promote/create social support activities that promote physical wellbeing; promote/encourage social support; advocate at organizational level for peer support groups or programs across therapists; advocate for organizational wellness benefits that support emotional labor and mental health
Systemic & Environmental Issues	Therapists who feel they cannot have open dialogue with supervisors	Knight, 2013; Weatherston & Barron, 2009	Guardedness in supervision; low initiation of discussion related to personal responses to work	Relationship enhancement within supervisory dyad; use of reflective supervision techniques
	Work drain	Cordes & Dougherty, 1993; Lasalvia et al., 2009; Shaufeli et al., 2009; Shirom, 2003;	Early signs of burnout (e.g., reduced empathy, exhaustion, low sense of professional accomplishment), behind in work, spending excessive hours at work, diminished view of	Assess for burnout; assess work demands and encourage delegation of activities; explore workflow and look for more manageable long-term solutions; explore negative feelings toward work; assess for insufficient empathy with clients and parallel process (organization-

			agency, high organizational turnover	therapist, therapist-client); organizational level interventions to increase balance and reasonableness of workloads
Burnout: Risk Factors, Warning Signs, and Supervisory Response				
	Risk Factors	References	Warning Signs	Supervisory Response
Individual Characteristics	Depleted emotional resources	Edwards et al., 2006; Heaney et al., 1995; Schaufeli et al., 2009; Shirom, 2003	Cynicism, negative self and work perceptions, isolated in work, emotional detachment from others at work, lowered work-related self-efficacy, fatigue, reduced motivation, feelings of helplessness, reduced job commitment, loss of creativity in work	Assess for and respond to burnout; increase organizational social support (e.g., peer support, group consultation teams, retreats); advocate for townhalls or other methods for employees to have a voice; encourage use of employee benefits (e.g., vacation time, wellness programs, etc.); explore ways to reduce emotional labor on the job and when possible allow for job enrichment; advocate for therapist to be sent to a training away from campus to renew motivation and creativity; assist therapist in internalizing effectiveness, success, and positive feedback; assess and address needs related to work drain (see Secondary Traumatic Stress section above)
	Depersonalization of clients	O'Rourke, 2011; Paterson, 2011; Schaufeli et al., 2009; Shirom, 2003; Small et al., 1991; Van der Kolk & Fisler, 1995; Zimmerman & Cohler, 1998	Emotional numbness, callousness toward clients or those served; view of clients as a set of needs/demands rather than complex individuals; increasing use of punitive measures or unnecessary behavioral control with clients	Assess for and respond to burnout; increase use of reflective supervision practices; ; encourage use of employee benefits (e.g., vacation time, wellness programs, etc.); explore ways to reduce emotional labor on the job and when possible allow for job enrichment; use of reflective supervision practices; assist therapist in case conceptualization exercises that increase empathic perspectives; help therapist identify core values and corresponding therapist behaviors that convey their

				values in the therapy room; explore therapist's emotional needs; referral for therapy as needed and appropriate
	Low sense of personal accomplishment	Bakker & Schaufeli, 2008; Heaney et al., 1995; Shirom, 2003	Dismisses praise or success, negative self and work appraisals, negative forecasting for work or clinical cases	Advocate for organizational/team flattening procedures; provide job enrichment and empowerment; assist therapist in internalizing effectiveness, positive feedback, and successes; when possible and appropriate, give therapist role in a project that cycles to completion faster to foster continued successes (as opposed to therapy that takes many weeks) where opportunities for completion and success are more frequent than therapy
Systemic & Environmental Issues	Crisis-driven organizational culture	Bakker et al., 2007; Bloom & Farragher, 2013; Dejoy & Wilson, 2003	Therapist experiences of helplessness, fragmentation, loss of meaning in work, cynicism, depersonalization of others,	Advocate for organizational level interventions such as strategic planning that involves every ecological layer of the organization; when applicable, advocate/begin team strategic planning, retreats; team building activities; townhalls or other methods for therapists to feel empowered or able to voice needs/opinions related to their work to a higher level of the organization without fear of reprisal; optimize work flow and referral to prevent inappropriate referrals that destabilize and deskill therapists
	Supervision focused on administrative issues, management of staff, job performance	Bogo & McKnight, 2006; Gilkerson, 2015; McGuigan et al., 2003; Mor Barak et al., 2009;	Low work satisfaction, high organizational turnover, tardiness, poor work performance, missing deadlines	Assess for burnout and respond to burnout related needs; increase use of relationship focused supervision; increase supervisory social and emotional support; increase therapist empowerment within the organization; increase use

				of reflective supervision practices
	Organizations with hierarchical structures that have rigid adherence	Avey et al., 2006; Bakker & Schaufeli, 2008; Harter et al., 2002; Luthans et al., 2008; Sparks et al., 2001	Cynicism, absenteeism, tardiness, poor work performance, low motivation, turnover	Advocate/initiate organizational or team flattening, employee autonomy, and employee input procedures that encourage equal value and communication of ideas from all members of the team regardless of title/status in the organization

Assess Supervisee Needs. Trauma-informed supervisors assess risks related to HEL outcomes relevant to the supervisee and the supervisee's clients. Assessment within supervision requires a range of skills on the part of the supervisor and takes many forms, such as gathering supervisee's perspectives and reports of their work, chart reviews, observation of supervisee clinical work, supervisee self-report questionnaires, client satisfaction surveys, and others (Bernard & Goodyear, 2014). Assessing HEL risk factors for the therapist includes attending to therapist factors, therapist-client factors, and environmental factors.

Therapist factors include characteristics of the therapist that increase the risk of HEL outcomes. The literature identifies factors related to personal and work history and temperament. Scholars have identified novice therapists and those new to trauma work (Pearlman & MacIan, 1995) as being at higher risk for HEL outcomes. Personal characteristics associated with higher risk include unresolved personal trauma history (Baird & Kracen, 2006), engaging in maladaptive coping (Adams & Riggs, 2008), and possessing neurotic personality traits (Bakker et al., 2006).

Therapist-client factors include difficulties that arise from the therapist's interactions with the client or the client's material, such as transference/countertransference, reminders of personal traumatic experiences, vicarious trauma, compassion fatigue, and burnout, to name a few.

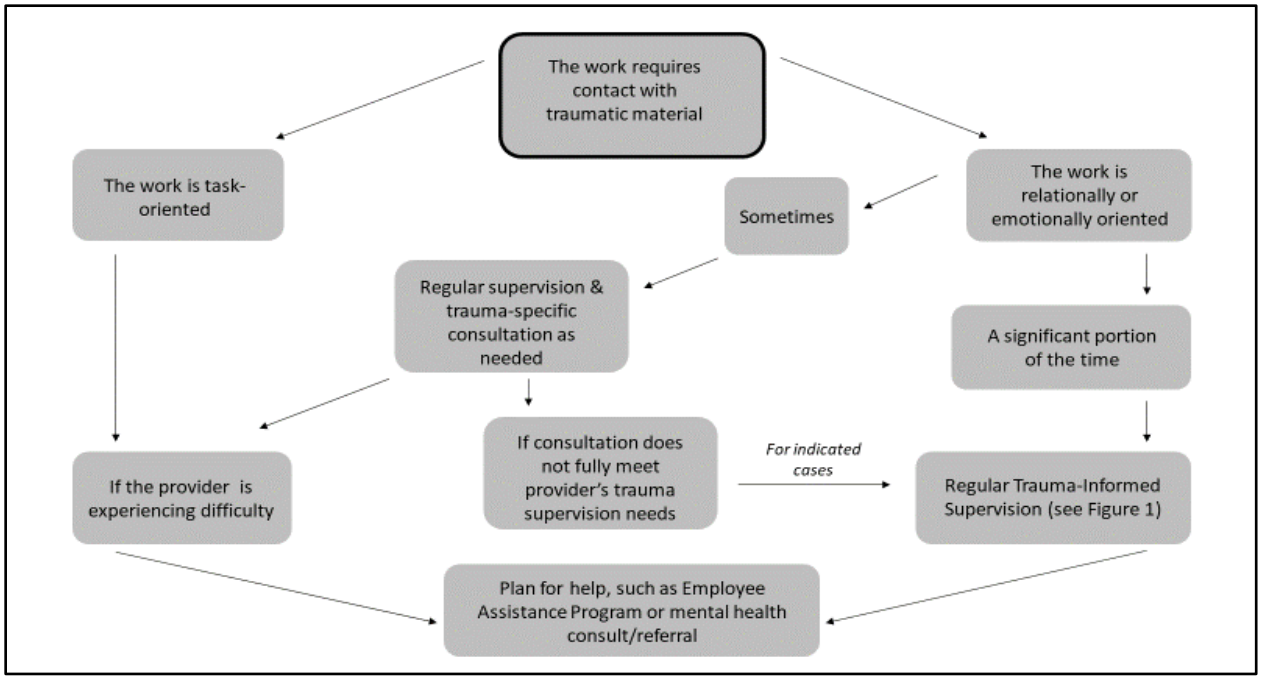
Historically, such assessment has varied (see Table 1). While there is no current best-practice for assessing supervisees' emotional labor related needs, supervisors are urged to evaluate therapists' risk regularly. The frequency of such assessment may vary according to therapist need, the therapist's caseload intensity, and other individual and organizational factors. Such regular evaluation could fit within normal supervisory activities, as supervisors regularly evaluate supervisees to monitor and enhance supervisee growth, prevent ill-prepared clinicians from practice (i.e., gatekeeping), and structure the supervisory relationship (Bernard & Goodyear, 2014). Regular, ongoing assessment would increase the likelihood that therapists' needs are addressed quickly (Baird & Kracen, 2006).

Environmental/contextual factors are also salient to therapists' emotional labor experiences and related needs. Supervisors must possess contextual knowledge of their supervision practice, such as the knowledge of the ecological layers in which supervision occurs, including the systemic, sociopolitical, and community contexts that affect the supervisee and client (Falendar & Schafranske, 2004; Hernandez, 2008; Milne et al., 2008). We encourage supervisors to be aware that the workplace environment may have intersecting influences on supervisees emotional labor (Edwards et al., 2006; Moulden & Firestone, 2007) or pose specific challenges to therapists' wellbeing (Abramovitz & Bloom, 2003; Jameson et al., 2009; Montgomery et al., 2011; Rainer, 2010) due to uncertain environmental safety (Abramovitz & Bloom, 2003; Johnson et al., 2011), high vicarious trauma exposure (Bober & Regehr, 2006; Goodman et al., 1997; Moulden & Firestone, 2007; Sprang et al., 2011; Voss Horrell et al., 2011; Walker, 2004; Way et al., 2004), and insufficient job resources (Bakker et al., 2007; Bakker & Demerouti, 2007; Bakker & Schaufeli, 2008; Dejoy & Wilson, 2003; Egan, 2013; Eisenberger et al., 2002).

These ecological layers (e.g., therapist, therapist-client, environment) influence the needs of supervisees and the subsequent support they require. Because ecological impacts will vary across therapists, not all therapists will require TIS (see Figure 2). Many therapists will receive sufficient benefit from a competent general supervisor most of the time. However, there may be times that therapists atypically come into contact with trauma related material (e.g., career counselor), and may benefit from limited TIS through a one-time consult, time-limited supervision, or case-limited supervision. Others will require ongoing TIS as their primary source of clinical supervision or consultation. While all those receiving any form of TIS may benefit from the supervisory actions summarized below, we focus the following overview on the needs of therapists who would benefit from ongoing, regularly scheduled TIS.

Figure 2

Work Indicators for Trauma Informed Supervision



Address Supervisee Needs: Provision of Trauma-Specific Education. Trauma education is important for professionals because it increases the therapist's self-efficacy for trauma

work (e.g., Layne et al., 2011); assists in occupational coping (Chrestman, 1995; Follette et al., 1994; Gubi & Jacobs, 2009); prevents poor client care (Wilson & Lindy, 1994); and reduces the negative impact of emotional labor (Chrestman, 1995; Pearlman & Saakvitne, 1995). Supervisees may or may not begin a job with trauma knowledge (Courtois & Gold, 2009; Miller et al., 2004; West, 2010) and may require specific didactics in basic trauma theory. Because it has been acknowledged as partially instructive in nature, supervision is a natural process through which to provide trauma knowledge (Courtois & Gold, 2009; West, 2010). The salutogenic practice of offering trauma training in a relational context (Wells et al., 2003) supports supervision as a venue for trauma education and training.

Address Supervisee Needs: Guidance for Ethical/Administrative Issues Related to Trauma Work. In addition to providing trauma education, supervisors also need to provide supervisees with administrative and ethical guidance. Therapists who engage in trauma-specific work may navigate unique situations, such as being called as a fact or expert witness to a client's court proceedings (Hafford & DeSantis, 2009; Smith et al., 2019), Additionally, unacknowledged emotional labor difficulties are a gateway to ethical issues (Saakvitne & Pearlman, 1996). For therapists consistently working with trauma, failure to adequately perform administrative duties may pose an ethical issue and signal that the therapist is not coping well (Avey et al., 2006; Bakker & Schaufeli, 2008; Sparks et al., 2001). As symptoms increase and therapist schemas become distorted, the potential for clinical error and boundary violations (e.g., negligence, abandonment) in the therapist-client dyad increase (Walker, 2004). Dalenberg's (2000) work indicates that many clients with trauma exposure engage in behaviors to deal with relational boundary problems with therapists, including poor emotional boundaries (Etherington, 2009). Worse, expressly forbidden

boundary violations may occur, such as sexual relations between therapist and client (Koocher & Keith-Spiegel, 2008).

Address Supervisee Needs: Provision of a Supportive Atmosphere to Process Reactions to Trauma Work. Supervision is believed to be an antidote to a range of reactions therapists may have (Rosenbloom et al., 1995), including transference, countertransference (Dalenberg, 2000), projective identification, and parallel process (Tyler, 2012). This antidote is best delivered by a supervisor who provides the supervisee with a safe emotional space to process these reactions (Trippany et al., 2004). Supervisors provide such a space by anticipating the needs that likely follow negative emotional labor experiences, such as validation, a safe space to organize one's experience and attach meaning to these work experiences, intervention to ensure sufficient supports are accessible to meet the therapist's social support needs (Trippany et al., 2004; Berger & Quiros, 2014), and empathy (Rosenbloom et al., 1995). For example, Sommer and Cox (2005) emphasized the importance of talking about personal feelings related to work during supervision. This requires therapists to be vulnerable with their supervisors to explore feelings that may otherwise be hidden (Azar, 2000). Given the need for a supportive and safe supervisory atmosphere in which supervisees can explore these issues (Berger & Quiros, 2014), healthy doses of reflective supervision may be of great benefit because of its focus on the supervisor-supervisee relationship as the conduit to provide instrumental, emotional, and knowledge support to the supervisee (Van Buckelaer, 2011) in contexts in which being trauma-informed is desirable (Badeau, 2012).

While a thorough review of reflective supervision is beyond the scope of this work, we highlight the tenets of reflective supervision here: reflection (Shahmoon-Shanok et al., 2005), collaboration (Weatherston et al., 2010), regularity of predictable and uninterrupted supervision

meetings (Barron & Paradis, 2010; Weatherston et al., 2010), client focus (Watson et al., 2016), curiosity, thinking/feeling, compassion, shared attention (Weatherston & Barron, 2009), and therapists' responses to trauma work (Tomlin et al., 2014; Weatherston et al., 2010). The ability to provide an environment with these elements is based on the supervisor's reflective capacity, which refers to an awareness of "one's own personal thoughts, feelings, beliefs, and attitudes as well as understanding how these practices affect one's behaviors and responses when interacting with others" (Tomlin et al., 2014, p.71). This reflective capacity allows trauma-informed supervisors to self-monitor their own trauma responses while also monitoring and supporting supervisees during times when they may experience reactions while working with clients. This maintains the client focus of supervision and supports effective therapeutic work (Watson et al., 2016). Possessing this reflective capacity allows for the creation of an emotionally safe supervisory space, in which the supervisor-therapist dyad can explore the therapist's thoughts, feelings, and responses to trauma work with curiosity, compassion, non-judgmentalness, and shared attention (Tomlin et al., 2014; Weatherston et al., 2010). Engaging the element of curiosity allows the supervisor to explore the supervisee's reactions and statements while remaining grounded in fact. Reflective supervisors model the ideology that individual reactions are normal processes in clinical work by allowing themselves to have thoughts and feelings in response to material brought in by their supervisees (Weatherston & Barron, 2009). In doing so, the supervisor helps the supervisee expand their reflective capacity, thereby increasing their awareness of ways clinical work impacts them. Additionally, regular access to supportive, reflective supervision reduces negative emotional labor outcomes such as provider burnout (Tomlin et al., 2014).

Address Supervisee Needs: Supervisory Interventions to Reduce HEL Outcomes. Supervisors address supervisees' needs in an appropriate, prescriptive way that is supported by a

positive, working supervisor-supervisee relationship (see Table 2) to reduce the likelihood of HEL outcomes (e.g., vicarious traumatization, secondary traumatic stress, compassion fatigue, burnout, unhelpful transference/countertransference, etc.). As trauma-informed supervision is in its early phases (Knight, 2018), we recognize that all forms of HEL outcomes may not be known or well understood and encourage supervisors to seek ways to ameliorate the negative effects engaging in trauma work causes within the lives of their supervisees. Interventions that have been cited multiple times in the literature to combat HEL outcomes include providing reflective supervision (Weatherston & Barron, 2009), encouraging self-care (Norcross & Guy, 2007), helping therapists identify transference/countertransference issues (Wilson et al., 1994), promoting use of therapeutic skills such as mindfulness (Fatter & Hayes, 2013; Harrison & Westwood, 2009), and referral to individual therapy as appropriate (Bernard & Goodyear, 2014).

Addressing Supervisee Needs: Supervisory Interventions to Increase Salutogenic Emotional Labor Outcomes. We believe trauma-informed supervisors should seek ways to increase therapists' positive effects of engaging in trauma work. The literature indicates that trauma therapists may experience salutogenic results of their emotional labor, such as vicarious resilience (Bartoskova, 2015; Hernandez et al., 2010), vicarious posttraumatic growth (Arnold et al., 2005), compassion satisfaction (Pooler et al., 2014; Stamm, 2010), and general personal growth (Benatar, 2000; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). Vicarious resilience, or the therapist's personal growth resulting from exposure to the client's resilience (Hernandez et al., 2007), includes positive changes in hope, self-awareness, resourcefulness, life goals, recognition of own power and privilege, and full presence in therapeutic work (Hernandez-Wofe et al., 2015). The literature indicates that therapists experience posttraumatic growth in the form of positive changes in worldview, being more emotionally expressive in relationships, finding purpose and

meaning in trauma work, self-growth (Bartoskova, 2017), increased appreciation for the resiliency of the human spirit, and spiritual wellbeing (Brady et al., 1999; Tedeschi & Calhoun, 1996). Compassion satisfaction, or the positive feelings trauma professionals experience from their effective work, is thought to occur through similar transmission processes as vicarious posttraumatic growth, as they both utilize empathic connection with a client as a catalyst for the therapist's growth (Arnold et al., 2005; Barrington & Shakespeare-Finch, 2013; Bride & Figley, 2007; Engstrom et al., 2008; Hernandez et al., 2007; LaFauci Schutt & Marotta, 2011; Linley & Joseph, 2007). Trauma therapists also report increases in wellbeing or other types of personal growth as a result of emotional labor, such as wisdom, improved clinical functioning, feelings of empowerment (Benatar, 2000), and more meaningful perspectives on life (Decker, 1993). These positive transformations of the therapist's inner self is connected with the therapist's emotional processing (Arnold et al., 2005; Barrington & Shakespeare-Finch, 2013; Engstrom et al., 2008) and environmental supports such as supervision (Linley & Joseph, 2007; Schauben & Frazier, 1995) and peer support (Brockhouse et al., 2011; Manning-Jones et al., 2016).

Systemic Advocacy

Given supervisors' close work with supervisees, active knowledge of their work responsibilities and needs, and their higher organizational status compared to supervisees, trauma-informed supervisors should engage in organizational-level advocacy for supervisees. Trauma-informed supervisors advocate to meet therapists' occupational needs, including time and funding for training, supervision (Bakker & Demerouti, 2007; Bakker & Schaufeli, 2008; Bakker et al., 2007; Bloom & Farragher, 2013), and social support (e.g., consultation, peer mentoring) (Egan, 2013; Heaney et al., 1995; Marmot et al., 2006; Reid et al., 1999). Similarly, trauma-informed supervisors advocate for organizational changes that benefit therapists, such as drafting or

encouraging policies and benefits (e.g., Henry, 2004) that decrease therapists' work-related risks and increase therapists' opportunities to pursue wellness (Pearlman & Saakvitne, 1995). For example, a supervisor may promote that the organization limit the number of trauma-specific cases assigned to a therapist (Adams & Riggs, 2008; Bober & Regehr, 2006; Trippany et al., 2003) to mitigate job strain (Karasek et al., 1998), provide mental wellness days, offer employee assistance programs for wellness, and/or provide on-site health programs to combat illness associated with job stress (e.g., Firth-Cozens, 2001; Rogers et al., 2004; Suzuki et al., 2004). Some scholars (Dill, 2007; Pearlman & Saakvitne, 1995; Sommer, 2008) believe employers have a duty to provide trauma therapists with job resources to decrease the frequency or likelihood of employees experiencing negative side-effects of trauma-related work (Dill, 2007; Lasalvia et al., 2009). This perspective is supported by research indicating that therapists in agencies are at higher risk for HEL experiences, perhaps due to disparities in organizational power that make therapists' self-advocacy difficult or ineffective (Williams et al., 2012). Therefore, supervisory advocacy is critical to the supervisee's view of the organization as fair and just, a perspective that reduces the likelihood of experiencing work-related side-effects (Knudsen et al., 2008; Knudsen, et al., 2013; Lawler et al., 1995, Schabracq, 2003). Advocacy could include a variety of activities, such as those outlined in Table 2 and 3. The examples highlight that supervisors engage in organizational-level interventions that are catalysts for change to organizational processes, policies, employee resources, and employee benefits on behalf of the supervisee.

Table 3

Positive Emotional Labor Outcomes for Therapists: Characteristics, Supervisor Actions to Increase Positive Outcomes

Vicarious Resilience: Characteristic/Trait, Supervisor Action			
	Characteristic/Trait	References	Supervisor Action
Individual Characteristics	Positive changes unto self: positive change in life goals, increased self-awareness, increased resourcefulness, healthy perspective on own problems, development of boundaries	Antonovsky, 1993; Fatter & Hayes, 2013; Harrison & Westwood, 2009; Weatherston & Barron, 2009	Reflective supervision techniques; encourage regular mindfulness practice; activities that foster sense of coherence; allow therapists to sit with uncomfortable feelings related to work and encourage a focus on finding meaning
	Positive changes in perspective: Recognition of human capacity to heal from trauma, Recognizing power of community healing	Engstrom et al., 2008; Hernandez et al., 2010; Hernandez-Wolfe et al., 2014;	Direct more conscious attention to clients' resilience; promote consideration of how resilience might change the supervisee's perspective, attitudes, behaviors
	Positive emotional changes: client-inspired hope, increased confidence for coping with adversity, developing hope and commitment, experience of self as emotionally stronger, increased tolerance to frustration	Engstrom et al., 2008; Hernandez et al., 2010; Weatherston & Barron, 2009	Encourage discussion of therapeutic successes, highlight times therapist used effective self-regulation and therapeutic skills to foster client growth; reinforce therapist's ability to hold the tension when clinical cases are ambiguous or challenging
	Positive professional attitudes/behaviors: Being fully present during therapy work, recognition of own power/privilege relative to client, reaffirmation of value of therapy, incorporating spirituality into treatment, desire to engage in advocacy work regarding client trauma, increased use of self in therapy work, using community intervention	Bernard & Goodyear, 2014; Craig & Sprang, 2010; Hernandez-Wolfe et al., 2015; Pieterse, 2018; Pooler et al., 2014	Exploring client's intersectional identities in supervision, use of ADDRESSING model to conceptualize client experiences, modeling advocacy work, promoting agency involvement in advocacy in which therapists can participate, encouraging community professional networking, role play techniques that require increased use of self, observe sessions (live/recorded) and give feedback (including praise) that identifies where therapist can increase use of self in work; encourage therapist to engage in regular treatment

			monitoring to highlight therapeutic progress and success; training in and promotion of use of evidence-based practices
Systemic & Environmental Characteristics	Trauma-informed organizational culture	Bloom & Farragher, 2013; Craig & Sprang, 2010	Encouragement at the organizational and team levels and enactment at the supervisory level of the tenets of trauma-informed care (e.g., choice, collaboration, empowerment, safety, and trustworthiness); advocate for and enact trauma-sensitive services at every ecological level of the organization, provide training, education, and support for evidence-based trauma specific services
Vicarious Posttraumatic Growth: Characteristic/Trait, Supervisor Action			
	Characteristic/Trait	References	Supervisor Action
Individual Characteristics	Positive changes in perspective: positive changes in worldview, openness to new possibilities, deeper appreciation for life	Bartoskova, 2017; Brockhouse et al., 2011; Cohen & Collens, 2013; Joseph & Linley, 2008; Tedeschi & Calhoun, 1996	Encourage empathic engagement with client; allow therapist to sit with and process emotional distress encountered in work and search for meaning and sense of coherence; provide social support through supervision, peer support, and organizational/team initiatives; encourage coping responses to distress
	Positive work changes: newfound purpose and meaning to trauma work, satisfaction in observing clients' growth and being part of the healing process	Bartoskova, 2017; Brady et al., 1999; Weatherston & Barron, 2009	Encourage empathic engagement with client; allow therapist to sit with and process emotional distress encountered in work and search for meaning and sense of coherence; use of reflective supervision practices; encourage coping responses to distress
	Positive interpersonal changes: more emotionally expressive in relationships, ability to relate to others	Bartoskova, 2017; Brockhouse et al., 2011; Tedeschi & Calhoun, 1996	Encourage use of social support through supervision, peer support, and organizational/team outlets; encourage community service that has social aspects

	Positive intrapersonal changes: increase in personal strength, spiritual changes	Calhoun & Tedeschi, 2006; Tedeschi & Calhoun, 1996	Encourage processing of vicarious traumatic exposure, reinforce openness to religious change or encourage therapist to seek spiritual mentorship such as a chaplain or a person within their religious community
Systemic & Environmental Characteristics	Organizations that support trauma specific work	Barrington & Shakespeare-Finch, 2013; Manning-Jones, de Terte, & Stephens, 2016	Encourage effortful meaning making processes; reduction of work-related risks; promote coping; encourage use of humor, self-care, peer support
Compassion Satisfaction: Characteristic/Trait, Supervisor Action			
	Characteristic/Trait	References	Supervisor Action
Individual Characteristics	Positive work changes: professional gratification of doing trauma work well, feeling optimistic about ability to make a difference, contentment when client heals/functions better Positive interpersonal changes: positive feelings toward coworkers	Craig & Sprang, 2010; Miller & Sprang, 2017; Sprang et al., 2007; Stamm, 2010;	Utilization of evidence-based practice; provision of trauma specific training; encouraging and supporting the CE-CERT model (i.e., experiential engagement, managing rumination, intentional narrative, reducing emotional labor, parasympathetic recovery strategies)
Systemic & Environmental Characteristics	Organizations that support evidence-based practice and trauma specific training; lower turnover rates than average for similar organizations	Carmel & Friedlander, 2009; Craig & Sprang, 2010; Sprang et al., 2007;	Provision of and support for evidence-based practice; Require client loads are consistent with evidence-based practice (e.g., number of clients on caseloads reflects that clients are seen weekly not bimonthly or monthly)
Professional Accomplishment: Characteristic/Trait, Supervisor Action			
	Characteristic/Trait	References	Supervisor Action
Individual Characteristics	Lower levels of burnout; feelings of accomplishment related to work; positive feelings toward work, job related self-efficacy	Schaufeli et al., 2009; Shirom, 2003	Encouragement of adaptive coping and engagement with emotions; promote internalization of work-related accomplishments; opportunities for job enrichment
Systemic & Environmental Characteristics	Organizations that engage in burnout prevention strategies (e.g., organizational flattening, employee empowerment and feedback, provision of wellness initiations and social	Bakker et al., 2007; Dejoy & Wilson, 2003; Schaufeli et	Promotion of teamwork; feedback loops that allow employees to vocalize needs and concerns; promotion of team-based work and collaboration within organization

	support, manageable workloads, specific job descriptions)	al., 2009; Shirom, 2003	and broader community; reinforcement of creativity; celebration of successes at the agency level; provision of work socialization opportunities

Summary and Conclusions

We promote the use of trauma-informed supervision (TIS) for therapists engaged in trauma-related work by providing an overview of the complexities of emotional labor. We demonstrate the importance of TIS as a specialized form of supervision with applications for its use across therapist developmental levels. We have delineated a nascent framework for TIS that includes suggestions for TIS core competencies and core activities that are infused with trauma literature and theory. This model is intended to provide guidance to supervisors as they engage in TIS. It is our hope that this model will spark discussion and future research, as there are multiple deficits in this area. Little research has been done on the most effective utilization of supervision to combat therapists HEL experiences and little research explores strategies to increase the likelihood of therapists receiving positive benefits from the emotional labor of trauma work. Other areas for exploration include investigating best practice methodology for assessing therapist risk, identifying the intersection of TIS and work/organizational health, creating more advanced guidelines as research becomes available on TIS best practice, and exploring how supervisees may uniquely present to supervision when experiencing HEL symptoms (e.g., blocked, numb, eager to refer clients off caseload). Furthermore, research devoted to understanding HEL experiences should engender further recommendations at the supervisory and organizational levels regarding how to best support therapists who engage in trauma-related work.

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