

REFRAMING VICARIOUS TRAUMA IN CLINICAL SUPERVISION THROUGH THE
LENS OF ABORIGINAL/INDIGENOUS FOCUSING-ORIENTED THERAPY

by

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Abstract

Clinical supervision is consistently mentioned in the documented literature on vicarious trauma as an essential part of addressing stress in trauma therapists. However, there has been little documented on how clinical supervision could be approached in practice, in order to serve this end. This study aims to address the gap in the literature by exploring what happens in Aboriginal/Indigenous Focusing-Oriented Therapy (A/IFOT) clinical supervision: informed by a modality specifically designed to address complex trauma. Three semi-structured interviews of A/IFOT clinical supervisors were collected and analyzed, employing Amadeo Giorgi's qualitative method: the descriptive phenomenological psychological approach. Three prominent and reoccurring themes emerge from the data, related to the process of A/IFOT clinical supervision, that are crucial to addressing vicarious trauma. These themes serve to reframe the phenomenon of the vicarious and constitute approaches that are somatic, land-based, and engage with the vicarious through an Indigenous ontological lens. These findings—among the first academic research to date, to describe A/IFOT clinical supervision for trauma therapists—have important implications for clinical supervision, the well-being of trauma therapists, and ultimately the well-being of their clients and all relations concerned.

Keywords: clinical supervision, vicarious trauma, Aboriginal focusing-oriented therapy, Indigenous focusing-oriented therapy, somatic, land-based, Indigenous ontological lens

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Contents

CHAPTER 1: INTRODUCTION	1
Purpose of the Study	3
Significance of the Study	4
Focus of the Study.....	5
Limitations and Delimitations	5
Research Methodology.....	6
Terminology	6
CHAPTER 2: LITERATURE REVIEW	11
Literature Review Organization	13
Literature Search Strategy	14
Clinical Supervision as a Strategy in Alleviating Therapist Stress	15
Vicarious Growth and Resilience.....	17
Somatic Approaches to Trauma Therapy	20
CHAPTER 3: METHODOLOGY	26
Introduction	26
Descriptive Phenomenological Psychological Approach	28
Ethical Considerations, Setting and Sample	30
Interview Questions.....	31
Data Collection Process	32
Data Analysis	35
Trustworthiness and Integrity.....	37
Summary	38
CHAPTER 4: RESULTS	40
Background and Choosing Participants	40
Summary of Findings	41
Summary	50
CHAPTER 5: DISCUSSION	51
<i>All My Relations</i> Relational Approach.....	51
Vicarious Growth and Resilience.....	52
A/IFOT Clinical Supervision Approach	53

Implications for Clinical Supervisors.....	57
Implications for Trauma Therapists	58
Implications for Future Research	58
Limitations of the Study	59
Reflections on the Research Process	60
Implicated Researcher	61
Conclusion.....	63
References	64
Appendix.....	74
Institutional Review Board Certificate of Approval	74
Sample Research Participant Informed Consent Form	75

Reframing Vicarious Trauma in Clinical Supervision through the Lens of Aboriginal/Indigenous Focusing-Oriented Therapy

Back in the car I switch on the engine to fend off the cold. Here I am. Heart racing, chest heaving, snot soaked and alone. What the fuck to do now? Can I sleep with this and not speak to the police? *Primum non nocere*. First do no harm. These are good guiding words for medicine and for life, but inaction should also be a conscious choice. What can I do to be helpful and not harmful? None of my business some might say and they would be wrong.

This is and is not my story.

In health care we call it vicarious trauma.

Madeleine Cole, M.D.

Vicarious traumas, 2019

CHAPTER 1: INTRODUCTION

So what of this phenomenon that *is* and *is not* my story? This “and, and” place where both are true. What if there were spaces to notice what is mine and what is not mine, and demark that? How could we get a little bit more comfortable with the uncomfortable and find out not so much about the *story* of “all that,” but what the *experience* of that story that sits in the bodily felt sense of “all that” has to say about being helpful as a helper?

Getting curious about what the vicarious holds, is a place that I have been keeping company with for the past fifteen years, ever since I first started hearing about the phenomenon labelled, “vicarious trauma.” In particular, for the past eight years, I have been even more intrigued about helping helpers in supervision: seeking support for myself as a helper and increasingly finding myself in a supportive role to assist helpers as well.

The concept of vicarious trauma or vicarious traumatization is typically used in the world of counselling, psychology, social work and other helping professions to describe how those who

work with people who have gone through traumatic experiences may themselves experience disruptive and painful “profound psychological effects” that can “persist for months or years after work with traumatized persons” and their empathic engagement with them (McCann & Pearlman, 1990, p. 133). Research consistently points to the importance of clinical supervision as a key factor in alleviating trauma therapist stress (Courtois, 2018; Etherington, 2000; Knight, 2013; Pack, 2014; Pack, 2017; Peled-Avram, 2017). While clinical supervision models continue to be developed, these models often lack an integration of trauma-informed principles and the critical task of discerning “how to address therapists’ reactions to working with trauma survivors” (Knight, 2018, p. 18). Most research that does make the connection between clinical supervision and the alleviation of therapist vicarious trauma tends to focus on the relationship between the supervisor and the therapist: seeing the pair as “effective allies in self-assessment and self-care” (Pack, 2017, p. 67). Clinical supervisors are encouraged to create a climate in which the impact of their work and potential vicarious trauma effects may be communicated openly with therapists (Pack, 2017). Therefore, clinical supervision is considered to be a place in which therapists may identify and discuss their responses to the work that they engage in and “any personal transformation/ vicarious traumatization responses they arouse” (Courtois, 2018, p. 51). However, more information regarding what happens in supervision when trauma therapists communicate (both implicitly and explicitly) an experience of vicarious trauma to their supervisors, could be used to develop a more comprehensive understanding of how clinical supervisors may respond.

Purpose of the Study

The purpose of this pilot, qualitative study is to address this gap in the literature through exploring what happens in the lived experience of clinical supervisors when vicarious trauma responses are shared by those they supervise. Three clinical supervisors were interviewed who specifically approach supervision through an Aboriginal/Indigenous Focusing-Oriented Therapy (A/IFOT)¹ lens. These supervisors were explicitly chosen because the A/IFOT supervisory lens was created with the intention to work with trauma therapists. A/IFOT as a therapy, is recommended by the Canadian Psychological Association of Canada and the Psychology Foundation of Canada as a “culturally appropriate treatment modality” in their *Response to the Truth and Reconciliation Commission of Canada’s Report* (2018, p. 23). A/IFOT was developed by Métis knowledge keeper and Registered Clinical Counsellor, Shirley Turcotte. Her approach offers trauma therapists practical tools to work with clients experiencing complex trauma and employs an anti-oppressive, genocide-informed, Indigenous ontological lens. This lens is “fundamentally relational” in which people are not conceived of as “separate from the world around them, but rather embedded in and constituted from relationships with the world, people, language, landscape” (Turcotte & Schiffer, 2014, p. 50).

A/IFOT builds on the focusing approach of Eugene Gendlin (1978) who developed a therapeutic technique to identify and transform the thoughts and emotions that are held in the body. The findings of Gendlin’s research in which he analyzed thousands of tape-recorded therapist-patient sessions, revealed that “successful” patients who demonstrated “real and

¹ I refer to both Aboriginal and Indigenous Focusing-Oriented Therapy (A/IFOT) as one may see reference in the literature and modality curriculums to both. In recent years, most instructors of A/IFOT have tended to favour the term, *Indigenous Focusing-Oriented Therapy (I/FOT)* in my personal witnessing.

tangible change” do something inside of themselves differently than others (Gendlin, 1978, p. 3-4). Gendlin found that those who could contact within themselves a “special kind of internal bodily awareness” were able to benefit the most from therapy (Gendlin, 1978, p. 11). More importantly, Gendlin also discovered that all was not lost for those who did not naturally tap into the felt sense because they could be taught how to do it and benefit as well (Gendlin, 1978, p. 11). Over the past few decades, Shirley Turcotte has trained numerous instructors, coaches and practitioners to teach and learn specific skills to work with complex trauma in an Indigenous focusing-oriented way: a relational, body and land-based approach through both a comprehensive seven module A/IFOT program and an *Indigenous Tools for Living*, briefer workshop series.

Significance of the Study

Knowledge of how A/IFOT clinical supervisors address the vicarious in clinical supervision will contribute to increased understanding of how clinical supervisors may support trauma therapists and address the abovementioned gaps in the literature. Previous studies demonstrate that clinical supervision is a major factor in alleviating therapist vicarious trauma symptomology, but the findings from this study will work to understand the lived experiences of A/IFOT clinical supervisors in relation to vicarious trauma. Therefore, the findings may have implications for clinical supervisors, trauma therapists and the clients they serve. This study will contribute to clinical supervision knowledge about ways in which clinical supervisors approach implicit and explicit disclosures of vicarious trauma symptomology. This study could be replicated through interviewing a larger number of clinical supervisors. While the focus of this study is on the lived experience of clinical supervisors, the study could also be enhanced by interviewing trauma therapists who seek supervision for support with vicarious trauma. Because

of the study's potential for multiple applications, it may be significant for both the training of clinical supervisors as well as trauma therapists.

Focus of the Study

The focus of this qualitative study is to explore the lived experiences of clinical supervisors through semi-structured interview questions. Specifically, the interviews served as a space for participants to delineate what happens in A/IFOT clinical supervision when trauma therapists share that they are experiencing vicarious trauma or they appear to be experiencing vicarious trauma symptomology. These interviews serve this study with a dual purpose: to provide information about the experience of supervising trauma therapists as well as to provide insight about the A/IFOT process with specific reference to the phenomenon of how vicarious trauma is addressed in clinical supervision. Findings will be geared towards supervisors, therapists and researchers, by identifying the potential of clinical supervision to influence the alleviation of therapist stress. This study will also provide a potential theoretical background to direct future research in which a larger scale study could follow this pilot study and include more participants. The outcomes of this study would serve to inform the direction of the work and the questions asked.

Limitations and Delimitations

The number of participants was limited to three A/IFOT clinical supervisors due to the short timeline imposed on the completion of this thesis and due to circumstances in which two of the five clinical supervisors approached were not available during the limited timeframe. Because this study is a pilot, qualitative study, the quantity of three participants was determined to be sufficient. The fact that the clinical supervisors are trained in A/IFOT, limits transferability of the study, unless clinical supervisors in future studies are also trained in A/IFOT. The study

will be confined to a purposive sampling and interviewing of A/IFOT clinical supervisors who live on Coast Salish territories whose schedules and time zones were more accessible to the researcher.

Research Methodology

There has been no documented peer-reviewed research to date on clinical supervision in A/IFOT; in order to accomplish this study, a qualitative approach was chosen as it will facilitate more emergent findings to surface. Moreover, qualitative research facilitates the increased possibility of providing an open, accurate, and holistic representation. In particular, the research methodology used in this study is Amadeo Giorgi's descriptive phenomenological psychological method: a qualitative approach in which participants "describe in as faithful and detailed a manner an experience of a situation that an investigator is seeking" (Giorgi, 2012, p. 251). Following the systematic review of the literature in order to provide a frame of reference for the phenomenon of the vicarious as it may arise in clinical supervision, Giorgi's method will be applied to a verbatim transcript of each participant's interview. This approach follows specific steps leading to essential theme identification and is discussed in detail in chapter three. In this manner, the lived experience of A/IFOT clinical supervisors will be elucidated, discovering how they address the vicarious in clinical supervision. From there, a full discussion of the results will take place. This discussion will critically analyze the ramifications of omitting an understanding of the vicarious through Indigenous ways of knowing, and the importance of relational, body-centred approaches when working with trauma.

Terminology

Key terms related to the vicarious are articulated below in order to fully orient the reader to the material being discussed. For the most part, I will use the term, "vicarious trauma"

throughout the body of this thesis. However, vicarious trauma and vicarious traumatization are often used interchangeably or in relationship to other terms, and their meanings are often blurred. Sabin-Ferrell and Turpin (2003), point specifically to the confusion and overlap between the definitions of vicarious trauma, secondary traumatic stress, compassion fatigue and burn-out. They conclude that all of these terms share four important elements (Sabin-Ferrell & Turpin, 2003, p. 453):

1. cognitive, emotional, behavioural, and physical responses, which might be considered as a normal response to hearing traumatic material;
2. symptomatic responses, which might be considered as extreme versions of the responses described in 1;
3. cognitive changes in beliefs and attitudes; and
4. additional effects on interpersonal and occupational functioning.

The definitions articulated below will contextualize the nature in which these terms emerged to inform our understanding of the vicarious. In engaging in a literature review in chapter two, I did not limit my search to clinical supervision in relation to vicarious trauma because of the confusion in the literature over the terms used to describe vicarious trauma. Thus, I made certain to extend my search to include clinical supervision literature in relation to vicarious trauma, secondary trauma, compassion fatigue, burn-out and even countertransference. All of these terms have been used in the literature over the years in order to describe the effects on helpers in working with survivors of trauma. There is much overlap and there are some specific distinctions worth noting.

Vicarious Trauma/ Vicarious Traumatization

Vicarious trauma or vicarious traumatization are terms that appear to have been used first by McCann and Pearlman (1990) referring to the potentially severe and lasting harmful effects on those who work with trauma survivors as a result of helper empathic engagement; it is considered to be a cumulative process (Pearlman & Saakvitne, 1995, p. 279). Pearlman and Saakvitne (1995) add that vicarious traumatization leads to identity changes including worldview changes and one's sense of safety. As scholars began to research vicarious trauma, many of the symptoms attributed to vicarious trauma were found to be similar to those attributed to Post-traumatic stress disorder in the *Diagnostic and statistical manual of mental disorders*. This overlap is seen in symptoms such as nightmares, flashbacks and other physical and psychological reactions (Blair & Ramones, 1996).

Secondary Trauma, Secondary Traumatization/ Secondary Traumatic Stress

Secondary trauma was originally described by Charles Figley (1995) as also exhibiting symptoms of Post-traumatic stress disorder. However, secondary trauma is conceived of as having a “quicker onset” than vicarious trauma, and “may be more temporary” than the more “gradual and chronic” vicarious trauma (Tarshis & Baird, 2019, p. 92). It is a term still used currently in the literature, correlating to any behaviours or emotions that arise from hearing about a traumatic event and any related stress that can be correlated with wanting to assist trauma survivors (Figley, 1995). Figley later renamed secondary trauma to “compassion fatigue” so as not to sound as stigmatizing (Figley, 2002).

Compassion Fatigue

The term compassion fatigue is correlated to helpers who “internalize pain or anguish related to other people in their work environment” (Todaro-Franceschi, 2019, p. 84). As

mentioned above, Figley changed his mind about the term, secondary trauma, and preferred compassion fatigue: describing it as a chronic lack of self-care in which helpers find themselves when they are too preoccupied with the experience of traumatized others (Figley, 1995).

However, despite Figley's change in preference, both continue to be used in the literature.

Compassion fatigue is seen on a continuum of sorts in which if not addressed, leads to burn-out (Figley, 1995). Figley's definition of compassion fatigue does not appear to take into full account the cognitive changes in worldview, for example, that vicarious trauma definitions place importance upon (Sabin-Farrell & Turpin, 2003, p. 453). Interestingly, compassion fatigue is considered to extend beyond working with trauma survivors to include anyone caring for persons with any type of illness or physical challenge (Bride, Radey, & Figley, 2007).

Burn-out

As mentioned above, definitions of compassion fatigue warn that if this phenomenon is not addressed, it will ultimately lead to burn-out. Consequently, the relationship between compassion fatigue and burn-out is seen on a spectrum in which burn-out is more severe. The concept of burn-out is connected to stressors linked exclusively to the work environment; and these stressors extend to factors beyond stress influenced by other people (Maslach, 1982). According to the World Health Organization (2019), burn-out is not a medical condition but it was included as an "occupational phenomenon" in the International Classification of Diseases 11th revision (ICD-11). The ICD-11 definition of burn-out is as follows:

Burn-out is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: feelings of energy depletion or exhaustion; increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy (para 1).

Countertransference

Countertransference is considered to be a therapist's personal response to clients; it is the "conscious and unconscious reactions and feelings" a therapist experiences in counselling sessions and it is understood as the therapist's own reactions (Tarshis & Baird, 2019, p. 96). While countertransference might contribute to practitioner trauma "indirectly," it is not vicarious or secondary trauma (Tarshis & Baird, 2019, p. 96). It is particularly noteworthy to make the distinction between countertransference and vicarious trauma for the purposes of this thesis, because the participants interviewed also make this distinction in the accounts of their lived experiences.

Before we delve into the research findings from their lived experiences, the next chapter of this thesis will be a review of the literature, focusing on clinical supervision as a major factor in alleviating therapist stress for those who experience symptoms of vicarious trauma. Surveyed literature will also interact with the realms of neuroscience, neurobiology and somatic approaches to trauma therapy that contribute to the understanding of vicarious trauma and interventions, and Indigenous, decolonizing approaches to trauma work. Indigenous ways of knowing are critical to our understanding of the vicarious, allowing an expansion of the lens of clinical supervision to encompass multiple factors at play when the vicarious arises in clinical supervision. This includes more than just "the how" but also "the *why*" about the vicarious. Chapter three will speak to the research methodology being used, which is qualitative, and based on Amadeo Giorgi's descriptive phenomenological psychological method. Chapter four will discuss the results of the research, and chapter five will offer further reflection and discussion specific to a reframing of the phenomenon of the vicarious, possible recommendations for clinical supervisors and trauma therapists as well as future avenues of research.

CHAPTER 2: LITERATURE REVIEW

Therapists and other helpers who work with clients who experience significant dysregulation and/or clients who share traumatic material with their helpers, are purported to risk the development of vicarious trauma/traumatization, secondary trauma, burn-out and/or compassion fatigue (Craig & Sprang, 2010; Figley, 1995,1999; Finklestein et al.,2015; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Sprang et al., 2007). The literature consistently maintains a significant cautionary tone towards professionals who inevitably fall prey to the development of these symptoms, warning that succumbing to the vicarious in all its iterations, renders helpers less effective in the work they do with clients and can even lead to negative health outcomes for those helpers in the long-term (Baird & Jenkins, 2003; Craig & Sprang, 2010; Figley, 1995; Pearlman & Saakvitne, 1995; Trippany et al., 2004). While some research focuses on vicarious resilience and post-traumatic growth as concepts that may contribute to the sustainment and empowerment of trauma therapists (Edelkott et al., 2016; Hernandez et al., 2007; Hernandez-Wolfe, 2018; Killian et al., 2017; Michalchuk & Martin, 2019), vicarious trauma is still conceived of as an inevitable “cost of caring” and a risk to be avoided (Mathieu, 2012; van Venrooij & Barnhoorn, 2017).

Clinical supervision is often cited in the literature as a significant factor in alleviating therapist stress for those who experience symptoms of vicarious trauma, vicarious traumatization, secondary trauma, burn-out and/or compassion fatigue (Etherington, 2009; Knight, 2013; Pack, 2014; Pack, 2017; Peled-Avram, 2017). As mentioned in chapter one, most research on the relationship between clinical supervision and the alleviation of therapist vicarious trauma tends to focus on the relationship between the supervisor and the therapist as "effective allies in self-assessment and self-care" (Pack, 2017, p. 67). Clinical supervisors are encouraged

to create a climate in which "communication about the effects of vicarious traumatization can be openly discussed together with an exploration of how vicarious traumatization may be impacting on the individual" (Pack, 2017, p. 67). Nevertheless, specific aspects that would constitute the quality of approaches, techniques and/or skills used by clinical supervisors in relation to supporting trauma therapists is lacking in the research.

While clinical supervision is not therapy, aspects of somatic therapies have a significant part to play in how clinical supervisors could support trauma therapists experiencing vicarious symptoms, because understanding the role of the body in the treatment and etiology of trauma is paramount to the understanding of a trauma-informed approach to clinical supervision. Body-centred therapies support the development of therapist skills to address trauma and significant evidence has accumulated over the past few decades of the crucial role these approaches contribute to trauma treatment (Levine, 2010, 2015; Ogden, Minton, & Pain, 2006; Stanley, 2014; van der Kolk, 2014). While it is beyond the scope of this present study to engage in a comprehensive inquiry into all the nuances and implications of neuroscience, neurobiology, attachment research and body based therapies in the treatment of trauma, reference will be made to the important role somatic approaches can play in future research about the dialogue between clinical supervision and addressing therapist vicarious trauma.

Aboriginal/Indigenous Focusing Oriented Therapy (A/IFOT) is one such somatic approach that offers trauma therapists tools beyond cognitive therapeutic interventions to work with clients experiencing complex trauma. As mentioned in chapter one, A/IFOT is "fundamentally relational": a modality in which people are not conceived of as "separate from the world around them, but rather embedded in and constituted from relationships with the world, people, language, landscape..." (Turcotte & Schiffer, 2014, p. 50). However, while

research exists on the effectiveness of focusing-oriented therapy (Gendlin, 1978, 1996), little research exists on A/IFOT itself. This is important to note because A/IFOT is designed specifically for the treatment of complex trauma. Furthermore, currently no research exists on the interface between clinical supervision and A/IFOT, despite anecdotal accounts from students and practitioners of A/IFOT and the experience and witnessing of clinical supervision by the present author. The “affirmation of bodily wisdom” is a critical component of Indigenous methodologies; an “all our relations pedagogy” affirms the body’s centrality in Indigenous teaching, “learning... unlearning, relearning and transforming ways of being” (Ritenburg et. al., 2014, p. 77). Consequently, the present qualitative study outlined in subsequent chapters will seek to initiate and inspire a dialogue between the current research and the contribution of A/IFOT clinical supervision as it is situated at the intersection between Indigenous ways of knowing, relational and body-centred practices and the findings of neuroscience and neurobiology that one could argue, are catching up to Indigenous ways of knowing about the healing of trauma and notions of the vicarious (Ritenburg et al., 2014; Turcotte & Schiffer, 2014).

Literature Review Organization

This review will take into account scholarship referencing vicarious trauma, secondary trauma, compassion fatigue, and/or burn-out in relation to clinical supervision (as the terminology is often blurred and used interchangeably in the literature despite the efforts of various authors to define the terms as articulated in chapter one). Research that emphasizes vicarious growth and resilience and the importance of the relational aspect of clinical supervision will be reviewed. This process will demonstrate that additional research is needed to discover what actually could happen in the relational aspect of clinical supervision and why that could be

helpful to trauma therapists experiencing vicarious traumatization. Moreover, while the research does not address the link between clinical supervision, vicarious trauma and somatic approaches to trauma treatment, it is not a far stretch to consider how a trauma-informed lens inspired by somatic approaches might have much to contribute to the work of clinical supervision. Somatic approaches to trauma treatment employ relational, body-based practices that are compatible with evidenced based theories of developmental neuroscience and neurobiology (Porges, 2007; Schore, 2009; Stanley, 2016; van der Kolk, 2014). This means that reference will also be made to their contribution to our understanding of the tools required to work with trauma symptoms. Implications arising for clinical supervision practice through this review will be noted briefly in this chapter and subsequently discussed in chapter five, juxtaposed with the findings of the descriptive phenomenological psychological analysis of A/IFOT clinical supervisors' experience.

Literature Search Strategy

A general search through all Simon Fraser University and University of British Columbia's library databases was conducted. A subsequent search was conducted through EBSCOhost using the search terms, "clinical supervision," "supervision," "vicarious trauma," "vicarious traumatization," "secondary traumatization," "compassion fatigue," "vicarious resilience," "vicarious growth," "trauma treatments," "body-based," "relational" and "somatic" therapies in PsychARTICLES, PsychBOOKS and PscyHINFO databases. Finally, a secondary manual search of reference lists from peer reviewed journals was conducted to identify any literature that may have been overlooked.

Clinical Supervision as a Factor in Alleviating Therapist Stress

Several studies cite relational-oriented supervision as a significant factor in alleviating therapist stress. For example, in a 2017 study of 109 social workers who provide services for trauma survivors in Israel, not only was clinical supervision considered to be strategic from a preventative and coping point of view in “ameliorating vicarious traumatization,” enhancing therapeutic performance; but also, based on the findings, recommendations are made that supervisors acquaint themselves with the “principles of the relational approach and experiment with its implementation” in supervision (Peled-Avram, 2017, p. 30). The relational approach to clinical supervision is emphasized as one in which there is a greater “emphasis on mutuality, allocation of authority, and co-construction of knowledge,” inspired by relational theorists who centre their perception of the human psyche on relationships, attachment and connection (Peled-Avram, 2017, p. 24). A questionnaire was created for the purpose of their study based on an interview with relational approach experts. In general, the results of the study evidenced lower levels of vicarious traumatization reported in those social workers who participated in a more relational-oriented supervision and “evaluated their supervision as more effective” (Peled-Avram, 2017, p. 22).

Berger & Quiros (2014) address the adaptation and application of supervision principles and strategies to “foster the professional and personal growth of supervisees and enhance their mastery of trauma informed practice” (p. 296). In particular, they maintain that such principles and strategies will decrease practitioner vicarious traumatization (Berger & Quiros, 2014, p. 297). They provide anecdotal evidence in order to support their argument and cite a case study of the supervision of two clinicians in a residential substance abuse treatment centre. In this case study, it was observed that the supervisor modeled, “acceptance, respect, empathy and

maintained a balance between praise and accountability” (Berger & Quiros, 2014, p. 300).

However, Berger & Quiros note that research examining the effectiveness of “diverse models of supervision for trauma-informed practice” is lacking and outcomes associated with “different supervision modalities” is needed (Berger & Quiros, 2014, p. 300).

DelTosta et al. (2019) found that the strength of the supervisory alliance was a powerful predictor of trainee therapist vicarious trauma, despite the fact that their findings revealed that it did not lessen the risks. Consequently, they emphasize that a supervisory working alliance limits vicarious trauma, and research should continue on identifying the “most relevant factors” associated with vicarious trauma (DelTosta et al., 2019, p. 305).

Finkelstein et al. (2015) studied the relationship between supervision and other professional supports among 99 mental health professionals exposed to high levels of trauma (both direct and vicarious) related to Gaza Strip rocket attacks and concluded that professional supports *may* buffer concurrent direct and vicarious traumatization. However, they did not provide details about what kind of supervision was received except for the mention of opportunities to debrief and they did not address a particular model of supervision. The fact that this study includes mental health professionals who simultaneously may be experiencing traumatic events themselves, while supporting their clients, points to the importance of having multiple opportunities to engage with a clinical supervisor (and not a one-off experience) because experiencing and hearing about trauma on a regular basis may have a cumulative, layering effect.

The importance of the relational aspect between clinical supervisor and supervisee has led some scholars to propose models of supervision that incorporate an emphasis of empathy for helpers. One such model is the CARE Model of crisis-based supervision that emphasizes the

significance of empathy in the clinical supervisor-counsellor relationship (Abassary & Goodrich, 2014). In fact, CARE is an acronym for context, action, response and *empathy*, underscoring empathy as a vital component of the model (Abassary & Goodrich, 2014, p. 64). The focus of providing empathy and emphasizing self-care is considered a safeguard against vicarious trauma (Abassary & Goodrich, 2014, p. 69). Abassary & Goodrich (2014) cite a Brockhouse et al. (2011) study to support the empathic focus of their model in which Brockhouse et al. (2011) investigated the mitigating factors of “counselor coherence, organizational support, empathy, and their impact on alleviating vicarious exposure to trauma” and discovered that the strongest predictor of growth was “overwhelmingly a therapist’s empathy with the client” (Abassary & Goodrich, 2014, p. 69). Consequently, Abassary & Goodrich (2014) consider the supervision technique of empathy for a counselor, would likely have the same effect (Abassary & Goodrich, p. 69).

Vicarious Growth and Resilience

Harrison & Westwood (2009) challenge previous conceptualizations of vicarious trauma with findings from their qualitative study by interviewing six therapists who shared their experiences of protective practices; the most challenging aspect of their findings correlated empathic engagement with their clients as a protective factor and not a contributor to vicarious trauma (Harrison & Westwood, p. 203). Research such as Harrison & Westwood’s, that focus their attention on vicarious growth and resilience, highlight protective factors and clinical supervision is mentioned by participants as facilitating the development of post-traumatic growth through “relational healing” (Harrison & Westwood, p. 208). They emphasize the need for more research on protective practices that facilitate growth.

To this end, Cohen & Collens (2013) engaged in a metasynthesis of findings from qualitative research that took into account vicarious trauma and vicarious post-traumatic growth in helpers. They found that the impact of working with clients who present with traumatic material can be managed through “personal and organizational coping strategies”; their findings emphasized that “distress does not necessarily preclude growth” (Cohen & Collens, p. 570). However, their findings are limited in part due to their suggestion that vicarious post-traumatic growth is caused primarily by a therapist’s exposure to their client’s growth. Specifically, they recommend that the phenomenon of vicarious post-traumatic growth could be achieved through more “long-term engagement with clients” in order to increase the chances of experiencing and witnessing their clients’ “recovery process and growth” (Cohen & Collens, p. 578). While future research may support these findings, the reality of many therapeutic encounters is that therapists do not always have the luxury of witnessing clients over the long-term and there exists the distinct possibility that their clients may not sufficiently recover to suit the vicarious “needs” of their therapists.

Other research such as that of and Andreychik, (2019); Gil & Weinberg, (2015); and Hernandez et al. (2007, 2010) focuses more pointedly on the concept of meaning-making. They work to shift perspectives and focus on the positive aspects of therapeutic work with clients who disclose traumatic material. Their concept of vicarious resilience attempts to uncover a less pathology-oriented or deficit-based approach than the concept of vicarious trauma. For example, in a qualitative New Zealand study, Pack (2014) interviewed 22 counsellors registered as trauma therapists and the research findings suggested that symptoms of vicarious trauma were experienced as fleeting and what these therapists exhibited more, over the long-term, was vicarious *resilience*, and ability to “bounce back” that was ironically engendered by the

experience of vicarious trauma (p.18). In fact, the results reflected that their experience generated a meaning search that evolved previous strategies to “personal and professional resilience” (Pack, 2014, p. 18). The resilience exhibited by participants was specifically linked to their own reflexive practice and other coping mechanisms and associations with other therapists engaged in the same process. The focus on vicarious resilience points to the need for further research that involves a more balanced view of both the positive and negative consequences of working with clients who disclose traumatic material (Pack, 2014, p. 28).

However, while the concept of vicarious resilience is a way of perceiving the vicarious in a more strengths-based manner, it runs the risk of implying that those who are capable of merely *thinking* positively are more suited to the work and runs the risk of glossing over important processes that may be engaged in to address vicarious trauma symptoms. For example, in a recent study, Michalchuk & Martin (2019) employed interpretive phenomenological analysis in their qualitative study of six psychologists, exploring their lived experiences of resiliency and growth in their work with survivors of trauma. In this study, their findings contribute to the positive outcomes connected to trauma work. Rather than problematize the concept of vicarious trauma, their study highlights other experiences of trauma work that shift the focus to resiliency, satisfaction and growth in the way that these particular psychologists perceived their experience. The lens through which the participants looked at their experience was reported as making the difference in their capacity to continue to find strength in meaning, purpose and serving humanity (Michalchuk & Martin, p. 153). This study relies on a focus that shifts to internal cognitive strategies involving perception rather than techniques that could directly address vicarious trauma symptomology.

An approach that attempts to address this need is a restorative one linked to clinical supervision. Neswald-Potter and Trippany Simmons (2016) propose a regenerative model of supervision in their restorative approach to supervising trauma therapists. Their proposed model employs an expressive arts counselling supervision model in order to elicit therapist “articulation of intersession dynamics that may be difficult to verbalize” (Neswald-Potter & Trippany Simmons, p. 78). They cite the benefits of “intentional, authentic and reflective processing” for those who may be experiencing vicarious trauma symptomology (Neswald-Potter & Trippany Simmons, p. 88). A case study is provided in order to illustrate how the model might work in practice. While this model sounds promising, additional research with practicing therapists could better elucidate the model’s efficacy and usefulness in the promotion of vicarious growth and resilience.

Somatic Approaches to Trauma Therapy

While it is beyond the scope of the current study to do a comprehensive review of all somatic approaches to trauma therapy, such approaches hold significant implications for clinical supervisor awareness, trauma-informed practices and effective strategies to support trauma therapists. According to Schore (2009), significant neuroscience research suggests “a special role for the emotion-processing right hemisphere in empathy, identification with others, intersubjective processes, autobiographical memories, own body perception, self-awareness, self-related cognition, as well as self-images that are not consciously perceived—all essential components of the therapeutic process” (Schore, 2009, p. 143). Somatic approaches demonstrate how therapists might create a safe space for their clients to explore self-regulation. Porges’ polyvagal perspective focuses on “how an understanding of neurophysiological mechanisms and phylogenetic shifts in neural regulation leads to different questions, paradigms, explanations, and

conclusions regarding autonomic function in biobehavioral processes than peripheral models” (Porges, 2003, p. 116). The groundbreaking work of Stephen Porges informs an understanding of “pathways for recovery and integration” (Levine, 2010, p. 97). Porges’ polyvagal theory of emotion backs up the perspective of somatic approaches which assert an understanding of why “certain common approaches to trauma psychotherapy frequently fail” (Levine, 2010, p. 97). Porges’ theory details the three basic neural energy “subsystems” that underpin the “overall state of the nervous system and correlative behaviors and emotions” (Levine, 2010, p. 97). As Bessel van der Kolk (2014) emphasizes, the story of a traumatic event “takes a backseat to exploring physical sensations and discovering the location and shape of the imprints of past trauma on the body” (van der Kolk, 2014, p. 219).

Somatic Experiencing

Somatic experiencing (SE) is a somatic or body-focused therapy that permits therapists to address trauma without the “full, explicit retelling” of traumatic events. SE integrates “body awareness into the psychotherapeutic process”; it creates “awareness of inner physical sensations”, which are seen as the “carriers” of traumatic memory. SE links posttraumatic stress disorder (PTSD) symptoms to activated stress and links “incomplete defensive reactions” to traumatic events. The therapeutic objective with SE is therefore to discharge activation and decrease stress and PTSD symptoms (Brom et.al. 2017, p. 304). Epayne et al. (2015) conceive of trauma and chronic stress as a “functional dysregulation of the complex dynamical system formed by the subcortical autonomic, limbic, motor and arousal systems” (Epayne et al, 2015, p. 1). SE therapists ensure that they avoid “direct and intense evocation of traumatic memories”; any “charged” memories are approached indirectly and gradually while new “corrective interoceptive experiences” that physically contradict any experiences of “overwhelm and

helplessness” are facilitated (Epayne et al., 2015, p. 1). The very opportunity in SE to support clients in the development of a “sensate focus” and an ability to track their own bodily experiences is a key factor in enabling the therapist to avoid client re-traumatization –which is a real possibility should client defense systems be reactivated by verbally or cognitively “retelling their traumatic experiences” (Carleton and Gabay, 2012, p. 55).

Somatic Transformation

“Somatic transformation” is an emergent model for healing trauma designed by Sharon Stanley (2016). It employs relational and body-centred approaches, making best use of research on human growth and development, the wisdom of multiple Indigenous cultures, emerging neuroscience and phenomenological inquiry. Following Schore, Stanley points to the importance of evidence theories to support her trauma work: “we are moving from evidence-based outcomes to evidence based theories of human development where clinical expertise involves knowledge of neuroscience and practice of embodiment, empathy and intuition” (Schore, 2012, as quoted by Stanley in Trauma-Informed Somatic Practice workshop notes, July, 2019). Stanley has developed an approach that outlines extensive embodiment practices and a whole bodily-based clinical model for trauma treatment. It is beyond the scope of this literature review to do a thorough inquiry into Stanley’s model. However, Stanley’s work and evidence-based theoretical practice may be of particular interest to scholars who intend on pursuing future clinical supervision research with respect to supporting therapist stress. Stanley’s scholar/practitioner emergent model (Stanley, 2016) could inform the way in which vicarious trauma is approached and understood in clinical supervision; a theoretically supported, relational and somatic approach.

Aboriginal/Indigenous Focusing-Oriented Therapy (A/IFOT)

A/IFOT is an Indigenous, land-based, all my relations therapy that pays particular attention to the “felt sense” of “bodily experience of interconnected emotion, energy and sensations that are an expression of knowledge of collective experiences through time” (Turcotte & Schiffer, 2014, p. 51). A/IFOT differs significantly from Eugene Gendlin’s focusing-oriented therapy. However, it is important to reiterate that Gendlin (1978) articulated focusing as a therapeutic technique to identify and transform the thoughts and emotions that are held in the body. The findings of Gendlin’s research in which he analyzed thousands of tape-recorded therapist-patient sessions, revealed that “successful” patients who demonstrated “real and tangible change” do something inside of themselves differently than others (Gendlin, 1978, p. 3-4). Gendlin discovered that those who could contact a “special kind of internal bodily awareness” within themselves, were able to benefit the most from therapy. More importantly, Gendlin also discovered that people could be *taught* how to do it and benefit as well (Gendlin, 1978, p. 11). Just as in the abovementioned SE approach, Peter Levine acknowledges the importance of the felt sense in working with trauma as he considers the felt sense as a “portal through which we find the symptoms or reflections of trauma” (Levine, 1997, p. 66). Levine also asserts that in “directing our attention to these internal bodily sensations, rather than attacking the trauma head on, we can unbind and free the energies that have been held in check” (Levine, 1997, p. 66).

A/IFOT builds on Gendlin’s techniques significantly, encompassing the much wider perspective of the Indigenous lens. In A/IFOT supervision, time is spent on connecting into “implicit and ancestral memory knowledge, through the generations, that teaches us when to trust, how to trust and where to move ourselves forward for all life concerned” (Turcotte &

Schiffer, 2014, p. 51). Even traumatic intergenerational knowledge can particularly help “direct and inform our interactions and actions so that we may connect with decolonized knowing for the survival and growth for all of life and land” (Turcotte & Schiffer, 2014, p. 51).

In 2014, I had the great privilege to study with Shirley Turcotte, Métis knowledge keeper and Registered Clinical Counsellor, who pioneered Aboriginal/Indigenous Focusing-Oriented Therapy (A/IFOT). After graduating from her certificate program in 2015, I subsequently became a regular volunteer program helper in the program, supporting students to practice their A/IFOT skills and I participate regularly in ongoing clinical supervision for program graduates.

In A/IFOT clinical supervision for program graduates, clinical supervisors facilitate a three hour experience. During the first part of clinical supervision, graduates break off in triads to take turns checking in with each other about what they would like to work on. It might be something related to themselves as a therapist, something about working on their A/IFOT skills or it might be something that has come up for them in working with a client that they would like consultation on. The second half of the experience consists of meeting in the larger group with the clinical supervisor to bring up any pieces that feel unfinished or make requests for consultation. For example, a supervisee might be seeking case consultation and want to work on an issue connected to a client and this is witnessed by the entire group. Once the clinical supervisor has worked with the graduate, the rest of the witnesses may share what they have witnessed, directing their sharing to the clinical supervisor. A/IFOT has been likened to a ceremony: in fact, some maintain that it *is* a ceremony that comes out of a bodily and spiritually centered therapeutic experience. “The bodily felt sense” informs the communication (Turcotte & Schiffer, 2014, p. 61). A/IFOT clinical supervisors also provide one-to-one clinical supervision to helpers who may or may not be trained in A/IFOT and still benefit from their approach.

A/IFOT clinical supervision has much to teach helpers about the phenomenon of the vicarious in general. However, not only is there is a gap in the literature about A/IFOT as a therapeutic modality, no research exists to date on the contribution of A/IFOT to clinical supervision in relation to its particular framing of the vicarious and the tools that could be employed in supervision to support therapist stress (as is the case for the important connection between somatic approaches with respect to clinical supervision). This study aims to reflect the lived experience of A/IFOT clinical supervisors as a pilot study, with the intention to inspire future research about this particular modality as well as to inspire clinical supervisors and trauma therapists to understand the phenomenon of the vicarious in a different light.

Following a comprehensive search and exploration of literature on clinical supervision and how clinical supervisors might support trauma therapists, scant research was discovered about techniques or tools clinical supervisors could employ. Moreover, the literature on this topic continued to reiterate that clinical supervision was an important factor in alleviating therapist stress, yet often failed to evidence why and how that might be. In addition, literature on clinical supervision in relation to vicarious trauma paints a somewhat pathologizing and deficit-based picture of the vicarious despite the best efforts of scholars who wish to shift the narrative to the strength-based, resilience focus.

Chapter three focuses on the methods used to conduct a pilot study to begin to address the gap in the literature regarding how clinical supervisors might support trauma therapists when they notice the presence of the vicarious, to use that material to inform future therapeutic interventions for their clients.

CHAPTER 3: METHODOLOGY

Phenomenology is not so much contradictory to empiricism as it is more comprehensive because phenomenology acknowledges certain realities that empiricism does not...

— Amedeo Giorgi, Barbro Giorgi and James Morely, *The Descriptive Phenomenological Psychological Method*, *The SAGE handbook of qualitative research in psychology*, 2017

Introduction

As I narrowed down the focus of this thesis, I considered my own experiences as a helper over the past twenty years and the times in which I felt a certain level of distress in my role. I thought about those who supported me to make sense of what I was experiencing and I thought about those whose approach influenced me to feel that what I was experiencing was “wrong” or a sign of “weakness” – especially those who in the power differential of our collegial relationship, held the upper hand. I found myself able to detect visceral differences between encounters that made matters better and those that made matters worse. I became curious about how one might be able to clinically supervise effectively; not only to alleviate therapist stress, but also, to support therapists to make sense of what they were experiencing.

A phenomenological approach to this study appealed to me because Cresswell and Cresswell (2018) infer that descriptive and exploratory research approaches promote context and meaning development. I settled on engaging with clinical supervisors trained specifically in Aboriginal/Indigenous Focusing-Oriented Therapy (A/IFOT): a modality that addresses trauma pointedly. I reasoned that interviewing those supervisors could contribute a compelling perspective on the phenomenon of vicarious trauma. Before doing so, I first had to exhaust existing research on the subject.

As discussed in chapter two, a comprehensive search and subsequent examination of the literature revealed little research on specific tools clinical supervisors might employ to address vicarious trauma, should it arise as an issue in supervising therapists. In fact, while the literature on this topic primarily focuses on the importance of clinical supervision in alleviating therapist stress, it often neglects to delineate or document what it is about clinical supervision that was helpful, save for its relational aspect (Pack, 2017; Peled-Avram, 2017). Furthermore, while some researchers fall into a somewhat “pathologizing” tone connected to vicarious trauma, others who pay lip service to normalizing vicarious trauma, tend to focus the narrative on the phenomenon as something that is inevitable, yet somehow preventable and manageable through self-care, self-awareness and work/life balance (Abassary & Goodrich, 2014). Moreover, therapists who have a history of trauma themselves are believed to be the most impacted by vicarious trauma, further implying a stigmatizing narrative rather than reading that experience as a strength. Most of the literature does not emphasize the meaning behind the phenomenon of the vicarious itself, its purpose, or the therapeutic information contained in it.

Consequently, this pilot study aims to address the gap and is specific in nature; it examines the lived experience of clinical supervisors and illustrates how they notice the presence of vicarious trauma in the trauma therapists that they supervise. Additionally, this study looks into what they do to support therapists to not only sense and articulate what they are experiencing, but also, to use that material to inform future therapeutic interventions for their clients. This chapter focuses on the methods used to conduct this study and is comprised of the following components: (a) descriptive phenomenological psychological approach, (b) ethical considerations, setting and sample, (c) interview questions, (d) data collection process, (e) trustworthiness and integrity, and (f) summary.

Descriptive Phenomenological Psychological Approach

Amadeo Giorgi (1985, 2003, 2009, 2014; Giorgi et al., 2017) developed a descriptive phenomenological psychological method of analysis to obtain a phenomenon's meaning, as experienced by human subjects, by following specific steps that lead to essential theme identification. His research framework was chosen in order to better explore the lived experiences of clinical supervisors. Giorgi's method will permit a first-person perspective from clinical supervisors about implicit and explicit experiences of vicarious trauma in therapists that may arise in clinical supervision. This method's first-person perspective facilitates an opportunity to elucidate psychological aspects of an experience such as thoughts and perceptions. In this manner, the purpose of this study is to systematically analyze the point of view of clinical supervisors to learn about vicarious trauma in a psychologically-oriented way (Giorgi, 1985, 2009). This framework may contribute to our understanding about how to meet the supervision needs of trauma therapists who encounter traumatic material in their clinical work.

Three clinical supervisors volunteered to participate in this study. Each participant was interviewed about their experience and the various ways in which they address vicarious trauma in clinical supervision when therapists appear to be experiencing it. Interviews were audio recorded and transcribed at a later date. The transcripts of these recorded interviews served as the raw data that was then analyzed employing the five steps of the descriptive phenomenological psychological method. A critical part of Giorgi's method in this process also involved transforming the data by synthesizing a general structure of participant experience (Giorgi, 2009).

The synthesis of this structure emerged using Giorgi's recommended "imaginative variation" to examine meaning units and figure out pieces that could be similarly categorized for essential meaning in all three participant accounts. Through this process, "one is able to discriminate and clarify the psychological meaning for the particular meaning unit and then one tries to express it as accurately as possible" (Giorgi, 2009, p. 136-137). In other words, psychological aspects of participant experiences, similar for all, form the basis "for the writing of the general structure of the experience" (Giorgi, 2009, p. 137). Therefore, this study aims to use Giorgi's method to provide significant insights into the experience of clinical supervision and the understanding of vicarious trauma.

The descriptive, qualitative nature of the results in this study may be useful to clinical supervisors or instructors who are responsible for supervising or teaching trauma therapists to understand the phenomenon of vicarious trauma and how to address it. Trauma therapists may also find new insights and understandings of vicarious trauma that could inform and influence their work with clients. The intention is for the clinical supervisors' perspective to be given voice in this descriptive phenomenological psychological research.

Of significance to Giorgi's method is participant lived experience as it is recalled to consciousness (Giorgi, 1986, 2009). The meaning of different elements of their experience is understood as related to the whole situation – in this case, clinical supervision. This means that in Giorgi's method their analyzed experience depends on the meaning participants attach to their circumstances. The goal of the process of data collection is to elicit "as complete a description as possible" of the clinical supervisors interviewed (Giorgi, 2009, p. 122). Participant interviews not only reflected detailed information about their clinical supervision experiences, but in keeping with Giorgi's method, also made space for their own perceptions and spontaneous

responses (Giorgi, 2009). That is why the audio-recorded interviews were transcribed verbatim. According to Giorgi (1986), it is not only important for his method to be descriptive and use phenomenological reduction, but to search for essences and focus on intentionality as well. The concept of phenomenological reduction involves bracketing any of the researcher's preconceived notions (Giorgi & Giorgi, 2003, p. 249). In this case, that would include anything that I know or have experienced about clinical supervision, including my own experience with A/IFOT and familiarity with vicarious trauma. A requirement of Giorgi's method is for me to take participant meaning experiences exactly as they arise in participant consciousness in the interviews.

Ethical Considerations, Setting and Sample

In accordance with City University of Seattle in Canada's research requirements, an ethics application was submitted to the Institutional Review Board and was approved. Experimental protocol, participant recruitment, informed consent, confidentiality, and appropriate storage and destruction of data were included in the ethics application. Five A/IFOT clinical supervisors were initially approached to be interviewed. This decision was made because a sample size of three to five participants is considered to be a reasonable range for a pilot study, so that one does not generate an overwhelming amount of data, but can still speak to a gap in the literature. The selection criteria required the participants to have past experience in providing clinical supervision to trauma therapists. Each participant provided informed consent to participate in interviews with the researcher, after reading the required information about how the data they would provide would be used by the researcher for the purposes of this study.

Three voluntary clinical supervisors agreed to be interviewed in the Fall of 2019. Both in person and phone interviews were suggested to the participants as options; all three participants

elected the phone option. The consent form was discussed with the participants before the interviews commenced. The consent form provided details regarding the required time commitment, purpose of the research, confidentiality, and expectations. Participants were informed that they were free to withdraw from the study at any time. Permission to audio-record the interviews was requested from and given by each participant. The open-ended interviews were conducted over the phone and all three participants were given the same questions. Participants were asked to describe their experiences of clinically supervising trauma therapists and were invited to share what happens in clinical supervision when a therapist appears to be experiencing vicarious trauma, including any strategies that are drawn upon to help support the trauma therapist. Participants received the complete list of questions outlined below prior to the interview. Questions and comments by the interviewer were limited to requests connected to clarification, and elaboration or contemplations on what participants had already recounted. The interviews were recorded and transcribed verbatim. Once the verbatim transcript was completed, participants were provided with a copy of their interviews and invited to make any changes or additions to their interviews as they saw fit. Two out of three participants provided minor adjustments to the wording of their interviews which were incorporated. Otherwise, all participants were satisfied with their verbatim interview transcripts.

Interview Questions

The purpose of this qualitative, phenomenological study is to explore the experience of clinical supervisors who supervise trauma therapists trained in A/IFOT. I intend to derive information about the experience of supervising trauma therapists and provide details about the A/IFOT process, with specific reference to the phenomenon of how vicarious trauma is

addressed in clinical supervision. These questions are designed to explore how clinical supervisors engage with the trauma therapists they supervise:

1. Please describe what happens in Aboriginal/Indigenous Focusing Oriented Therapy (A/IFOT) clinical supervision when you notice a trauma therapist is experiencing vicarious trauma as a result of witnessing the disclosure of traumatic material from their client(s)? How do you support the therapist through their experience?
2. What are the essential elements of A/IFOT clinical supervision that are important in this process?
3. What strategies are used to help the trauma therapist?
4. What are the signs that vicarious trauma is present in clinical supervision?
5. Is there anything else that you would like to share about your experience facilitating clinical supervision?

Data Collection Process

Research participants were clinical supervisors of trauma therapists and instructors in A/IFOT. Five participants were approached and three were chosen due to the nature of their training and expertise, their roles as clinical supervisors and their availability within the needed time frame of thesis deadlines. Participants were identified through recruitment approaches approved by the lead instructor of Aboriginal/Indigenous Focusing Oriented Therapy (A/IFOT). As mentioned above, participants received a detailed briefing and explanation of the interview process, including a copy of the questions to be asked, which were sent in advance of an agreement to be interviewed. Supporting documents used in the recruitment and briefing process are included in the Appendix.

As discussed earlier in this chapter, Giorgi's method was used to study clinical supervisors' experience of supervising trauma therapists. The stages of Giorgi's analysis involved five steps including 1) Grasping a basic sense of the whole, 2) Assuming an attitude of scientific phenomenological reduction, 3) Delineating psychological meaning units, 4) Highlighting psychological meanings, and finally, 5) Describing the psychological structure of the experience through synthesis of the transformed meaning units (Giorgi, 2017). In this case, the "experience" being analyzed in this study is that of the participants who clinically supervise and support trauma therapists who may display vicarious trauma symptomology.

Basic Sense of the Whole

Once the original interviews were transcribed verbatim, the written descriptions of the clinical supervisors' lived experience were read in entirety by the researcher in order to get a "basic sense of the whole" (Giorgi et al., 2017, p. 182). The data reviewed consisted of 28 pages of transcribed interview text. According to Giorgi and Giorgi et al., (1985; 2017), it is important to do this initial step of a complete read-through to get a clearer picture of the participants' perspectives and to grasp a comprehensive sense of the interviews, which in turn gives the researcher the ability to begin an effective analysis. Moreover, the intention of this initial step is to immerse the researcher in the participants' lived experiences to attempt to comprehend the intention behind the meanings that the participants have communicated.

Scientific Phenomenological Reduction Attitude

The next step in the method was to assume an "attitude" towards the material of phenomenological psychological (or scientific) reduction (Giorgi et al., 2017, p. 182). Giorgi defines this assumption of an "attitude" as a moment when "the objects that emerge within the description are taken to be phenomena," presenting themselves to the consciousness of the

participants interviewed (Giorgi et al., 2017, p. 186). The remainder of the analysis is meant to be undertaken with this attitude assumed.

Delineating Psychological Meaning Units

The third step in the method was to break down the descriptions into parts that Giorgi calls “meaning units” so that they could be thoroughly analyzed (Giorgi et al. 2017, p. 186). This process of delineation allows for data to be more manageable for the researcher, as descriptions are often lengthy. By breaking down units of meaning into parts, I was then able to discern meanings. The transcripts were carefully re-read again, in order to distinguish each moment in which the description of the participant experience shifted to a significant change in meaning. These shifts in meaning were marked with slanted lines. All first person statements were changed to third person statements so as not to confuse my experience as a researcher with that of the participants interviewed.

Highlighting Psychological Meanings

The next step was to transform the meaning units in “phenomenologically psychologically sensitive ways” (Giorgi et al., 2017, p. 187). The intention of this step is to express psychological meanings more directly, by generalizing them into broader categories so that they may integrate the descriptions of all three interviews together. Each step of the analytic process is presented explicitly, so that a transparent facilitation of the prospective analysis of a critical other can take place later. Initially two columns were completed using Giorgi’s free imaginative variation, mentioned above, which attempted to render implicit factors, *explicit* to the best of my ability as a researcher (Giorgi et al., 2017). What emerged from this process was a subsequent third and fourth column which acts as a step in between Giorgi’s traditional fourth

and fifth steps, that encapsulate three emergent themes and meaning clusters detailed in chapter four.

Psychological Structure of the Experience

The final step, following Giorgi's method, was to encapsulate the general structure of the experience of clinically supervising trauma therapists as they encounter vicarious trauma. This step required a review of all of the transformed meaning units that happened in step four in order to determine "essential ones" (Giorgi et al., 2017, p. 187). The meaning units in step four correlated to separate parts of meaning, while the general structure in step five is related to a comprehensive description. A comprehensive description of the experience of A/IFOT clinical supervisors was then formed. This description acknowledges three emergent themes which are presented separately, taking into account the thematic clusters that contribute to each theme. Additionally, quotes from the clinical supervisors interviewed, which correspond to each emergent theme, were included in the explanation of each one. Each participant's perspective was not recounted separately but rather, portrayed contextually within the full description of the theme itself, so as not to detract from the comprehensive representation of all three participants of the study. A table reflecting the aspects of each one of the themes was constructed as a way to reveal how the emergent themes were established from the meaning units and is found in chapter four.

Data Analysis

Data analysis following Giorgi's method (Giorgi, 1986; Giorgi & Giorgi, 2003) aims to accurately encapsulate the phenomenon being studied as experienced by the participants - in this case, clinical supervision. The raw data of the verbatim interviews were broken into meaning

units, restructured into clusters of meaning and translated into language consistent with their central meaning. Finally, data was synthesized into a coherent description of their experience in relation to vicarious trauma.

Step 1: Familiarity with the data as a whole.

As a starting point, I re-listened to each participant's interview and read through the verbatim transcripts several times to fully familiarize myself with the data as a whole. The intention was to glean a holistic sense from each participant's point of view.

Step 2: Phenomenological reduction attitude.

I adopted an attitude of phenomenological reduction for the rest of the analysis. I bracketed my personal views about clinical supervision and vicarious trauma so that I could increase the chance of understanding the data through the participants' own points of view (Giorgi & Giorgi, 2003).

Step 3: Meaning units identified.

Each participant's entire verbatim transcript was broken up into separate parts, to identify meaning units. I did this by marking the text with a slanted line each time the transcript appeared to reflect a change in meaning. During this stage, it was important to not question those identified meaning units, but rather simply accept them as described (Giorgi, 1986).

Step 4: Grouping meaning units in clusters of meaning.

I then grouped the meaning units into "clusters of meaning" so that I might get a more complete understanding of the lived experience of the participants (Giorgi et al., 2017, p. 187). These clusters of meaning were chosen for their particular relevance to the study of clinical

supervision in relationship to addressing vicarious trauma. Giorgi & Giorgi (2003) recommend (that for where it is possible) to note anything that may not have been *explicitly* expressed, but may glean a richer description of what the participants intend to convey, once intuited from the meaning units.

Step 5: Synthesis of meaning unit clusters into descriptive expressions.

The final step in the descriptive phenomenological psychological analysis involves the construction of a synthesis of all of the meaning units that were clustered. Through this process, themes from each of the clinical supervisors interviewed were clustered into general themes that were relevant to all participants interviewed. For example, several participants reported strategies they used to help therapists differentiate vicarious material; not only to bring awareness and relief to therapist symptomology but also, to provide therapists with valuable knowledge about what might be the next therapeutic intervention for their client or clients. This particular theme was an example of an even broader theme that was reflected in all three participant interviews – that encompassed a somatic approach to identifying, sorting and making sense of vicarious material detailed in chapter four.

Trustworthiness and Integrity

It has been important to outline the data collection and analysis process above in detail in order to contribute to the qualitative validity of this study. Enough data has been gathered that any researcher could use the same questions to interview other clinical supervisors. Additionally, one could potentially use the same data to replicate the findings. One may not arrive at the exact same conclusions but there is enough information available to reproduce the design, data collection and system for analyzing data for this study.

Checking for accuracy or correctness is recommended by Cresswell (2014) in order to achieve qualitative validity. One of the ways this was achieved in this study was by asking the abovementioned questions to all three participant clinical supervisors. Moreover, participants were asked to review the verbatim interview transcripts that had been documented by the researcher. This process provided participants with an opportunity to confirm their statements, add any further thoughts, and/or modify their interviews as they saw fit (Cresswell, 2014). The purpose of this step is to allow participants time to reflect and comment on their documented statements. My intention as the researcher is to convey respect to the participants and foster trust that their lived experience would be documented as accurately and comprehensively as possible.

As the researcher, I also present myself as a partial insider to this work. I am transparently a student of counselling and I have been trained in A/IFOT. I have experienced vicarious trauma as a helper and have benefited from A/IFOT and other forms of clinical supervision. While engaging in the interviews and descriptive phenomenological psychological approach, I was required to suspend my own understanding of A/IFOT clinical supervision processes in order to permit the comprehensive and accurate sharing of the participant lived experiences, separate from my own.

Summary

The purpose of this pilot study was to explore the experience of clinical supervisors who address vicarious trauma with the therapists they supervise, should it arise in supervision. I chose a qualitative approach in order to address gaps in the literature about vicarious trauma in relation to the role of clinical supervision. This study was an opportunity to reframe the phenomenon of vicarious trauma itself, as well as to encapsulate potential ways in which clinical supervisors

could support the trauma therapists they supervise. I conducted open-ended interviews. The results of the study provide particular insight into how vicarious trauma may be viewed by clinical supervisors, as well as provide innovative approaches for the work of clinical supervisors. Awareness of the participants' lived experiences may assist other clinical supervisors to consider ways in which they could support supervisees more effectively.

The chapter that follows will provide an overview of the results of the study, constituting research findings from the interview transcript analysis. The analysis was conducted by employing Giorgi's method as outlined above. Following the entire five step process, the research findings were synthesized into three key emergent themes: (1) a somatic approach to identifying, sorting and making sense of vicarious material, (2) a land-based therapeutic workspace on which to address conversations and (3) an understanding of and an approach to the vicarious through an Indigenous, ontological lens; these themes are detailed in chapter four.

CHAPTER 4: RESULTS

The land knows you, even when you are lost.

— Robin Wall Kimmerer, *Braiding Sweetgrass: Indigenous Wisdom, Scientific Knowledge, and the Teachings of Plants*, 2015

Background and Choosing Participants

The participants in this qualitative study were A/IFOT clinical supervisors who provide supervision in two different ways: for graduates of the A/IFOT certificate program and for trauma therapists and other helpers who may or may not be trained in A/IFOT. While clinical supervisors and instructors of A/IFOT may be found throughout North America, those residing locally on Coast Salish Territory in British Columbia were chosen because of their proximity to the researcher. The following criteria guided participant selection: clinical supervisors who were also instructors of A/IFOT; Certified Focusing Professionals who were also preferably Registered Clinical Counsellors, Registered Social Workers and/or Registered Psychologists; and most importantly, A/IFOT Instructors who had at least five years of clinical supervision experience. Five A/IFOT clinical supervisors were contacted; two were unavailable during the necessary time constraints of the interview process. Please refer to chapter three for information about the ethical considerations of this study, such as the setting and sample of interviews with the three participating A/IFOT clinical supervisors. The data collection and analysis process was also outlined in chapter three, in accord with Giorgi's descriptive, phenomenological, psychological method.

This chapter will focus on the findings from the application of Giorgi's method. Essential themes will be identified in this process, with quotes taken from the interview transcripts and are summarized below.

Summary of Findings

Three key themes emerged from a synthesis of the research findings and included: (1) a somatic approach to identifying, sorting and making sense of vicarious material, (2) a land-based therapeutic workspace on which to address conversations and (3) an understanding of and an approach to the vicarious through an Indigenous, ontological lens.

Emergent Theme 1: Somatic Approach to Identifying, Sorting and Making Sense of Vicarious Material

One strong theme that arose from the data analysis was the participants' articulation of the A/IFOT approach to clinical supervision as a *somatic* one. Reference was made to the importance of embodiment, the body's felt sense and implicit information made *explicit* through the types of questions asked of supervised therapists. If the presence of vicarious material is noticed by the therapist, it is not assumed that the "material" belongs exclusively to the therapist (a form of countertransference) or the client (vicarious trauma). Clinical supervisors shared that they assist therapists to notice the presence of vicarious material and to subsequently begin to differentiate or demark *whose* traumatic material it is or where it is from. This means that in inviting the process of inquiring into the therapist's own bodily felt sense of their experience, what often arises *could* be their own felt sense, *and/or* the experiences of their clients, or even others in the life of the therapist or the client: the collective or the intergenerational. The clinical supervisors placed significant importance on the need for the clinical supervisor *themselves* to be

embodied as well. In this manner, they may be able to simultaneously track what is going on for the therapist by demarking their own felt sense of their relational connection to their supervisee. Through assisting a therapist to demark their own implicit bodily experiences, one participant reflected that clinical supervision “is not about correcting the things you are doing wrong or just dotting the ‘i’s’ and crossing the ‘t’s’.” Rather, they shared that something shifts when therapists have the opportunity to “set some stuff down, get a bit of space from it, and then see what is going on in their whole system about it.” Moreover, they stated that it can help the therapist “get out of the way *more*, when doing the work with clients.”

It is of particular significance to note that the process of differentiation and demarking is not an end in itself. Creating a space between themselves and what they are experiencing, through differentiating component parts, was conceived of by participants as a process in which therapists may have a better *relationship* with their experience. One participant shared, “I’m making a different relationship through my words with [the vicarious material or symptomology]; it’s *wise*, there is a whole lot of knowing about it- through the generations and nature is here too... we’re doing a lot of clearing space, size, distance and placing in nature... so that it is unpacked and out in the space so there’s more room to demark and more choices in responses.”

Participants conveyed that everything is in relationship and conversation in an A/IFOT approach to clinical supervision. This could include the client/therapist relationship but it could also include all the experiences a client brings to therapy: their multiplicity of relationships to people, land, generations, ancestors and different spaces in time. There are conversations to be had among the web of relationships and history carried in the body which also includes body language. In fact, the participants placed emphasis on the information gleaned from rendering the

implicit, *explicit* through the awareness of the felt sense and the ability to get a handle on the “conversations” that the felt sense is implying –including body movements.

Participants emphasized a somatic approach to identifying, sorting and making sense of vicarious material by checking in with their own bodily awareness and felt sense. Checking in with the felt sense gave them clues about how to support the therapists they supervised. In turn, participants shared that they often invite therapists to check in with their bodily awareness about what was happening for them and their clients as well. This provides the therapist with valuable knowledge about what might be the next therapeutic intervention for the client.

Emergent Theme 2: Land-based Therapeutic Workspace on which to have Conversations

Another strong theme that emerged from the participant interviews was consistent reference to the “ground” or “land,” that is in front of the clinical supervisor and therapist or therapist and client, as the therapeutic workspace. This workspace is considered the appropriate space for having and directing conversations, in which one may sit alongside or at an angle to the other, rather than adhering to the conventional Western practice of face-to-face counselling. Participants stressed the importance of grounding supervision or therapy work away from one’s body. One participant, in particular, explicitly pointed out that sitting alongside (versus face-to-face) is “an anchor to their relationship into land... creation and/or to all their relationships beyond humans” and they need a space to do that. This participant went on to explain that “if we’re shuttling back and forth with no space, it’s very hard to demark *whose* symptomology is whose and we can’t hear the conversations or the wisdom that is trying to come out of these loud symptomologies.” This is understood from the point of view of participants to also “reduce or

prevent burn-out.” Additionally, this practice permits the therapist or clinical supervisor to track knowledge that will likely inform the next therapeutic steps in client work.

Emergent Theme 3: The Vicarious is Understood and Approached through an Indigenous Ontological Lens

Significant emphasis was placed by participants on clinical supervision approached through an Indigenous lens. An important characteristic of this lens was described by participants as “right relationship” and “attitude.” It is expected that an “open, kind, curious and non-judgemental” attitude is held towards all those involved in the web of connections and history that arises in therapeutic conversation between therapists and clients. One participant described this respectful attitude as an “interconnected, *all my relations* aspect” in which one is a “visitor in a client’s *territory*.” Another participant shared that “...the Indigenous focusing attitude is probably the most important part of successful clinical supervision – in the sense that everything is welcomed and everything is looked at through the kindness of an interconnected, intergenerational lens – and a lens of *all my relations*. So whatever is being presented to the clinical supervisor– you see it all *holistically*- you don’t tie it specifically to the person who is sitting in front of you.”

The Indigenous experience of time and space affords participants significant tools with which to make sense of the vicarious. They track the time and space of what a therapist is presenting in supervision through their implicit, felt sense. One participant shared that their experience of time is that, “all time is here, *now*.” They went on to share that “different time zones will show up and we can work with them; and earlier time zones often have some pretty smart stuff to say about what’s going on now.”

The participants shared that in A/IFOT, phenomena such as “different places in time” and stages of life may be tracked implicitly and they use the language of the “four directions” to demark four stages of life: North (Elder), South (Adolescent), East (Infant/Child) and West (Adult). One participant explained that as a “clinical supervisor sitting with the therapist, who sits with their client,” the Indigenous focusing attitude of the therapist is “connected to and needs to be in the West and the North.” They elucidated that in the West, “you are very present and you have today’s clarity all sitting right there... right in front of you and in the *North*, you have *all* that interconnected intergenerational knowledge that is accessing *you*.” The participant related that “all” is happening “right now” because “time is also there- time is a big thing in the Indigenous world- past, present and future is all right here.” They explained that “what is happening in clinical supervision is also happening in the life, in the *collective* life of the client.” This concept of time impacts the collective therapeutic encounter, as this participant shared, “so whatever you’re doing in the room *there* is actually in real time.” Moreover, the participant maintains, “when that therapist goes back to that client, some work has been done for everyone involved because all time (past present and future) is also in the room.”

An aspect that also emerged from the Indigenous lens that particularly stood out was the framing of the vicarious as “*sacred*.” In fact, a participant expressed their concern about the potential, implied, “underlying message that somehow vicarious is *negative*” in the Western concept of vicarious trauma. This participant wished to illustrate a deeper meaning of the vicarious and stressed “the *great* importance of honoring and working with the opportunity that vicarious comes along with; and that is not a train you can ever not have anyway- because interconnectedness means vicarious; and that is *fundamentally a sacred thing*.” Clinical supervision and psychotherapy in this regard is experienced by participants as a “deep

interconnected healing and a way of being.” In fact, another participant explicitly stated that, “it is a *remembered* way of being; it’s ancient.” The reframing of the vicarious in this regard is a significant departure from the Western concept of vicarious trauma and we will return to this reframing in chapter five.

Emergent themes derived from meaning clusters and meaning units.

The below table was constructed to transparently demonstrate how the abovementioned emergent themes arose from the meaning units, constructed from the verbatim transcripts following Giorgi’s method.

Table I

Emergent Themes Derived from Meaning Clusters and Meaning Units

Meaning clusters	Meaning Units
	Somatic approach to identifying, sorting and making sense of vicarious material
Reported reference to checking in with supervisor’s own bodily awareness	Participant states that in the process of noticing that a trauma therapist that they supervise may be experiencing vicarious trauma, they are simultaneously sensing into their own body and their own felt sense to attempt to discern what is going on for the therapist. Participant states that as a clinical supervisor, they have to “try on what is going on” for the therapist as well, emphasizing the need for the clinical supervisor to also be embodied and check in their whole system to notice if the clinical supervisor is “able to pick up something vicariously” that the therapist may not be noticing. Participant states that as a clinical supervisor they do not want to be “busy in their head all the time” and being embodied helps them to “settle in, connect and notice.” Participant states that “it’s like an intergenerational blood memory that just sits with me... I’ve always felt things so collectively and so it felt more natural for me.”
Reported reference of supervisor inviting therapist to check in with their own bodily awareness	Participant states that the supervised therapist may be recounting their experience “from their head” and not paying attention to or noticing what is going on in the implicit conversation that their body is having as presented in supervision. Consequently, the clinical supervisor will invite the therapist to notice that implicit conversation from their own felt sense. Participant states that the supervised therapist is supported to “get a bit of space for themselves,” “actually set the issue down,” and “see what the body needs to do with all of that” whether it’s their own issues or vicarious “shared stuff.” Participant states that they reflect to the therapist what their body is showing by describing their body language to them which helps the therapist notice it more

as well.

Participant states that clinical supervisors invite therapists to notice in their body how they are experiencing what they are experiencing.

Participant states that in clinical supervision, they are collaborating with the therapist to discover what the therapist's body knows (the implicit) rather than solely what they verbally recount from the explicit story of the cases presented about the therapist's clients.

Participant states that listening to and noticing the implicit conversation of the felt sense, facilitates an explicit conversation to happen about what is going on for the therapist, the client, those around the client, ancestors, and/or communities.

Participant states that "if we are divorced from bodies for whatever reason" or the "body's wisdom", we just don't have a "full range of tools that can help manage the human experience in a connected way."

Participant states that "it's important that a therapist be able to sample, somewhat, what a client is experiencing in their body because that experiencing helps the clinician be able to form their next steps and next set of questions."

Participant states that as a clinical supervisor, they help the supervised therapist to "notice in their own bodies, and to also see if what they are vicariously experiencing" is activating them personally.

Participant states that as a clinical supervisor, they help the supervised therapist to "notice their own felt sense... have them clear space of the client and have them notice their own felt sense and have them track their own felt sense because often within their own felt sense, they'll find knowledge and medicines that they have which might be important not just for themselves- but for the collective client that they're sitting with."

Participant states, "if you're not sampling some of what is going on, there will be a weakness in the actual therapy process as far as A/IFOT is concerned because you're missing out on the interconnected, all my relations aspect; there are lots of bits that won't come forward if that therapist is not willing to sample bits of it."

Reported strategies used by the clinical supervisor to help therapist differentiate vicarious material not only to bring relief to therapist but to provide therapist with valuable knowledge about what might be the next therapeutic intervention for the client

Participant states that the context of clinical supervision differs from the context of therapy in that in A/IFOT therapy, the therapist may be helping a client differentiate what is theirs from what is that of others such as the community or others around them such as family members or intergenerationally. In the context of clinical supervision, the clinical supervisor may be helping the therapist more often than not, to notice in their bodies how it might not be theirs *period*. The participants stated that "if the therapist situated themselves correctly in a clinical setting- from an Indigenous perspective- it is quite likely what they are carrying is *most* likely not theirs and it's trying to inform them" about the circumstances correlating to the client.

Participant describes that the process of clinical supervision may encompass assisting supervised therapists to notice if what they are vicariously experiencing is also activating them personally. Participant describes one of the ways this may be detected is through noticing any regression. Participants states that when checking in with a therapist, the clinical supervisor may support them to notice if, in their felt sense reaction or response to what their client is presenting, is coming from what is called in A/IFOT, "the East" (child-like regression) or "the South" (adolescent-like regression). Participant describes how therapists may find they are activated and not "all adult" and present or grounded or "not feeling themselves." Participant states if the therapist is activated, there will be a reaction that can be tracked with the support of the clinical supervisor to determine what is being touched from the therapist's own life that "actually might be good for them to be able to connect with" because it might help "inform what their next steps are with the client that they are actually struggling with."

Participant states that a clue to notice that a therapist in clinical supervision may be experiencing vicarious trauma is that their “*affect* is greater than fits the therapist sitting there.”

Participant states that when it is a “vicarious piece” that the therapist has taken on from the client or their clients in general, it even feels to the clinical supervisor that “it’s too big for that person- there’s something – there’s like there’s a bit of a dissonance... you can feel it doesn’t just belong to that person so it can feel a little bit out of place; it can feel a little strange for that person; it can feel too big for that person-;there’s just a sense that there is something a little bit off about the symptom.”

Participant states that scaling is a strategy that can be used in A/IFOT clinical supervision in which a clinical supervisor would invite a therapist to check in with their own felt sense of on a scale of one to ten, how much of what they are noticing is theirs, how much is the client’s, how much is of the community, ancestors, generations etc.

Land-based therapeutic workspace on which to have conversations

Reported reference to how to physically sit alongside therapist

Participant states that how therapists can support themselves and prevent or reduce traumatization from the vicarious is to not sit squarely, face-to-face with their clients and clinical supervisors don’t position themselves that way with the therapists they supervise either. This is what is called, “connect and protect” in A/IFOT. This means that they can indicate with their “energy and their body language” that they are “interested and connected with their client” or therapist being supervised but they are not making too much eye contact so they won’t “be getting hit with a whole bunch more vicarious material.”

Participant states that therapists “don’t get as rocked by things if you’re sitting on the side, setting things down on the land and knowing you’re never alone with whatever it is that comes up.”

Participant states that A/IFOT clinical supervisors and therapists “don’t take things viscerally straight on;” they have techniques in how (they) position themselves within the therapeutic connection so that (they) “sample but don’t deeply absorb that which the client is experiencing.”

Participant states that it is important how a room is physically set up and if a therapist is sitting right across from a client, the likelihood increases of the vicarious not having “a path into land.” Participant states that this method will assist therapists to avoid or reduce burnout symptoms “to have that space and not to shuttle conversations back and forth without addressing that critical space in front of them which contains all the relationships.”

Reported reference to the space in front of the clinical supervisor and the therapist or the therapist and client on the ground/land as the space to talk into and place things.

Participant expands on the “connect and protect” approach above and explains that it is the land that is the place to “put things” rather than the therapist’s own body.

Participant states that an essential element of A/IFOT clinical supervision that is important in the process of supporting therapists with vicarious materials is the idea that the land is always with us and that people can set issues down.

Participant states that if a therapist is “over-absorbing” vicarious material from their client, then as a clinical supervisor, their question to the supervised therapist is, “How are you situating yourself in those sessions?” The participant emphasizes the abovementioned “connect and protect” position and states that it is important not to be “swallowing” what is happening but rather to make the “space that is required to be able to set down what the client is experiencing” on the therapeutic window of the ground in front of their feet.

Participant emphasizes that sitting alongside versus face to face is “an anchor to their relationship into land... creation and/or to all their relationships beyond humans” and they need a space to do that. Participant goes on to state that “if we’re shuttling back and forth with no space, it’s very hard to demark whose symptomology is whose and we can’t hear the conversations or the wisdom that is trying to come out of these loud symptomologies.”

The vicarious is understood and approached through an Indigenous ontological lens

Open, kind, curious, non-judgmental and normalizing

Participant states that vicarious experiencing is very normal.

Participant asserts that A/IFOT clinical supervision witnesses what is happening for the therapist and their clients holistically. Participant explains that an “Indigenous focusing attitude is probably the most important part of successful clinical supervision in the sense that everything is welcomed and everything is looked at through the kindness of an interconnected, intergenerational lens, and a lens of all my relations.” Participant emphasizes that what is happening is not tied specifically or solely to the client or to the supervised therapist in front of the clinical supervisor. Participant goes on to explain that the attitude towards what is happening is of openness and curiosity about what is happening in the therapeutic *connection* because it’s all interconnected instead of “*you, therapist-what are you doing to cause this?*”

Participant notes that the Indigenous focusing attitude is really important and helpful and we need to unpack what is happening in the therapeutic connection so that it can be determined what the best steps are for this “amazing client you get to have the privilege of sitting with.” The attitude of kindness, curiosity, non-judgment and humility is so important since “ancestral, intergenerational, knowing can’t enter the space without that level of acceptance and wonderment.”

Participant relates that the therapist in A/IFOT is conceived of as a visitor in a client’s “territory.”

Time and space

Participant notes that they have witnessed in therapeutic interventions that intergenerational trauma is “interconnected through time.”

Participant states that in A/IFOT, they are constantly in flux with all time here now: “past time, intergenerational time and now time.”

Participant states that as a clinical supervisor sitting with the therapist who sits with their client, the Indigenous focusing attitude of the therapist is connected to and needs to be in the West and the North. In the West “you are very present and you have today’s clarity all sitting right there... right in front of you and in the North, you have all that interconnected intergenerational knowledge that is accessing *you*.”

Participant relates that all that is happening is right now because “time is also there- time is a big thing in the Indigenous world- past, present and future is all right here- so in other words, what is happening in clinical supervision is also happening in the life, in the collective life of the client so whatever you’re doing in the room there is actually in real time, so to speak, so the clinical supervisor, helping the clinician, helping the client, that’s all taking place; so when that therapist goes back to that client, some work has been done for everyone involved because all time (past present and future) is also in the room.”

All my relations

Participant states that they conceives of the client as a “collective client,” meaning that a client is in an “all my relations” relationship with all of creation. Participant states that clinical supervision is akin to supporting people to remember all that they are and that they are connected to many relationships. Participant states that through inquiring about the therapist’s own felt sense, it is an opportunity to help them “lean into land-based, ancestral or animal helpers,

Vicarious as sacred

and medicinal based territorial needs and offerings that come therapeutically”. Participant goes on to mention there are usually some “vital, good bits of help there intergenerationally.” Participant goes on to relate that they have witnessed that the vicarious and intergenerational interruptions that therapists experience from sitting with their clients can be “absolutely wonderful opportunities for - not just the client- but for the whole therapeutic process and all concerned.” Participant discusses the Indigenous psychotherapeutic lens which participant describes as an “interconnected, all my relations aspect.”

“I’m talking about Indigenous human relations –interconnectedness and all my relations which is through an Indigenous psychotherapeutic lens which comes at that whole thing quite differently.”

Participant states that it is important as a clinical supervisor and a therapist that you are respectful because you know that “it’s not just the therapist sitting there, the client is sitting there too and all their relations; so time is very different in the Indigenous world than the colonial world it’s not linear.”

Participant states that the Indigenous lens knows vicarious as something sacred and a way of being more than it is a therapy: an “ancient, remembered way of being” in which “we’re meant to share; we’re designed to connect – we’re designed to interconnect; and that’s survival.”

Participant describes the whole process of Indigenous-informed therapy is “interconnected and sacred- it’s a meeting of all humanity.”

Summary

Chapter four identified the essential themes arising from the participant interviews through Giorgi’s method of analysis. The goal was to follow Giorgi’s systematic method to initially grasp a basic sense of the whole, assume an attitude of scientific phenomenological reduction through the duration of the analysis, delineate psychological meaning units, highlight psychological meanings, and finally, describe the psychological structure of the experience through synthesis of the transformed meaning units. This systematic analysis of the verbatim interview transcripts resulted in three emergent themes, which arose through a descriptive phenomenological psychological lens, as a multi-faceted process of unfolding that is a) somatic, b) land-based, and c) seen through an Indigenous ontological lens. Chapter five will discuss these findings in detail; divulge limitations of the study; make recommendations for future research; and share reflections on the process of writing this thesis.

CHAPTER 5: DISCUSSION

We are in connection and in relationship with water, air, fire, earth, and all the relatives who have wings, fins, roots and paws and this connection flows forwards and backwards in time, through the generations. Trauma fallout is a relationship issue and we are in relationship with life and land through the generations.

— Shirley Turcotte, developer of Aboriginal/Indigenous Focusing-Oriented Therapy

As discussed throughout the body of this thesis, clinical supervision is consistently mentioned in the research as a key factor in reducing therapist stress and vicarious trauma symptomology in helpers (Etherington, 2000; Knight, 2013; Pack, 2014; Pack, 2017; Peled-Avram, 2017). Building upon the current research to date, I focused on the experiences of three clinical supervisors who approach the vicarious through the lens of A/IFOT. Their verbatim interview transcripts were analyzed following Giorgi's method, outlined in chapter three, in order to identify themes. This final chapter will discuss how the A/IFOT approach to clinical supervision reflected in chapter four, dialogues with existing literature, reframes the phenomenon of the vicarious, and has implications for clinical supervision. Additionally limitations of the study, recommendations for future research and reflections on the thesis writing process are explored.

All My Relations Relational Approach

The concept of a relational approach to supervision as a key factor in alleviating therapist stress is an important one in the dialogue about clinical supervision that arises from the literature. The emphasis on the collaborative approach and time spent on discussing the relationship between therapist and client, as well as the relationship between clinical supervisor and therapist,

often characterizes a relational approach. The relational approach to clinical supervision places greater “emphasis on mutuality, allocation of authority, and co-construction of knowledge,” inspired by relational theorists who centre their perception of the human psyche on relationships, attachment and connection (Peled-Avram, 2017, p. 24). Based on the verbatim transcripts of the A/IFOT clinical supervisors interviewed, their perspective is not in contradiction to a relational approach but their lens is much broader. Their empathic approach is reflected in the description of the focusing attitude as a kind, open and curious approach to what is being presented in supervision. However, what arises from their lived experience is an expansion on the concept of relations to encompass a much wider collective sense. *All* relations are considered in A/IFOT clinical supervision and taken into account. When an A/IFOT clinical supervisor is collaborating with a therapist during supervision about their client work, the client is conceived of as a *collective client in relationship* with all of creation and connected to many relationships (see chapter four). It is in this broad field that the relational approach takes place in order to make sense of how to approach client work. There is a vast network of interconnections and relationships to draw upon to inform the clinical supervisor and therapist about potential therapeutic interventions.

Vicarious Growth and Resilience

As outlined in chapter two, the literature on vicarious growth and resilience challenges the concept of vicarious trauma by asserting that therapeutic empathic engagement promotes vicarious *growth* in addition to vicarious trauma (Cohen & Collens, 2013; Harrison & Westwood, 2009; Michalchuk & Martin, 2019; Pack, 2014). The A/IFOT clinical supervisors interviewed also challenge a deficit-based approach to the concept of the vicarious. However, the A/IFOT clinical supervisors interviewed, did not focus their attention as much on engaging

the therapists they work with in exploring coping strategies to help them “manage” traumatic symptomologies. Rather, more attention is focused on the demarking process in which therapists are invited to notice that what they may be experiencing in their bodies may actually be what their *collective client* is experiencing as discussed in chapter four. This means that they are in relationship with the vicarious and the connection to the vicarious is conceived of as a collective conversation, informing the next steps in their therapeutic interventions. In this manner, the vicarious is not something to *manage*, but something that is *meant to be shared* in order for therapists to be effective.

A/IFOT Clinical Supervision Approach

Each participant shared their approach to the phenomenon of the vicarious and what that might look like in a clinical supervision setting. Specifically, this study demonstrated that there are significant themes that arise in A/IFOT clinical supervision. These include: 1) a somatic approach to identifying, sorting and making sense of vicarious material; (2) a land-based therapeutic workspace on which to address conversations; and (3) an understanding of and an approach to the vicarious through an Indigenous, ontological lens. What emerged from this approach could be described as a reframing of the vicarious within the context of clinical supervision.

A Somatic Approach

As outlined in chapter four, the clinical supervisors emphasized the importance of the supervisor’s own embodiment prior to inviting those that they supervise to check in with their own bodily awareness. This approach is unique and departs from previous literature on clinical supervision. It is in A/IFOT clinical supervision where supervisors undertake the critical task of discerning “how to address therapists’ reactions to working with trauma survivors,” (Knight,

2018, p. 18) that most clinical supervision models lack. The Indigenous focusing tools employed are described by the clinical supervisors interviewed as an opportunity in clinical supervision for collective knowledge to arise through the “felt sense” of both supervisor and therapist. The A/IFOT approach to clinical supervision is not solely an opportunity for supervision to be a place to identify and discuss therapist responses to the work they engage in and discharge stress (as recommended by authors such as Courtois, 2018 and Pack, 2017). Supervision, in A/IFOT, is also a space in which one may employ the skill of demarking felt sense experiences to ultimately discern what they are informing the therapist about, with respect to how to engage therapeutically with their clients.

Land-based Therapeutic Workspace

As outlined in chapter four, the clinical supervisors challenged the standard therapeutic convention of sitting face-to-face in the therapeutic encounter between therapist and client. This also includes where clinical supervisor and supervisee position themselves in relation to each other. The clinical supervisors interviewed explained that the “therapeutic window” should not be the therapist or clinical supervisor’s own body. It should be the *land*. In this manner, by sitting alongside the therapist (or the therapist sitting alongside their client), it permits the clinical supervisor (or therapist) to sample what is going on for the other without completely “swallowing it” vicariously. This is what is meant by the concept of “connect and protect,” as shared by the participants through the meaning units outlined in Table 1 in chapter four. It is recommended that a clinical supervisor or therapist indicate with their “energy and their body language,” that they are “interested and connected with their client” (or therapist being supervised) but they are not making too much eye contact so they will not “be getting hit” with “vicarious material” (see Table 1, Chapter 4).

While there are therapeutic modalities such as narrative therapy that employ externalization as a discursive shift to build an inner observer, no other therapeutic modality, approach or intervention that I have come across to date besides A/IFOT in the literature, actually positions the dyad in this way with the express intention of grounding the therapeutic work into land instead of into the therapist or clinical supervisor's own body. It is beyond the scope of this study to explore the depth and profundity of this dynamic. However, rich research possibilities lie in studying this one aspect alone connected to A/IFOT. This point of view has much to contribute to the dialogue among scholars of trauma treatment about a therapist's role as co-regulator in the process of healing trauma. For example, one could study the long-term effects on therapists who sit face-to-face with their clients, versus those who sit alongside their clients in order to *sample* but not fully "take on" what is being experienced by their clients.

Indigenous Ontological Lens

Vicarious trauma is typically depicted in the literature as the disruptive and painful effects of empathically engaging with traumatic material presented by clients (McCann & Pearlman, 1990, p. 133). The A/IFOT approach to clinical supervision may be conceived of as one that challenges the notion of vicarious trauma with a unique take on human suffering in general. In fact, A/IFOT takes into account the perspective of scholars like Nadeau and Young (2006) who also point to an Indigenous way of knowing that challenges the medical models of suffering itself. Nadeau and Young affirm:

PTSD, like much trauma language, reduces suffering to a condition of medical pathology rather than a spiritual or moral problem caused by political violence. This *social suffering*, a term from medical anthropology, is transformed into individual cases of dysfunction. The language of deficiency and dysfunction

reduces to personality traits or syndromes behaviours that have emerged as survival or resistance responses to oppressive conditions. Nadeau & Young, 2006, p. 91.

In this manner, A/IFOT clinical supervision turns the tables on vicarious trauma to look at the vicarious as the *opposite* of a pathologizing concept. In effect, it serves to *decolonize* the vicarious. In the seminal work, *Decolonizing Trauma Work: Indigenous Stories and Strategies*, Renee Linklater (2014) eloquently explores healing and wellness in Indigenous communities through engaging Indigenous health care practitioners in dialogue, critiquing psychiatric diagnoses and discussing Indigenous approaches to working with trauma and other phenomenon. Linklater asserts that, “Indigenous people who share in the experience of multigenerational effects of historical trauma must be at the forefront of developing Indigenous trauma practice and theory” (Linklater, 2014, p. 27). Moreover, this will not only benefit Indigenous communities, but also, “non-Indigenous practitioners and healing movements searching for new and creative ways to work” (Linklater, 2014, p. 27). In this regard, Linklater explores a decolonizing approach to trauma which emphasizes the relevance of Indigenous worldviews which “evolve out of a direct wholistic relationship that encompasses our spirit and the universe” (Linklater, 2014, p. 27).

The A/IFOT clinical supervisors interviewed emphasized that if a therapist is not “sampling some of what is going on,” there will be a “*weakness* in the actual therapy process” because the therapist will be “missing out on the interconnected, *all my relations* aspect.” A therapist is conceived of as “a visitor in that client’s territory”; it is a territory that is understood as “interconnected through time” and inter-generational. One of the participants asserted that

there are “lots of bits that won’t come forward if that therapist is not willing to sample little bits of it- it can inform their next piece.”

Consequently, clinical supervision has emerged in this study as an opportunity to notice vicarious symptomology in the therapist as crucial information. As one participant explains, “if you’ve situated yourself correctly in a clinical setting, from an Indigenous perspective, it is quite likely what you are carrying is *most* likely not yours and it’s trying to inform you.” Participants stressed the importance of knowing that the vicarious is actually *interconnectedness*: “honoring and working with the opportunity that the vicarious comes along with.” Clinical supervision may thus be viewed in a larger context as “growing a community that knows how to work in this way.” Consequently, as one participant affirmed, the A/IFOT approach to clinical supervision is “a social justice piece,” because “if we are divorced from bodies -for whatever reasons: the body’s wisdom- we just don’t have a full range of tools that can help manage the human experience in a connected way.”

Implications for Clinical Supervisors

This research is a contribution to the gap in the literature on how clinical supervision may address vicarious trauma in the supervision of trauma therapists. Incorporating the A/IFOT lens and the voices of A/IFOT clinical supervisors into the literature has the potential to improve the quality of clinical supervision. This research study points to specific skills that may be developed by clinical supervisors who are trained in A/IFOT that could support their effectiveness in their role in influencing the alleviation of therapist stress. Based on the findings of this research, clinical supervisors may want to consider this lens as part of their supervision competency. It is my suspicion that any research that focuses on helping helpers, will inevitably have ripple effects to the clients they serve.

Implications for Trauma Therapists

The focus of this research was on the experience of clinical supervisors. However, the implications for trauma therapists are significant. The specific skills that could be developed by clinical supervisors may also be developed by trauma therapists in order to enhance their effectiveness with the clients that they serve. Additionally, training in A/IFOT may broaden therapist awareness of the vicarious in providing them with significant information about what the next steps may be in addressing what is happening in the lived experience of their clients.

Implications for Future Research

With respect to future research on clinical supervision, trauma therapy and vicarious trauma, I would propose more qualitative studies that not only examine the lived experiences of other clinical supervisors but also trauma therapists and the clients that they serve. The present study exclusively focused on the lived experience of A/IFOT clinical supervisors. While reflecting on the process of interviewing participants, I considered that future studies could also document case studies of therapists participating in A/IFOT clinical supervision as an effective way to illustrate the tools employed in A/IFOT clinical supervision. Moreover, if it is possible to then document subsequent case studies of therapist sessions with their clients prior to and after clinical supervision, it may be possible to deeper illustrate the comprehensive process and collective impact of the modality quite poignantly. However, in that particular potential future study, there may be complex ethical implications involving both client confidentiality as well as therapist self-disclosure. Nevertheless, if care were taken to provide fully informed consent and to ensure client and therapist confidentiality, there may be an ethical way to conduct such comprehensive case studies.

Limitations of the Study

The following is an acknowledgement and an articulation of limitations within this study. The participants included in this study were limited to three A/IFOT clinical supervisors residing on unceded Coast Salish territory in British Columbia. I could have involved more participants who clinically supervise through the lens of A/IFOT in order to involve more diverse perspectives from diverse peoples who live in different corners of the world. Focusing specifically on the topic of the vicarious as it arises in clinical supervision, amplified a specific aspect of clinical supervision; consequently, the results did not provide the full span of knowledge and lived experience of all that clinical supervision might entail from the participants' point of view. Not only is this study limited by its small size, but also by the lack of opportunity to compare factors such as years of supervisory experience, a comparing/contrasting of other supervisory frameworks, and/or structure of other aspects of supervision. A larger study may reflect whether or not these factors influence how the vicarious is addressed within supervision.

Additionally, the themes that arose from the analyzed verbatim interview transcripts are based on how the participants articulated their lived experiences within one moment in time and another moment in time in which two of the participants reviewed their verbatim transcripts and offered minor adjustments to their discourse. Consequently, one could argue that participant interviews could have been different or captured alternate nuances of experience in other moments in time.

The following aspects could also factor into limitations in the study. One could argue that the quality of the research could be influenced by whether or not I have fully understood the lived experiences of participants enough to reflect their meaning. Each of the three interviews

lasted no more than one hour; one could argue that this may not have been enough time to recount enough about their experience. Perhaps if the interviews had been longer and spread out over time with the same participants, more information related to their lived experience may have been gleaned. Moreover, from the point of view of a fuller sense of the supervision experience, a larger study that included both supervisees and supervisors would provide an opportunity to learn about the lived experiences of supervisees in the context of A/IFOT supervision.

As mentioned in the literature review, limited research exists in the field of vicarious trauma and Aboriginal/Indigenous Focusing Oriented Therapy (A/IFOT). To date, there are no existing phenomenological research studies that link A/IFOT and vicarious trauma experiences; as a result, articles based on similar types of research had to be utilized to guide the study. Limitations aside, the presenting study provided valuable themes, truly deepened and reframed my understanding of the vicarious as it arises in clinical supervision from an A/IFOT lens.

Reflections on the Research Process

The process of writing this thesis has been a significant learning curve for me; the writing of research papers does not prepare one enough for the colossal feat and endurance test that is the thesis. For example, on a practical level, I had limited understanding of the myriad qualitative research methods; I have limited experience with philosophical discourse and struggled through all the philosophical nuances of phenomenological research before settling on Giorgi's descriptive phenomenological psychological method with the support of my thesis advisor. While I believe in the old adage that the more we know, the more we learn that *we do not know*, and though I still have much to learn about research methods, I have a much deeper knowing

now of the phenomenological research process than before the first stirring of this study's unfolding.

While there were other factors at play that consumed my time, the actual act of narrowing down the topic of this thesis took me over a year. While I knew early on that I sincerely desired to write about the modality of A/IFOT in some capacity, I later came to the realization that I wanted to narrow down my focus. I decided on clinical supervision when I finally had the opportunity to take a graduate studies course in the subject. Gaps in the literature on clinical supervision alone and gaps in the professional development of clinical supervisors are significant issues that the world of counselling is increasingly working to address (Camilleri, 2017; Shepard & Martin, 2012). I personally can attest to the fact that competent clinical supervision lends notable value to therapists and witnessing that level of support has contributed to sustaining and retaining me in helping work. Thus, coming to terms with how to do justice to a modality that I have so much respect for, and highlighting a component of the therapeutic process (accessing supervision) that I have experienced as so important in the work, and wanting to do so in a good way, consumed my every waking and non-waking moments.

Implicated Researcher

Despite never having provided clinical supervision to trauma therapists before undertaking this research, I have been a participant in A/IFOT clinical supervision as a student of A/IFOT and a participant in other forms of clinical supervision during my counselling internship process as well as having provided general supervision in other roles as a helper. Consequently, I have had the unique opportunity to experience A/IFOT clinical supervision and to compare it to other supervision experiences.

During experiences of A/IFOT clinical supervision, I have had the opportunity to witness both profound shifts in myself, as well as witnessing shifts in colleagues who have benefited from this approach to clinical supervision. Similar to the process described by this study's participants, I have had the opportunity to demark, notice a shift, and notice what the material has to teach me about the next steps in working with a client. The opportunity to conceive of the vicarious as non-pathologizing and instead, important information about what is going on for my client, was a pivotal experience in my growth as a counsellor.

It is important to acknowledge my involvement in this manner. While this means I have a significant understanding of the phenomenon being studied, it also means that I need to be transparent about my biases concerning clinical supervision experiences. Consequently, one of the reasons that Giorgi's approach to the research was chosen, was in order to introduce an as objective as possible, methodical, step-by-step process of analysis.

Inspired by the voices of the participants, as I re-read their words in the process of engaging with the interview transcripts, I found myself in awe of the awareness that the process of repetition provides. Listening and reading transcripts over and over again has the effect of revealing new nuances and depths of meaning. As I sought to make sense of the writing and research process, both the words and the voices of the participants evoked a bodily sense of increasing and building clarity. Their voices gave me the strength to carry on the herculean task of writing a thesis and refreshed and re-focused me. In fact, their words inspired an incredible sense of well-being, hope and renewal. Through this process, I felt as if I could sharpen my own emerging understanding of A/IFOT tools and their capacity to direct me in the next steps to be helpful to my future clients and to myself.

With this research, I endeavor to make space for new questions to bubble to the surface regarding how clinical supervisors and trauma therapists articulate and make use of vicarious material in order to enrich, enliven and ultimately work to heal their own and their clients' experience. I am so grateful to the participants of this research for sharing their experiences and permitting me to reflect on their clinical supervision experiences.

Conclusion

Because A/IFOT has not been fully documented in the literature, it is important to suggest further investigations of A/IFOT in clinical supervision and even A/IFOT as a therapeutic modality itself. Individuals who have experienced A/IFOT first-hand, both as a therapist and as a client, understand the impact this treatment has, but the approach is still relatively unknown in the literature on clinical supervision, vicarious trauma and trauma treatment. Further studies are needed. Moreover, it may be important to examine the A/IFOT approach to clinical supervision in work with therapists who have not been trained in A/IFOT. Lastly, it may be important to develop more studies that refine our understanding of the vicarious as well as those that contrast non-somatic (e.g., cognitive behavioral) together with somatic approaches to clinical supervision of trauma therapists.

According to the A/IFOT and Indigenous ontological lens, the bodily shifts in perspective experienced by trauma therapists not only permit the alleviation of therapist stress but also provide valuable information about the next steps in addressing their clients' needs. Based on the A/IFOT processes, clinical supervisors address the vicarious through a somatic approach that is land-based and through an Indigenous lens. My hope is that this study opens up more opportunities for other researchers to study A/IFOT both in the context of clinical supervision as well as a therapeutic modality.

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Appendix



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Institutional Review Board Certificate of Approval

IRB ID# Rodrigo_Stella042019

Principal Investigator (if faculty research):
Student Researcher: Jinny Rodrigo
Faculty Advisor: Maria Stella
Department: DASC

Title: Descriptive phenomenological research as a means to explore the clinical supervision of trauma therapist.

Approved on: July 20, 2019

- Full Board Review
- Expedited Review (US)
- Delegated Review (Can)
- Exempt (US)

CERTIFICATION

City University of Seattle has reviewed the above-named research project. The proposal was found to be acceptable on ethical grounds. The Faculty Advisor Maria Stella and the student researcher Jinny Rodrigo have the responsibility for any other administrative or regulatory approvals that may pertain to this research project, and for ensuring that the authorized research is carried out according to the conditions outlined in the original Ethical Review Protocol submitted for ethics review.

This Certificate of Approval is valid provided there is no change in experimental protocol, consent process, or documents. Any significant changes to your proposed method, or your consent and recruitment procedures are required to be reported to the Chair of the Institutional Review Board in advance of its implementation.

A handwritten signature in blue ink that reads "Brian Guthrie".

Brian Guthrie Ph.D., RSW, RCSW
Chair, IRB City University of Seattle

ICRG-IRB REGISTRATION: ICRG 0009785/IRB registration number: IRB000627 CITY UNIVERSITY OF SEATTLE IRB #1



School/Division of Arts and Sciences

CITYU RESEARCH PARTICIPANT INFORMED CONSENT

Title of Study:

Descriptive Phenomenological Research as a Means to Explore the Clinical Supervision of Trauma Therapists

Name and Title of Researcher(s):

Jinny Rodrigo, Master of Counselling student, City University of Seattle in Vancouver

For Faculty Researcher(s):

Department: _____

Telephone: _____

City U Email: _____

Immediate Supervisor: _____

For Student Researcher(s):

Faculty Supervisor: Dr. Maria Stella, Ph.D. R.C.C.

Department: Arts and Sciences

Telephone: XXXXXXXXXX

City U E-mail: XXXXXXXXXX

Program Coordinator (or Program Director):

Chantelle Stewart Lam, MC, R.C.C., Program Director

Sponsor, if any:

N/A

Key Information about this Research Study

You are being invited to participate in a research study.

The researcher will explain this research study to you before you will be asked to participate in the study and before you sign this consent form.

- You do not have to participate in this research.
- It is your choice whether or not you want to participate in this research.
- Your participation is voluntary and you can decide not to participate or withdraw your participation at any time without penalty or negative consequences.
- You should talk to the researcher(s) about the study and ask them as many questions you need to help you make your decision.

What should I know about being a participant in this research study?

This form contains important information that will help you decide whether to join the study. Take the time to carefully review this information.

You are eligible to participate in this study because you are a clinical supervisor of Aboriginal/Indigenous Focusing-Oriented Therapy.

You will be in this research study for approximately _1 hour_____.

About _3-5_ individuals will participate in this study.

To make your decision, you must consider all the information below:

- The purpose of the research
- The procedures of the research. That is, what you will be asked to do and how much of your time will be required.
- The risks of participating in the research.
- The benefits of participating in the research and whether participation is worth the risk.

If you decide to join the study, you will be asked to sign this form before you can start study-related activities.

Why is this research being done?

Purpose of Study:

The purpose of this pilot study is to explore the experience of clinical supervisors who supervise trauma therapists trained in Aboriginal/Indigenous Focusing-Oriented Therapy (A/IFOT). This serves a dual purpose: providing information about the experience of supervising trauma therapists as well as providing insight about how the A/IFOT process with specific reference to the phenomenon of how vicarious trauma is addressed in clinical supervision. The findings will be geared towards supervisors, therapists and researchers, identifying the potential of clinical supervision to influence the alleviation of therapist stress, and providing a potential theoretical background to direct future research.

Research Participation.**You will be asked to participate in the following procedures:**

I understand I am being asked to participate in this study in one or more of the following ways (initial options below that apply):

- Respond to in-person and/or telephone Interview questions; Approximate time _1 hour_
- Answer written questionnaire(s); Approximate time _____
- Participate in other data gathering activities, specifically, _____; Approximate time _____
- Other, specifically, _____. Approximate time _____

You may refuse to answer any question or any item in verbal interviews, written questionnaires or surveys, and, you can stop or withdraw from any audio or visual recording at any time without any penalty or negative consequences.

Are there any risks, stress or discomforts that I will experience as a result of being a participant in this study?

Taking part in this research involves certain risks: This could include: the possibility that participation in this study may be triggering and you have the right to withdraw at any time and the researcher will offer the opportunity for you to see a counselor of your choice to process anything that arises for you and/or debrief your experience.

Will being a participant in this study benefit me in any way?

We cannot promise any benefits to you or others from your participation in this research. However, possible benefits may include indirect benefits in which the study may address themes that you care about, may shed light on perspectives related to clinical supervision and/or may benefit future clinical supervisors, trauma therapists and/or researchers of A/IFOT.

You will receive _an honorarium_ for your participation in this research.

You will not receive any payment for participation in this study.

Confidentiality

I understand that participation is confidential to the limits of applicable privacy laws. No one except the faculty researcher or student researcher, his/her supervisor and Program Coordinator (or Program Director) will be allowed to view any information or data collected whether by questionnaire, interview and/or other means.

If the student researcher's cooperating classroom teacher will also have access to raw data, the following box will be initialed by the researcher.

Steps will be taken to protect your identity, however, information collected about you can never be 100% secure. Your name and any other identifying information that can directly identify you will be stored separately from data collected as part of the research study. The results of this study will be published as a thesis and potentially published in an academic book or journal, or presented at an academic conference. To protect your privacy no information that could directly identify you will be included.

All data (the questionnaires, audio/video tapes, typed records of the interview, interview notes, informed consent forms, computer discs, any backup of computer discs and any other storage devices) are kept locked and computer files will be encrypted and password protected by the researcher. The research data will be stored for 5 years. At the end of that time all data of whatever nature will be permanently destroyed. The published results of the study will contain data from which no individual participant can be identified.

Signatures

I have carefully reviewed and understand this consent form. I understand the description of the research protocol and consent process provided to me by the researcher. My signature on this form indicates that I understand to my satisfaction the information provided to me about my participation in this research project. My signature also indicates that I have been apprised of the potential risks involved in my participation. Lastly, my signature indicates that I agree to participate as a research subject.

My consent to participate does not waive my legal rights nor release the researchers, sponsors, and/or City University of Seattle from their legal and professional responsibilities with respect to this research. I understand I am free to withdraw from this research study at any time. I further understand that I may ask for clarification or new information throughout my participation at any time during this research.

I have been advised that I may request a copy of the final research study report. Should I request a copy, I understand that I will be asked to pay the costs of photocopy and mailing.

Participant's Name: _____

Please Print

Participant's Signature: _____ Date: _____

Researcher's Name: Jinny Rodrigo

Please Print

Researcher's Signature: _____ Date: _____

If I have any questions about this research, I have been advised to contact the researcher and/or his/her supervisor, as listed on page one of this consent form.

Should I have any concerns about the way I have been treated or think that I have been harmed as a research participant, I may contact the following individual(s):

Chantelle Stewart Lam, MC, R.C.C., Program Director, City University of Seattle, at

XXXXXXXXXX

This study has been reviewed and has been approved by the Institutional Review Board (IRB) of City University of Seattle. If you have questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact the IRB at IRB@Cityu.edu.