Integrating Trauma-Informed Supervision into Psychiatric Rehabilitation in Times of Shared Traumatic Reality

COVID-19

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ABSTRACT

People with severe mental illness (SMI) are exposed to a greater degree of trauma than the general population. Accordingly, community mental health rehabilitation service providers may be affected by the ongoing exposure to traumatic experiences, and the aftermath, in the lives of their service users. The COVID-19 pandemic constitutes as a shared traumatic reality, bringing to light issues of personal security and traumatization among service users and providers alike. In this article, we propose to broaden and integrate the perspectives of community rehabilitation processes and the trauma-informed standpoint using a case study. Thus, we present an option of incorporating principles from trauma-informed supervision into recovery-oriented supervision during times of emergency and adversity. This integration might be beneficial in areas of function and experience for both service users and service providers. Moreover, recommendations for future research are discussed.

KEYWORDS

trauma-informed supervision, rehabilitation, case study, shared traumatic reality, recovery, COVID-19

People with severe mental illness (SMI) are at greater risk of experiencing trauma and symptoms related to trauma exposure, such as posttraumatic stress, than the general population (Mazor et al., 2016; Mueser et al., 2004; Neria et al., 2002). Some elements of psychiatric hospitalization as well as certain aspects of illness-related symptoms can also be perceived as extremely traumatic (Mazor et al., 2018; Mueser et al., 1998; Mueser et al., 2010).

Although coping with psychosis or other SMI does not necessarily meet the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association, 2013) definition of "traumatic experiences," and therefore is not considered a trigger for posttraumatic stress disorder (PTSD); various researchers argue that the experience of psychosis or coping with SMI may indeed be perceived as a traumatic experience, which can lead to the development of PTSD (Bendall et al., 2007; Berry et al., 2013). Even without a formal diagnosis of PTSD, the hardships and poor functioning resulting from posttraumatic stress symptoms are evident in people with SMI (Mazor et al., 2018; Mueser et al. 2010). Moreover, since the *DSM-5* does not include a diagnosis of "Complex PTSD," those who cope with childhood abuse and neglect often receive other mental health diagnoses such as "depression, panic disorder, bipolar illness, or borderline personality" (van der Kolk, 2014, p. 143). Subsequently, experiences of community mental health professionals include exposure to trauma and vicarious and secondary traumatization (Canfield, 2005).

The COVID-19 pandemic has recently impacted the personal sense of security of both mental health staff as well as service users (people with SMI) (Griffin, 2020; Horesh & Brown, 2020). In the words of Collin-Vézina and colleagues (2020, p. 177): "Never before has trauma informed care been so important to promote the health and well-being of all, and to protect our marginalized population at greatest risk." Furthermore, people with SMI constitute a marginalized population (Cook & Mueser, 2016; Sylvestre et al., 2018), which makes them a population at elevated risk of suffering from adversity and revictimization at times of social adversity in general and social isolation, such as in the COVID-19 pandemic (Vinson et al., 2020).

One way to address the pandemic is via the lenses of shared traumatic reality (STR) (Dekel & Baum, 2010). Hence, a situation in which both staff and service users experience a similar traumatic reality, however it affects the professional staff, must still treat the service users. Indeed, the COVID-19 pandemic impacts both staff and service users in similar manners in terms of lockdowns, social distancing, loneliness, sudden death, fear of infection, and the crumbling of past life assumptions regarding relationships, health, and safety (Ashcroft et al., 2021; Horesh & Brown, 2020; Pfefferbaum & North, 2020). During a crisis, supervision of mental health rehabilitation professionals might have significant impact on their ability to cope under such pressures. Thus, trauma-informed supervision in

mental health rehabilitation might be advised, when such supervision lies heavily on the principles of the recovery approach (Wong & Leung, 2020).

During a worldwide pandemic when STR is inherent in the field of community mental health (Kopelovich et al., 2021), the question arises as to which interventions provide adequate care and supervision. In this article, the authors aim to broaden the perspective of recovery processes toward trauma-informed practices and supervision in crisis through a theoretical review and an analysis of a case study. The analysis of the case study is based on Fallot and Harris's model of trauma informed care (Fallot & Harris, 2006; Harris & Fallot, 2001). This model contains five key components that are directed at both mental health providers and users in the services: (1) Safety—a sense of physical and emotional security; (2) Trustworthiness—clear boundaries and transparency; (3) Collaboration—shared power and influence; (4) Empowerment—emphasis on acquisition of skills; (5) Choice—control over the organizational experience. These are summarized in Table 1. We shall present these elements and the manners in which they can integrate with key components of recovery-oriented interventions and supervision in this article. Next, we wish to discuss the concepts of recovery-oriented supervision.

Recovery-Oriented Supervision

Recovery among people with SMI is a complex and multifaceted concept that includes both internal aspects such as hope, empowerment, and relationships as well as external elements such as a society that promotes recovery-oriented services (Compton et al., 2020; Jacobson & Greenley, 2001; Jordan et al., 2020). These services emphasize principles such as **shared decision making**, which refers to the process by which service providers and users view intervention options, exchange information and knowledge, and decide together on a course of action through mutual respect, open communication, and consideration of individual preferences and values (Ramon et al., 2017); **community inclusion**, which refers to supportive relationships with peers, family and friends, and participation in the community (Tew et al., 2012); **learning from lived experience**, which represents the acknowledgment of personal experience as a valuable form of information and incorporating it in interventions (Miller et al., 2020; Zolnierek, 2011); and **co-production**, which represents a particular form of partnership between service users and providers that relies on

Table 1: Five Key Components Reflected in Trauma-Informed Processes

Safety	Sense of both the physical and emotional **safety** and security of the service provider and service user, through the physical environment and security in interpersonal relationships. The importance of safety has also been recognized by van der Kolk, who claims that "safety and terror are incompatible. When we are terrified, nothing calms us down like the reassuring voice or the firm embrace of someone we trust" (2014, p. 210).
Trustworthiness	The organizational climate maintains clear boundaries alongside transparency in the processes among the service users and service providers, that is, **trustworthiness**.
Choice	The extent to which both service users as well as service providers have control over the services and the experience within those frameworks, that is, **choice**. This component is manifested in recovery-oriented rehabilitation principles such as shared decision-making (Zisman-Ilani et al., 2017) and co-production (Owens & Cribb, 2012).
Collaboration	**Collaboration** as manifested by the service's ability to share the power and the influence it has among staff (i.e., service providers) and service users. For example, co-production as a strategy that represents a particular partnership between service users and providers that relies on the premise that they share a common belief of what is valuable in interventions and overall outcomes (Owens & Cribb, 2012; Reith-Hall, 2020).
Empowerment	**Empowerment** that is reflected by the ability of the organization to recognize strengths and promote the acquisition of skills of service users and service providers.

the premise that they share a common belief of what is valuable in interventions and overall outcomes (Owens & Cribb, 2012; Reith-Hall, 2020).

Supervision is the foundation upon which the helping professions including psychiatric rehabilitation services are based on (Yerushalmi & Lysaker, 2014). Supervision has three main components: (a) administration, which responds to organizational demands and values of the supervisee; (b) learning, of new materials and mastery; and (c) support, which addresses the supervisee's emotional needs and improvement in work satisfaction (Kadushin, 1992; Kron & Yerushalmi, 2000).

Different approaches exist in recovery-oriented supervision: (a) the system approach of Holloway (1995) in which supervision is affected by four characteristics: the supervisor's, the supervisee's, the environment's, and the client's characteristics; (b) the Integrated Model of Supervision

for Rehabilitation Counseling (IMSRC—Schultz et al., 1999) that incorporates developmental and systematic models into a single model for recovery-oriented supervision. From the systematic perspective, this model emphasizes the interactions in the triangle of supervisors, service providers (i.e., supervises), and service users (i.e., people with SMI). From the developmental perspective, the model discuses three stages in the development of the supervisee (i.e., service provider): the technical stage (practicum or early career), the integrative stage (internship or middle stage career), and the consultation stage (postgraduation or advanced career stage) (Schultz, 2007; Schultz et al., 1999).

There is also (c), in which the third approach of supervision in mental health rehabilitation consists of three main principles: first, acknowledgment of the different facets of the supervisee, that is, listening to the supervisee's unique voice and empowering them in the training process, without expecting them to become more like the supervisor or other supervisees (Kron & Yerushalmi, 2000); second, the supervisor as a realistic figure that takes an active part within the supervision, that is, disposing of the omnipotent position and demonstrating vulnerability and authenticity (Lachman, 1998; Yerushalmi & Lysaker, 2014); and third, the supervisor as "not knowing," that is, inviting the supervisee to a mutual investigation of questions, values, and information (Kron & Yerushalmi, 2000). These principles align with the tenets and values of recovery (e.g., shared decision making, learning from lived experience, and co-production) and guide supervisors and their supervisees to avoid their tendency to "do for" instead of working to "do with" service users, and preventing the negative impact that interventions might have on the service users' sense of self-efficacy (Miller et al., 2020).

In addition, Sheff-Eisenberg and Walston (2011) suggested that recovery-oriented supervision in mental health rehabilitation has two main components: supervision regarding the program (i.e., aimed at specific goals and challenges within the program or organization/community) and clinical supervision that helps service providers develop within the organization while addressing the needs and growth of service users. To ensure that organizations stay focused on recovery-oriented principles and practices, services must implement recovery-oriented values at all organizational levels (Davidson, 2009). Thus, there are linkages between recovery-oriented rehabilitation and supervision that are continually interactive (Garber-Epstein et al., 2013).

Furthermore, as suggested by Yerushalmi and Lysaker (2014), the best way for supervisees to learn and internalize the principles of the recovery approach "is by means of role-model internalization and identification" (p. 60). In this manner, recovery-oriented supervision involves applying key principles of recovery models to the process of supervision. By doing so, the supervisees can internalize recovery principles by experiencing them themselves (Milman & Pitts, 2018; Yerushalmi & Lysaker, 2014).

Although empirical evidence regarding the efficacy of recovery-oriented supervision is scarce (Hamm et al., 2016; Slade et al., 2014), some research suggests the efficacy of recovery-oriented supervision for preventing burnout, for avoiding psychological exhaustion, and for enhancing job satisfaction (Abraham et al., 2021). Indeed, supervision has various elements that enable the supervisee (i.e., service provider) to manage personal and professional needs and to provide the best possible care for service users. Such supervision is especially important in times of worldwide crisis and adversity, and in these times, supervision could benefit from being trauma informed.

Shared Traumatic Reality (STR)

STR refers to a situation in which service providers are personally threatened or hurt by the same traumatic experience as their service users (Dekel & Baum, 2010). Thus far, studies examining this phenomenon explored the vulnerability and stress responses of both service providers and service users in emergencies at times of trauma and referred to these experiences as "shared tragedy" or "shared reality" (Eidleson et al., 2003; Kretsch et al., 1997; Lev-Wiesel et al., 2009).

Moreover, according to Dekel and Baum (2010), other researchers whose work gives credence to STR theory, also examined service providers' professional coping in situations in which they were exposed to similar traumatic events as their service users (Adams et al., 2006; Boscarino et al., 2004). However, these researchers did not explicitly use the term STR, because they did not relate in their work to this unique aspect and were interested in service providers' compassion fatigue and emotional burnout (Dekel & Baum, 2010).

Studies suggest that STR has negative implications for caregiving, such as a decreased sense of professional efficacy and mental stress (Baum, 2004; Boulanger, 2013; Nuttman-Shwartz & Dekel, 2009). However, along with the negative aspects of STR, some positive elements can arise such as

growth, flexibility, an increase in the sense of meaning, efficacy, and resilience (Nuttman-Shwartz, 2015; Tosone et al., 2012). In such adverse times, training and consultation processes among professionals may produce a meaningful change in their ability to cope with the emerging stress in STR, that is, trauma-informed supervision (Baum, 2012).

Trauma-Informed Supervision

The trauma-informed supervision model stems from the ecological systems model of Bronfenbrenner (1979) that aims to understand human development in the context of trauma. Hence, trauma-informed supervision refers to a person's entire life systems and traumatic experiences, alongside a broad understanding of strengths, services, support systems, etc. (Jordan, 2016). Such supervision will be empathetic to several components in both the supervisee's (i.e., service provider) and the service user's lives, that is, demographic aspects, pre-disposition, traumatic background, and supportive factors (Substance Abuse and Mental Health Services Administration, 2014; Wolf et al., 2014). Thus, the trauma-informed supervisor must acknowledge the supervisee's life experience, the impact of traumatic exposure, the management of traumatic case load, and the reference to vicarious and secondary trauma (Berger & Quiros, 2014; Choi et al., 2009).

There are several definitions of trauma-informed supervision and care. Berger and Quiros (2016, p.145) claim that trauma-informed supervision aims to improve knowledge, awareness, and the skills set of the service provider, in their understanding of the complexities, dynamics, and potential behaviors of service users who experienced trauma. In addition, safety, trustworthiness, cooperation, empowerment, and choice must also exist as key elements in trauma-informed supervision (Fallot & Harris, 2009; Shulman, 2010). Furthermore, teaching about traumatic triggers and fragmentation, and the meaning of relationships for people who were harmed by their relationships (Gur, 2019; van der Kolk, 2014), should also be part of such supervision. The trauma-informed working model by Fallot and Harris (2006; Harris & Fallot, 2001) contains five key components that are reflected in trauma-informed processes: (1) Sense of both the physical and emotional **safety** and security of the service provider and service user, through the physical environment and security in interpersonal relationships. The importance of safety has also been recognized by van der Kolk, who claims that "safety and terror are incompatible. When we are terrified,

nothing calms us down like the reassuring voice or the firm embrace of someone we trust" (2014, p. 210); (2) The organizational climate maintains clear boundaries alongside transparency in the processes among the service users and service providers, that is, **trustworthiness**; (3) The extent to which both service users as well as service providers have control over the services and the experience within those frameworks, that is, **choice**. This component is manifested in recovery-oriented rehabilitation principles such as shared decision-making (Zisman-Ilani et al., 2017) and co-production (Owens & Cribb, 2012); (4) **Collaboration** as manifested by the service's ability to share the power and the influence it has among staff (i.e., service providers) and service users. For example, co-production as a strategy that represents a particular partnership between service users and providers that relies on the premise that they share a common belief of what is valuable in interventions and overall outcomes (Owens & Cribb, 2012; Reith-Hall, 2020); lastly, (5) **Empowerment** reflected by the ability of the organization to recognize strengths and promote the acquisition of skills of service users and service providers.

Trauma-informed supervision integrates knowledge about trauma and supervision and focuses on the characteristics of the interrelationship between the trauma, the supervisee (i.e., service provider), the helping relationship, and the context in which the work is done (Berger & Quiros, 2016; Etherington, 2009). Additional components of trauma-informed supervision include trauma awareness, emphasis on service users' opportunities to restore control, recovery as a primary goal, reduction of retraumatization, cultural sensitivity, and using a strengths-based approach (Bateman et al., 2013; Elliott et al., 2005; Hopper et al., 2010).

Multiple studies claim that trauma-informed supervision is highly effective in diminishing the negative consequences of working with people with traumatic backgrounds (e.g., compassion fatigue, secondary trauma, and exhaustion) (Berger & Quiros, 2016; Courtois, 2018; Jordan, 2018; Joubert et al., 2013; Knight, 2013; Pack, 2014). Such supervision was also found to promote positive consequences such as the process of meaning making, growth, resilience, coping, and self-efficacy in service users and service providers (Hernández et al., 2010; Jordan, 2018). Indeed, Berger and Quiros (2014) posed that trauma-informed supervision should be mandatory in helping professions since it has been recognized as a significant protective factor because it acts as a buffer against vicarious trauma.

Although traumatic experiences are common in people with SMI (Grubaugh et al., 2011) and may evoke adverse emotional, cognitive, and physical reactions in their providers (Halevi & Idisis, 2018), there is a need to promote the implementation of trauma-informed supervision in mental health rehabilitation settings (Veach & Shilling, 2018).

We propose an integrated working model of trauma-informed supervision and recovery-oriented supervision. The following case study illustrates the five elements of trauma-informed care (Fallot & Harris, 2009) as part of trauma-informed supervision in a recovery-oriented organization during the COVID-19 pandemic. The case study is an example of the work carried out with recipients of the Israeli academic support service for students coping with SMI. This supported-education service is part of the Israeli community's rehabilitation "Basket of Services" for people with SMI and provided by the Israeli Ministry of Health through "Nathan" company (Shor, 2017). Supported education services provide individualized and practical aid to help students with SMI, who were accepted to academic studies due to their individual capabilities, achieve their educational goals (Soydan, 2004). In Israel, the service is provided through the assistance of professional rehabilitation coordinators who are a part of the academic support centers in all academic institutions. In addition, some of the students who take part in the program receive peer-support mentoring (Hartley, 2010).

Case Study

Trauma-Informed and Recovery-Oriented Supervision in Mental Health Rehabilitation

Karen[1] is a 20+-year-old master of arts student of humanities studies, highly motivated to excel. She was diagnosed with borderline personality disorder and fibromyalgia and has a history of sexual abuse by her father and other family members. Since the beginning of the academic year, Karen took part in meetings with Maria, an MA-level social worker who works as a supported-education coordinator at the university.

Even though peer-support can be a central tool in the delivery of trauma-informed care, through reducing power dynamics and emphasizing reconnection (Blanch et al., 2012), from the very beginning, Karen clarified to Maria that she does not want a mentor to be assigned to her due to the fact that she "does not have the time or the required resources

to handle another relationship." Moreover, Karen made it clear to Maria that she does not want to share any of her experience in the mental health office with anyone from the student support center in the Dean of Students Office, since she was afraid of discrimination.

Considering this, the only support Karen received in her studies before the outburst of the COVID-19 pandemic was through her biweekly meetings with Maria. These hour-long meetings took place in Maria's office at the university. During this time, they worked on achieving the goals set in the rehabilitation program they built at the beginning of their relationship. To do so, they discussed issues concerning academic and social gaps as well as task prioritizing and time management skills in their meetings.

In the second semester of Karen's studies, the COVID-19 pandemic began, and university courses became online classes. Karen immediately had difficulties in participating in the online courses and specifically opening her camera during classes. In addition, Karen began suffering from panic attacks, trouble sleeping, night terrors, acute pain attacks, and elevated levels of dissociation and erratic eating, specifically on days of online classes. Although Karen attempted to ask her professor to keep her online camera closed, the professors declined. During the online sessions with Maria, the supported-education coordinator, Maria also demanded that Karen keep her camera on. Karen responded to Maria: *"I don't know what the problem with all of you is . . . you're all abusing me; you'll make me drop out."* In response to Karen's difficulties, Maria brought the subject to supervision.

Coordinators in the academic support service receive both group and individual supervision. The individual supervision setting is one and a half hours every two weeks and is provided by one of the service directors at the coordinator's office at the academic institution. In addition, once a month the service coordinators gather for group supervision that is provided by an external supervisor with an extensive background in recovery-oriented rehabilitation. Here, we will focus only on individual supervision aspects. As mentioned, Maria receives supervision from a director in the academic supported-education service, a PhD-level clinical social worker who is an expert in trauma, resilience, and mental health rehabilitation (Ezra, the first author). During the COVID-19 outburst, most supervision meetings were held online, and face-to-face supervisions occurred when possible (every two months for a period of a little over a year). During supervision Maria and her supervisor discussed Karen's reactions to the

demand to open the online camera in the context of traumatic triggers that possibly reactivated emotional, behavioral, physical, and cognitive defense patterns. Encouraged by the supervisor to investigate her emotional response to her relationship with Karen, Maria expressed both her feelings of anxiety and anger toward Karen, as well as her observations of Karen's reactions based on trauma-informed and recovery-oriented approaches. Maria recognized that Karen might have created a "split," putting Maria and the other academic authorities as one "bad" entity that should be destroyed or ignored, to protect herself from any harm. Considering trauma-informed approaches, the supervisor and Maria discussed the relationship patterns of sexual trauma survivors and the use of once-protective defense mechanisms that have turned into less-adaptive mechanisms in some situations. During supervision, Maria also learned about triggers, normal reactions to once abnormal situations, and the transference and countertransference that occurred between her and Karen started to unfold.

In addition, the supervisor used two main techniques to allow Maria to identify her own experience regarding the hardships she encountered in the attempts to balance work and home during lockdowns. The first is relational analysis (Rasmussen & Mishna, 2018) of the transference patterns that emerged in the supervision, and the second is the use of self-disclosure by the supervisor regarding his own lived experience (Zolnierek, 2011) in coping with the challenges caused by the pandemic. At this point, Maria reported elevated levels of anxiety and apprehension regarding the possibility that her older parents might get infected with the virus. She also described an overwhelming sense of uncertainty regarding her husband's professional future, after he was coerced to take an unpaid leave from his job, and a general sense of mistrust and suspicion toward others, after hearing about a kindergarten teacher that infected the kids she was responsible for. Thus, through the supervisor's self-disclosure of his own professional and personal difficulties during the pandemic, the shared lived experience of both coordinator and student became known through similar emotions of frustration, helplessness, blame, and shame. Moreover, the feelings of confusion regarding both the student's as well as coordinator's boundaries between work and home (in the coordinator's case) or school and home (in the student's case) were elucidated.

In the following supervision sessions, through a psycho-educational process, the supervisor and Maria observed both Maria's as well as Kar-

en's reactions and needs through the lenses of the five elements of trauma-informed care (Fallot & Harris, 2006):

1. **Safety:** the experience of Karen, the student, regarding the online learning and supportive-education sessions, specifically regarding opening the camera, was characterized with feelings of penetration of physical and emotional privacy and lack of security. Unknowingly, both Maria as well as the academy evoked a trigger within Karen that led to acute stress symptoms. Maria, the coordinator, was able to relate to Karen's feelings through her own experience of privacy loss during the pandemic, and thus enabled her to validate Karen's feelings in their following sessions. Also, Maria's validation of Karen's feelings enabled a renewed discussion of their recovery-contract specifically during the COVID-19 pandemic.
2. **Trustworthiness:** Karen's triggers were evoked considering Maria's and the academy's lack of awareness of the context of power and authority in Karen's traumatic past. Once Maria validated Karen's experiences and feelings, there was an opportunity to reconstruct their broken trust through discourse and the promotion of shared decision making. In addition, Maria's own firsthand experiences during the pandemic enhanced her empathy toward Karen's, thus further promoting their co-production and trust alliance.
3. **Collaboration:** Karen's experience in the academy as well as with Maria was that the demands made were unjustified, impersonal, and sudden, and thus she was left unable to be part of the decision making (i.e., a major trigger considering her traumatic past). Following Maria's supervision, the next session with Karen entailed a thorough and open discussion regarding the alternatives available to Karen in the current reality, thus enhancing collaboration and trust.
4. **Empowerment:** Following supervision, Maria offered to mediate between Karen and the dean of students support center and to enable flexibility in the supported-education sessions (i.e., to conduct sessions with no camera). These suggestions helped Karen feel that she had the power and voice to impact both the setting of sessions with Maria as well as the settings of online learning in various

courses. Karen and Maria's next session was conducted online but with the camera off, and the conversation with the dean of students support center resulted in an agreement for Karen to leave the camera off during her online courses. Karen later told Maria that she felt respected and in control of her life, and her fear of stigma decreased following their conversation.

5. **Choice:** Karen told Maria that she felt she had no influence on her education settings during the pandemic. After the supervision sessions, Maria was able to show Karen that she indeed chose to continue studying even during such challenging times and reinforced her feelings of meaning and efficacy in her choices. In addition, Maria's willingness to allow Karen to attend their sessions with the camera closed, and to choose the timing and manner of approaching the dean of students support center, helped with the feelings of free choice and control, that Karen felt were critically harmed in prior sessions since the beginning of the COVID-19 pandemic.

In conclusion, by emphasizing the mentioned trauma-informed elements within a recovery-oriented supervision, the supervisor encouraged Maria to assist Karen in grounding and controlling her responses to the online learning conditions caused by the COVID-19 pandemic. Moreover, through role-model internalization and identification processes and psychoeducation regarding the long-term effects of childhood trauma on survivors, Maria was able to assist Karen in establishing a "sense of agency" (van der Kolk, 2014) and feel more in charge of her life and her reactions to changes forced on her by the pandemic.

Summary and Future Recommendations

The purpose of this article is to present the potential of trauma-informed supervision in community mental health rehabilitation services. We briefly reviewed the rationale and background for the use of trauma-informed supervision in the field of psychiatric rehabilitation with an emphasis on the period of the COVID-19 pandemic as a shared traumatic reality. Through a case study, we presented the possibility of integrating trauma-informed supervision components into recovery-based supervision, possibly enabling improvement of the function and experience of both service users and service providers.

Since the COVID-19 pandemic continues to reappear—even at the time of authoring this article, we are at the beginning of a fifth "wave" of COVID-19 in Israel and worldwide—feelings of uncontrollability, uncertainty, stress, and trauma keep reoccurring both in the general population and among people with SMI. Thus, we recommend further studies to be conducted regarding the dimensions of trauma-informed supervision in psychiatric rehabilitation and recovery processes, both in routine and emergency situations. Moreover, quantitative studies are advised to measure and evaluate this integration and test its effectiveness in valid and reliable quality assessments.

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NOTE

1. All details and life events of the participants in the current case study have been changed to avoid identification.

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