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The Doctorate Program in Clinical Psychology

Illinois School of Professional Psychology
at National Louis University

CERTIFICATE OF APPROVAL

Clinical Research Project

This is to certify that the Clinical Research Project of

Madeleine R. Lane

has been approved by the CRP
Committee on

July 12, 2024

as satisfactory for the CRP requirement
for the Doctorate of Psychology degree
with a major in Clinical Psychology

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Exploring Psychology Graduate Students' Desire and Ability to Discuss Their Personal Trauma History With Clinical Supervisors

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A Clinical Research Project submitted to the faculty of The Illinois School of Professional Psychology at National Louis University in partial fulfillment of the requirements for the degree of Doctor of Psychology in Clinical Psychology.

Chicago, Illinois
April, 2024

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Dedication

Dedicated to my husband, Tucker Lane, for loving and supporting me through all the ups and downs (and sideways and diagonals) of my grad school experience, and of life in general. I could never have done it without you.

To my amazing parents, Lisa Orgren and Kirk Streb, for the unconditional love, wisdom, and help you've given me throughout my life. You truly are the best parents anyone could ask for.

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> For your kindness, I'm in debt to you
> And I never could have come this far without you
> For everything you've done
> You know I'm bound
> I'm bound to thank you for it.

– Natalie Merchant, 1998

Abstract

Inspired by the archetype of the "wounded healer," described by Carl Jung as a psychologist who enters the field with psychological wounds of their own, and the prevalence of such wounded healers in the mental health field today, this study aimed to explore clinical psychology doctoral students' experiences of self-disclosure of their personal trauma history, a specific type of psychological wound, in clinical supervision. The goal was to explore whether and how students' trauma history is discussed in clinical supervision; the importance of such discussions for students' professional and personal development; and the impact of having or not having these conversations on their well-being, professional identity, and clinical competence. Using a hermeneutic phenomenological approach, seven participants were interviewed regarding their personal thoughts and experiences related to discussing their personal trauma history in clinical supervision. Findings indicate the students have a strong desire and placed a high level of importance on self-disclosure of trauma history to the extent that it affected their mental health and their clinical work, and that such disclosures are an important aspect of improving their clinical competence and reducing burnout. Despite this desire, findings indicate the presence of significant barriers to discussing personal trauma history within clinical supervision, including perceived stigma, the strength (or lack thereof) of the supervisory relationship, structural factors, and personal or cultural identity factors. The study highlights the need for a supportive environment in which supervisees can safely explore the impact of their psychological wounds on their clinical work as part of their clinical training and better guidelines for both supervisors and supervisees on when and how trauma history should be explored in clinical supervision.

Chapter 1: Introduction

The term "wounded healer," described as a mental health professional with a history of personal suffering, was first coined by Carl Jung in the 1950s. Jung believed a healer's wounds can both burden them and motivate them to heal the wounds of others (Jung, 1966, 1989). The concept, however, long predates Jung, who was himself inspired by wounded healers who have existed across cultures beginning at least as far back as ancient Greece and repeating throughout history and myth (Benziman et al., 2012; Jung, 1989). Since Jung introduced this idea to psychology, research has shown up to 82 % (Victor et al., 2022) of applied psychologists have experienced adversity, trauma, serious mental health struggles or diagnoses, and even negative interactions with mental healthcare systems (Adame, 2011; Bond, 2020; Brown et al., 2022; Cvetovac & Adame, 2017; Mackay, 2019) referred to in this study as psychological wounds, with around 46% (Victor et al., 2022) meeting criteria for a mental health diagnosis. In fact, for many, these experiences served as a motivation to enter the field (M. Barnett, 2007; B. A. Farber et al., 2005; S. K. Farber, 2017; Hankir & Zaman, 2013; Sawyer, 2011). Many of these wounded healers have found that, with appropriate training and self-reflection, their history of psychological wounds can improve their clinical skills. Wounded healers report their own experiences can make them more aware of the power differentials inherent in mental health treatment, more empathetic to their clients' experiences, genuinely faithful in clients' ability to change, and hopeful for their clients' future (Adame, 2011; Cvetovac & Adame, 2017; Gilbert & Stickley, 2012; Mackay, 2019; White, 2000b).

Despite the potential utility of a healer's psychological wounds and the noted importance of addressing these wounds as part of professional competence, many professionals find it challenging to self-disclose psychological wounds in work environments due to the stigma

within the field (Cvetovac & Adame, 2017; Hankir & Zaman, 2013; Mackay, 2019; Pachankis, 2007; Sawyer, 2011; Zerubavel & Wright, 2012). Although mental health professionals are often less stigmatizing toward members of the public with psychological wounds compared to others, they are frequently more in line with the prevalent stigmatizing views when it comes to other mental health professionals (King et al., 2020). This could be because mental health professionals tend to hold each other to a standard of perfection that is not expected from those outside the profession; thus, they may view other psychologists as incompetent due to having psychological wounds (King et al., 2020).

Regardless of their hesitance to self-disclose, mental health professionals' psychological wounds inevitably overlap with their professional practice at times (Adame, 2011; Cvetovac & Adame, 2017; Zerubavel & Wright, 2012). If not appropriately handled, this overlap has the potential to lead to adverse outcomes for both the professional and their clients, making it an important topic to discuss in supervision (M. Barnett, 2007; Brown et al., 2022; B. A. Farber et al., 2005; Leung et al., 2023; Pachankis, 2007; Zerubavel & Wright, 2012).Though it is not appropriate for a supervisor to act as their supervisee's therapist, there will nonetheless be times in clinical supervision when the supervisee's psychological wounds affect their work. It is therefore vital that supervisors are ready and able to handle these situations (American Psychological Association [APA], 2014, 2017; St. Arnaud, 2017).

Providing clinical supervision is the eighth of nine profession-wide competencies identified by the APA (2015a, 2015b) and expected of all APA-accredited program graduates. Supervisors must act as professional role models, teachers, and gatekeepers to the profession of psychology to ensure their supervisees are competent in all nine profession-wide competencies. This includes adhering to the APA's (2017) *Ethical Principles of Psychologists and Code of*

Conduct, ensuring their program meets the APA's *Standards of Accreditation for Programs in Health Service Psychology* (APA, 2015a) and following the APA *Guidelines for Clinical Supervision in Health Service Psychology* (APA, 2014). It also requires that supervisees feel comfortable self-disclosing with their supervisors, which is part of the fourth identified profession-wide competency—professional values and attitudes. More specifically, as part of competent reflective practice, which includes engaging in self-reflection, self-care and participating in the supervision process (APA, 2015b). Supervisee self-disclosure is one of the primary ways through which professional development occurs in professional psychology training (J. E. Barnett & Molzen, 2014; Kozlowski et al., 2014; Staples-Bradley et al., 2019; St. Arnaud, 2017). Not only is it a crucial part of profession-wide competency, but it also facilitates the honing of supervisees' clinical judgement and application of interventions (J. E. Barnett & Molzen, 2014; Staples-Bradley et al., 2019).

The main factor influencing supervisees' comfort with self-disclosing is the strength of the supervisory working alliance, which refers to the nature and strength of the rapport between supervisee and supervisor (Gibson et al., 2019; Hutman & Ellis, 2020; Mackay, 2019; Mehr et al., 2015; Sawyer, 2011). A strong working alliance has been shown to result in higher supervisee self-disclosure and weaker alliances have been shown to be more likely resulting in nondisclosure (Gibson et al., 2019; Hutman & Ellis, 2020; Mehr et al., 2015). What is less clear are what factors go into creating a strong supervisory working alliance, although it appears the supervisor's own modeling of appropriate self-disclosure, perceived level of cultural competence, and willingness to be flexible with boundaries all strengthen the alliance and may lead to increased comfort with disclosure (Drinane et al., 2021; Guttman, 2020; Li et al., 2022; Pakdaman et al., 2015).

The Wounded Healer

The term "wounded healer" was officially introduced to the field of psychology in the 1960s when Carl Jung, a wounded healer in his own right, coined the term. In his autobiography *Memories, Dreams, Reflections*, Jung (1989) started by detailing multiple experiences of trauma, illness, isolation, and anxiety beginning in childhood. He went on to reflect on his training in medicine and coming to the realization that a "doctor is effective only when he himself is affected. Only the wounded physician heals" (p. 162). During his career, Jung argued that for a psychologist, "it is his own hurt that gives the measure of his power to heal" (p. 116), and that psychologists may learn from and use their own wounds much like characters from myth and history did in medicine (Jung, 1966, 1989).

It was those characters who initially inspired Jung (1989), who found solace from his own suffering in the tales of wounded healers that have existed in history, mythology, legends, and cultures, across various fields including religion, medicine, philosophy, and psychology. Jung was particularly inspired by the Greek myth of Chiron (Jung, 1966). In their article describing the history of the wounded healer across culture and history, Benziman et al. (2012) described the Greek myth. The centaur Chiron was horribly wounded but unable to die. Chiron could not heal his own injury but dedicated himself to healing others despite great personal suffering. Though not a martyr, he neither welcomed nor embraced his pain; he continued to teach medicine and heal others with kindness. His compassion was ultimately rewarded by Zeus, who gave him a place in the stars as Sagittarius. This archetype, the wounded healer who, through healing others is healed themselves, repeats throughout history, both in fact and fiction. Examples can be found in Arthurian legend, Hebrew lore, the teachings of Laotzu in China,

Babylonian myths, an Indian goddess, Islamic teachings, Shamanism, African Xhosa & Ngoma cultural practices, and even modern fiction (Benziman et al., 2012).

Benziman et al. (2012) also explored how a healer's wounds may be seen as necessary to their competence and capability as a healer. For example, even today, in Shamanism, experiencing illness is considered a prerequisite and indicates spirits chose the person for the position. Shamanic healers must go through a prolonged period of intentional physical and psychological illness as part of their initiation. The illness and its eventual healing are thought to prove the shaman has been chosen by spirits, and their power is thought to come from their ability to bridge the worlds of illness and wellness. Similarly, in traditional African Xhosa culture, the experience of physical suffering, or *Thwasa*, is a rite of passage to become a healer, or *igqira*. In these cultures, illness is thought to be how ancestors communicate with the person; therefore, part of the initiation includes induced states of physical and emotional distress. The ability to enter this state and return indicates the ancestors prefer the individual. The Ngoma in Swaziland conduct similar rituals as part of the initiation for their healers.

Benziman et al. (2012) specifically examined tales from three religions that each tell stories of a wounded healer. In the first, Islamic artist-turned-healer Abū Bakr Muhammad ibn Zakariyyāʾ al-Rāzī (c.865–930 AD) used his own blindness to inform groundbreaking scientific writings on the subject. Al-Rāzī went blind as a result of an eye disease for which he refused treatment from any physician other than himself. He often tested medications on himself before using them with clients, preferring to rely on his firsthand patient experience over trusting others.

The next example is a story told in the Talmud, a record of rabbinic discussions on Jewish law, ethics, customs, and history dating from 200–500 AD. The story is of Rabbi Johanan, a healer who fell ill but was unable to heal himself. Upon being healed by another Rabbi, Rabbi

Johanan's treatment style changed to be more sensitive and holistic. Rather than focusing solely on his clients' physical symptoms, he also began asking about their emotional well-being (Benziman et al., 2012).

In a more modern example, the Christian story Pollyanna, by Eleanor Porter, is a tale portraying a wounded healer through the character Pollyanna, a young girl who transforms her personal losses and physical pain into a source of hope and healing for others (Benziman et al., 2012). Her journey emphasizes the importance of acknowledging one's own vulnerabilities to foster empathy and mutual healing. Overall, Benziman et al. highlighted what Jung (1966) also noticed—healers' wounds have historically conferred both a level of authority and improved clinical skills upon those who have them.

In the first half of *Celebrating the Wounded Healer Psychotherapist*, S. K. Farber (2017) explored the history of wounded healers in psychology. In addition to discussing Carl Jung, she reflected on the beliefs of Alfred Adler, a contemporary of Jung, who had a long history of illness and also believed personal wounds could facilitate greater empathy and healing abilities. S. K. Farber also told the story of Alice Flaherty, a neurologist diagnosed with bipolar disorder who became a consultant at a hospital she once ben admitted to as a patient. She also reflected on the woundedness of famed trauma researcher Bessel van der Kolk who experienced the wounds of generational trauma and went on to conduct groundbreaking research in the field of trauma. Another example given was Marsha Linehan, who famously created Dialectal Behavioral Therapy (DBT), now a gold standard in the treatment of borderline personality disorder, after years of self-harm, suicidal ideation, and hospitalization. In the second half of her book, S. K. Farber shared her personal story of psychological wounding and its impact on her career, along with the first-person accounts of 10 other self-identified wounded healers who reflected on the

impact of their psychological wounds on their careers as psychotherapists. These stories further illustrate both the prevalence of wounded healers in the field and the impact a therapist's psychological wounds can have on their career.

Woundedness as Motivation to Enter the Mental Health Field

Woundedness not only serves as a marker of potential authority, it also serves as a motivation to enter helping professions. In fact, all 11 personal stories shared in S. K. Farber's (2017) book *Celebrating the Wounded Healer Psychotherapist*, including the author's own story, identified psychological wounds as a source of motivation to practice psychotherapy. For some it was a way of processing and healing their own wounds, whereas for others it was a way of understanding the psychological wounds left on their families by generations of trauma, and yet others found comfort in helping others as they themselves had once needed help. The literature discussed below supports these themes and the overall prominence of woundedness as a motivation for psychology training.

Through interviews with nine experienced therapists, M. Barnett (2007) uncovered two predominant motivations for entering the field: early losses and narcissistic needs. These findings align with the concept of the wounded healer and indicate personal trauma and unmet emotional needs likely influence at least some individuals' decisions to enter this field. M. Barnett emphasized the complex interplay between a therapist's personal history and their professional life and highlighted the importance of self-awareness and ongoing personal development to ensure clinical competence and the use of effective therapeutic practices. Although there was a small sample with limited generalizability, this study contributes to the body of evidence indicating psychologists are motivated by their own psychological wounds.

Similarly, inspired by their personal experiences, B. A. Farber et al. (2005) examined empirical and clinical literature exploring therapists' motivations for entering the field. Of the 12 common themes identified, five related to the concept of the wounded healer in some way. Related themes included having experienced cultural or social marginalization, painful childhood experiences, a need for self-growth and healing, a need for safe intimacy, and a history of engagement in personal therapy. These themes show that experiences of personal adversity and the resulting self-reflection and psychological awareness can inspire individuals to pursue a career in therapy. They may do so seeking self-understanding, desiring to help others, or because therapy relationships often offer safe but structured intimacy for both parties. Personal therapy was also highlighted as pivotal for many therapists, serving not only as a tool for personal healing but also as an inspiration to pursue the career themselves. This personal engagement with therapy and desire for self-growth also underscore the profession's introspective nature and highlight the interplay between therapists' personal and professional growth (B. A. Farber et al., 2005).

Two other therapists who explored their own personal stories as mental health service users also highlighted those experiences as motivations for entering the field. For Sawyer (2011), long before beginning her career, she knew it was her goal. However, after spending years in mental institutions and receiving multiple serious diagnoses, including schizophrenia, she had to overcome multiple barriers to ultimately obtain a degree and position in counseling. Her resolve never wavered; having experienced both positive and negative aspects of the field, she was determined to make her mark. Mackay (2019) had a similar journey, with her struggles beginning in childhood and resulting in hospitalizations and, ultimately, a diagnosis of bipolar disorder. Initially, Mackay entered the field as a peer counselor and found that by sharing her story, she

was able to help others while healing herself. This led her to pursue more formal training in counseling, and she also stated her personal experience helped her be a more compassionate and holistic therapist.

In her interviews with five survivor–therapists, Adame (2011) reported all five participants stated their motivation to reengage with the mental health system as providers was rooted in a desire to help others in the way they wished someone would have helped them. All of the participants indicated that having gone through their own psychological wounds and system involvement was foundational to their identity as mental health professionals. Adame argued that this indicates survivor–therapists fully believe mental health professionals serve an important function in society despite personally negative experiences in the mental healthcare system.

According to Adame (2011), survivor–therapists prioritize building genuine, understanding, empathetic relationships with clients and draw on personal experiences to guide therapeutic practices. She found survivor–therapists hope to lessen the "us vs. them" dichotomy between therapists and clients and to advocate for viewing psychological distress as part of the human experience, encouraging a more inclusive, less pathologizing approach to mental healthcare. Like shamans, survivor–therapists' dual identities offer valuable insight into the complexities of the ways in which wellness and illness can balance one another. Due to the small sample size, as only five survivor–therapists were interviewed, this study provides a good starting point but has limited generalizability and points to the need for further exploration of the topic.

The research discussed above indicates psychologists' own experiences of adversity and mental health difficulty often serve as a strong source of motivation for entering the field. This motivation for entering the field has existed for decades and has been reported among many

prominent clinicians. Beginning with Jung and Adler, carried on by Marsha Linehan with her creation of DBT, and continued by clinicians today, preexisting wounds have long been noted as motivations for entering the field of psychology and improving treatment options. Furthermore, these experiences may inform how clinicians interact with clients, colleagues, and the healthcare system overall. It appears based on the research discussed above that clinicians today continue to enter the field due, at least in part, to their personal histories of adverse experiences, psychological wounds, and stigma within healthcare systems (Adame, 2011; M. Barnett, 2007; B. A. Farber et al., 2005; Mackay, 2019; Sawyer, 2011).

Clinical Utility of a Healer's Wounds

The utility of a healer's wounds goes back as far as the concept of the wounded healer itself. In many ways, the two are intertwined, with the impaired professional, a clinician who actually does harm due to their wounds, standing out as the risk that occurs with the improper integration of a healer's wounds. The integration of wounded healers into mental health treatment started with recovering alcoholics. In the first half of his two-part essay series, White (2000a) examined the history of wounded healers as part of alcohol recovery programs. This began with the contributions of recovered individuals in Native American communities, where leaders who overcame their alcohol addictions played crucial roles in addressing alcohol-related issues within their tribes. This included using Native healing practices, lobbying for alcohol bans, and organizing temperance societies. In broader American society, recovered alcoholics became integral to the temperance movement, offering messages of hope and reform. They participated in movements such as The Washingtonian temperance movement, which marked a shift toward "experience sharing" and redefined alcoholics as people deserving of sympathy and

support. Alcoholics Anonymous (AA) is another example of a widespread and at least somewhat effective peer-led recovery program.

In the second part of his essay series, White (2000b) explored the role of professionalization and specialization within the field of addiction counseling. White focused on how individuals recovering from addictions began to assume paid helping roles within addiction treatment programs and highlighted the evolving role of recovered individuals as wounded healers within the addiction treatment landscape. White argued that from their initial roles in early treatment models to their professionalization and specialization, wounded healers have played a pivotal role in shaping the field of addiction treatment. Their psychological wounds, coupled with professional training and specialization, have enriched the therapeutic environment, and enable such individuals to offer unique insights and empathetic support to those navigating recovery. It therefore stands to reason that other types of personal experience, such as trauma history, could also provide valuable insight and enrichment when appropriately used (White, 2000b).

In a more recent study, Bond (2020) explored the impact of psychological wounds on the experiences of counselors working with trauma populations. Inspired by her own story, Bond interviewed six other therapists with childhood trauma histories and found counselors may be influenced by their own past experiences more than is generally acknowledged in the field. This extends to the methods they use in the therapy room, relationships with colleagues, relationships with clients, and beliefs about effective trauma treatment overall. Bond emphasized that the diversity of trauma narratives indicates a need for improved therapist training, self-care, and therapeutic strategies that are more adaptable and sensitive to the unique aspects of both therapists and clients with trauma histories. She also emphasized the importance of appropriate

self-reflection and personal healing before using psychological wounds as part of clinical practice. Because of the small sample size and unstructured nature of the research method used, Bond's findings offer an interesting starting point but have limited generalizability, indicating a need for further exploration of the topic.

Cvetovac and Adame (2017) conducted a qualitative analysis of 11 first-person narratives written by 10 different therapists who self-identified as having psychological wounds that revealed a complex interplay between personal trauma and professional practice. Their analysis uncovered four primary themes: the intersection of personal and professional experiences, tension between hiding and disclosing wounds, ways in which a therapist's wounds can hinder clinical practice, and the journey toward self-acceptance.

These themes highlighted that while therapists' psychological wounds can facilitate a deep empathic connection with clients, they can also pose significant challenges, especially when those experiences are unresolved or acutely distressing (Cvetovac & Adame, 2017). The perceived need to conceal their psychological wounds from colleagues and supervisors underscores the persistent stigma within the mental health profession regarding therapists' own mental health issues. However, the desire for authenticity and the potential therapeutic value of self-disclosure also emerged as important considerations, highlighting the complex nature of such disclosures in professional settings. Cvetovac and Adame (2017) argued for greater acceptance of therapists' psychological wounds and recognition that these experiences, when integrated appropriately, can deepen the therapeutic connection and foster healing in both therapists and clients.

Newcomb et al. (2015) found similar themes in their review of the literature regarding the experience of wounded healers. On the one hand, their personal understanding of distress and

suffering can foster profound connections with clients and facilitate client healing. On the other hand, the potential for countertransference and the heightened risk of vicarious trauma and burnout necessitates careful consideration and additional support for those mental health professionals who identify as wounded healers. Another review of 125 studies by Conchar and Repper (2014) reached a similar conclusion, finding that while there is a compelling argument for the therapeutic potential of personal suffering, it is also crucial to acknowledge the complexities and challenges inherent in integrating psychological wounds into professional practice. Further, they found self-reflection and support are needed within the field for mental health professionals with psychological wounds to attain and retain competence (Conchar & Repper, 2014).

Gilbert and Stickley (2012) found similar results in their qualitative survey of 30 mental health students' perceptions of the impact of their own psychological wounds on their future professional roles. Findings showed there was a strong belief among the students that their psychological wounds would not only inform their practice but also enhance their ability to empathize with clients within the boundaries of a professional relationship. Despite the optimistic view held by many mental health students, the authors discussed the challenges and dilemmas related to the disclosure of mental health problems within professional settings. They emphasized the need for supportive training environments that encourage honesty and openness about mental health issues among professionals without the risk of stigma or discrimination.

As part of her personal narrative, discussed above, Mackay (2019) created a list of strengths and challenges faced by self-reported "wounded healers" in mental health professions. The five unnamed wounded healers Mackay collaborated with identified their strengths as deeper empathic connections with clients, insight into experiencing distress, increased capacity for

holding hope, ability to empower clients, and belief in the client and in the recovery process, all of which speak to the potential clinical utility of psychological wounds. Mackay also directly discussed how her personal experiences in therapy influenced her practice and led to her focusing on holistic treatment, client empowerment and self-determination, and fostering safe, trusting relationships in which clients can feel heard and understood. Overall, Mackay argued that having experienced one's own psychological wounds increases the capacity for both personal reflection and awareness along with a deeper empathetic connection to clients.

Sawyer (2011) also stated in her narrative that as someone who had herself been a client and had adverse experiences in the system, she was highly aware of the power of a diagnosis and, therefore, the power those giving a diagnosis hold. She also felt her experiences gave her a better understanding of her clients' experiences, the importance of the therapeutic alliance, and the therapy process itself.

Similarly inspired by his own experience, primary author Dr. Hankir (Hankir & Zaman, 2013) explored his choice to pursue a career in psychiatry following negative experiences as a client experiencing mania. With the help of his supervisor and editor, Dr. Zaman, Dr. Hankir reflected on how his own experiences as a client struggling with bipolar mania gave him a better understanding of how important it is for healthcare professionals to seek help when needed. As a result of his own experiences and research indicating increased rates of depression, substance use, and suicide among medical professionals, Dr. Hankir has worked to reduce stigma toward psychological wounds and help-seeking in the healthcare field. Dr. Hankir argued that with personal experience, healthcare professionals can cultivate a more profound sense of empathy for their patients, advocate for more compassionate care, and contribute to de-stigmatizing psychological wounds within the medical profession.

Overall, research on the clinical utility of a therapist's wounds highlights the importance of recognizing the distinctive contributions and needs of students who have experienced adversity. When properly addressed, a therapist's psychological wounds can be a powerful tool for client progress. However, if ignored or mishandled, they run the risk of becoming problematic for both the therapist and their clients. It is therefore crucial that supervisors be ready and willing to assist supervisees in navigating how their psychological wounds influence their work with clients, how they can differentiate between their own and their clients' experiences, and how to appropriately use countertransference and self-disclosure as tools for client empowerment (Conchar & Repper, 2014; Cvetovac & Adame, 2017; Hankir & Zaman, 2013; Mackay, 2019; Newcomb et al., 2015; Sawyer, 2011; White, 2000a, 2000b).

Trauma and Burnout

Burnout is a risk in applied psychology fields (McCormack et al., 2018). In their systematic review of 29 peer-reviewed studies assessing burnout specifically among applied psychologists, McCormack et al. found emotional exhaustion in particular is highly prevalent among applied psychologists. Factors contributing to this burnout included those related to the work setting and those related to the psychologists' personal characteristics.

Work-related factors that contributed to burnout included high administrative workload, perceived time pressure, lack of autonomy, and high acuity clients. Personal characteristics that contributed to burnout included younger age, overinvolvement in client relationships, and limited external support resources. Results on the impact of gender differences were mixed, with some settings having higher rates of burnout among women, such as military settings, while others showed differences in the way burnout was expressed, as cynicism in men and emotional exhaustion in women, but not actual rate of burnout itself. Overall, this study highlighted the

prevalence of burnout among all applied psychologists regardless of their history of psychological wounds (McCormack et al., 2018).

Brown et al. (2022) explored the impact of adverse childhood experiences (ACEs), which are form of psychological wound, measured using the Adverse Childhood Experiences Study Questionnaire, and positive childhood experiences (PCEs), measured using the Positive Childhood Experiences Questionnaire, on the professional quality of life of 140 mental health counselors, measured using the Professional Quality of Life Scale. They employed a cross-sectional, non-experimental, correlational design and analyzed data using multiple regression models. Brown et al. observed significant relationships among the mental health counselors' rates of adverse childhood experiences, positive childhood experiences, and levels of compassion satisfaction and burnout. Higher ACE scores were associated with higher burnout rates and lower compassion satisfaction, while higher PCE scores were negatively related to burnout but were not significantly related to compassion satisfaction. Although not its initial purpose, the study also highlighted the prevalence of ACEs among mental health counselors, with over 42% of the participants reporting four or more ACEs, a known risk factor for adverse mental and physical health outcomes.

In addition to ACE scores, Brown et al. (2022) examined demographic factors such as gender, race/ethnicity, and childhood socioeconomic status as potential predictors of compassion satisfaction, burnout, and secondary traumatic stress. Interestingly, being female, belonging to a minority group, and having a lower childhood socioeconomic status were all associated with higher compassion satisfaction. These findings highlight the importance of adequately addressing and managing the mental health of mental health professionals, both due to the known impact of

adverse experiences on mental health and the high number of professionals reporting a history of ACEs.

Leung et al. (2023) also explored the impact of having psychological wounds on experiencing vicarious trauma, secondary traumatic stress, and burnout as a mental health professional. In their systematic review of 39 studies, they examined the relationships among personal trauma histories in mental health workers and secondary traumatic stress, vicarious trauma, and burnout. Their review revealed clear associations between psychological wounds and increased levels of secondary traumatic stress and vicarious trauma but no significant findings regarding burnout.

These findings indicate psychological wounds are a relevant factor in understanding the susceptibility of mental health workers to both secondary traumatic stress and vicarious trauma and highlight the need for supportive measures to mitigate the risks of secondary traumatic stress and vicarious trauma and enhance resilience among mental health professionals with personal trauma histories. However, a lack of diversity in the reviewed study designs and their tendency to put all trauma survivors into a homogenous group despite the diversity in trauma experiences call for more nuanced research into the impact of psychological wounds on mental health professionals' well-being and professional effectiveness (Leung et al., 2023).

In Mackay's (2019) article discussed above, Mackay and her collaborators identified vicarious trauma and vulnerability to relapse as potential challenges faced by wounded healers. Furthermore, during their discussion, many of her collaborators reflected on the importance of ongoing self-reflection and self-care, including recognizing the need for time off and requesting high-quality supervision as crucial in maintaining competence as a wounded healer. This is in line with Jung's (1989) assertion that "the psychotherapist must understand not only the patient;

it is equally important that he should understand himself. Only if the doctor knows how to cope with his own problems will he be able to teach the patient to do the same" (p. 160).

Overall, it is clear that though psychological wounds may have the potential to inform treatment and increase provider compassion, they are also a risk factor for negative professional outcomes if ignored or mishandled. As indicated by the studies discussed in this section, it is clear that a significant number of mental health professionals have their own histories of adversity. It is also evident that these histories have the potential to cause harm to both the professionals and their clients. Therefore, as part of maintaining professional competence and in order to adhere to the *Ethical Principles of Psychologists and Code of Conduct* (APA, 2017), it is necessary that wounded healers are able to recognize the signs of burnout and have the support to care for themselves when and how they need it. Although personal therapy, both before and during professional practice, plays a role in this ability to recognize and prevent burnout, supervisory support is also a factor in preventing negative consequences (Brown et al., 2022; Leung et al., 2023; Mackay, 2019; McCormack et al., 2018).

The Impaired Professional

Of the potential negative consequences, the most concerning is the potential for burnout to become professional impairment, defined by Smith and Moss (2009) as a decline in professional functioning due to personal issues such as substance abuse, depression, or burnout, that negatively affects patient care. Although their review indicated distress does not necessarily impair professional functioning, it may act as a precursor to impairment, which, in turn, directly compromises professional responsibilities (Smith & Moss, 2009). It is therefore crucial that both therapists and their colleagues are able to recognize signs of distress before it becomes impairment, as is required by the *Ethical Principles of Psychologists and Code of Conduct* (APA,

2017). Accurate rates of distress and impairment among therapists are difficult to measure due to differing definitions and research methodologies. There have, however, been some symptoms identified as potential contributors to psychologist impairment including depression, substance abuse, and burnout. This distress not only affects the well-being of therapists themselves, but also has the potential to diminish the quality of care they provide to clients (Smith & Moss, 2009).

Ashley et al. (2009), who reviewed literature related to substance use among helping professionals, found similar symptoms of distress and impairment. Aside from substance use, other signs of impairment included changes in behavior and problems with decision making. Ashley et al. also noted the high stress of professional training and education may contribute to substance misuse. The intense pressure to appear competent can lead some to rely on substances for the management of emotional or physical distress. Fear that admitting to substance use would threaten their professional or educational prospects can lead to further distress and impairment and may make individuals hesitant to disclose distress.

Another review of the literature regarding those who come into the field with wounds indicated they are at a greater risk for developing impairment than are those who do not have such wounds, though all helping professionals are at an increased risk compared to the general public (Zerubavel & Wright, 2012). These risks include challenges in managing one’s own healing journey, added difficulties handling countertransference, and a heightened risk of compassion fatigue. It is therefore crucial for there to be an open dialogue within the mental health field regarding the experiences and challenges of wounded healers. To support wounded healers, supervisors are encouraged to foster supportive environments and promote resilience and posttraumatic growth (Zerubavel & Wright, 2012).

Despite concerns that wounded healers are automatically impaired due to their wounds, Dickeson and Smout (2018) found no direct association between childhood adversity and a higher likelihood of violating professional boundaries in their study with 112 South Australian social work and psychology students. They did, however, find that lower psychological flexibility, defined as the capacity to accept and adapt to challenging emotions and thoughts, did increase the likelihood of violating professional boundaries. This indicates the ability to manage one's emotional responses and remain open to experience is crucial in maintaining ethical behavior in professional settings. Therefore, Dickeson and Smout argued that it is more important that training focus on improving psychological flexibility rather than weather or not trainees have personal wounds.

Mackay (2019) argued that although having psychological wounds can be a strength, as it can help clinicians be more effective and competent, those with psychological wounds or histories of adverse mental healthcare experiences are at higher risk of becoming impaired in some manner. Therefore, she emphasized the importance of participating in high-quality clinical supervision, regular self-care and reflection, and stated clinicians must ensure they are able to recognize the signs of burnout, ask for help when needed, and understand how their psychological wounds may be affecting their clinical work.

Similarly, Sawyer (2011) reflected on the importance of the various psychotherapists and clinical supervisors upon whom she was able to rely for both personal and professional support in times of increased emotional distress. She reflected on the risk that, without proper self-reflection and supervision, she could potentially underestimate serious symptoms or risks due to her strong desire to understand clients' thoughts or actions as reasonable within their context and avoid a potentially harmful diagnosis. Though her consciousness of the power of a diagnosis, and

therefore the one diagnosing, is a primary strength, it can also be a challenge as there are times when more serious diagnoses are truly warranted (Sawyer, 2011).

Overall, wounded healers may be at a higher risk for developing professional impairment than are those without preexisting wounds, but not necessarily. Given that all helping professionals have a risk of becoming impaired due to the nature of the work, it is therefore most important to focus on current signs and symptoms of distress, foster open and supportive environments in which mental health struggles are not stigmatized, and provide distressed professionals with resources before their distress becomes impairment (Ashley et al., 2009; Dickeson & Smout, 2018; Mackay, 2019; Sawyer, 2011; Smith & Moss, 2009; Zerubavel & Wright, 2012).

Stigmatization of the Wounded Healer

In their article, Hankir and Zaman (2013) explored the experiences of stigma that primary author Dr. Hankir experienced both as a client and as a mental health professional with a serious psychiatric condition. His account highlights the challenges and stigma faced by medical professionals who are dealing with their mental health issues and emphasizes the need for greater awareness, acceptance, and support of help-seeking behavior within the medical community.

In her personal account, Mackay (2019) also discussed negative experiences following self-disclosure of psychological wounds and reflected on the choice many survivor–therapists make between being their authentic self and potentially risking their job or hiding part of themselves to remain securely employed. Mackay argued that part of a commitment to diversity, equity, and inclusion in the mental health field requires adequately recognizing and supporting professionals with psychological wounds or disabilities. As part of her article, Mackay collaborated with five unnamed helping professionals who self-identified as having

psychological wounds to create a list of strengths and challenges commonly experienced by wounded healers. Some of the primary challenges discussed included stigma and discrimination within the field, pressure to be seen as “coping well,” and a lack of professional support.

For Sawyer (2011), her experiences of stigma as a professional started as soon as she began pursuing her education in psychology. She had immense difficulty enrolling in programs due to her serious diagnosis and history of hospitalization, but she persevered. Then, after decades of practicing psychology, a triggering event resulted in a relapse in her mental health, and she felt the need to hide her struggles lest she lose her job. Looking back, she recognized that feeling forced to hide that part of herself was a disservice not only to her own mental health but to that of her clients, who she felt did not get the benefit of her complete and genuine presence.

These personal narratives are only the beginning. In their review of 23 studies, King et al. (2020) explored factors influencing mental health professionals’ decisions to discuss psychological wounds in their workplace. Both environmental and interpersonal factors were identified in the review, including factors that reduce or enable self-disclosure. Concern about being seen as impaired by colleagues, pressure to adhere to standards of professional invulnerability, lack of integration between professional and personal identities, and discrimination following self-disclosure were all found to negatively influence professionals’ willingness to disclose psychological wounds in their workplace. On the opposite side, factors that increased willingness included having the opportunity to integrate personal and professional identities and having supervisors who invited self-disclosures related to mental health and fostered environments of openness and support (King et al., 2020).

Multiple studies and literature reviews conducted on the wounded healer phenomenon have uncovered the fear of stigma as a theme influencing the experiences of therapists with

psychological wounds. In her interviews with five survivor–therapists Adame (2011), participants reported facing challenges related to stigma and discrimination, both as recipients of psychiatric services and as professionals in the field. Their personal psychiatric history led to scrutiny by colleagues and clients, affecting their professional relationships and decisions about self-disclosure. Similarly, in their examination of 11 first-person narratives, Cvetovac and Adame (2017) found many therapists felt compelled to conceal their psychological wounds due to fear of stigma and professional repercussions.

In their literature review, Zerubavel and Wright (2012) also found that stigma, both social and internalized, can decrease psychologists' willingness to discuss personal struggles. This was particularly true for psychologists with higher levels of self-stigma, defined as social stereotypes that have been internalized and applied by the psychologist to themself. Self-stigma was also common among psychologists whose wounds were of a more highly stigmatized nature. For example, diagnoses carrying connotations of dangerousness or incurability, such as schizophrenia or personality disorders, were often viewed more negatively by colleagues than were diagnoses like anxiety and depression (Zerubavel & Wright, 2012).

Although hiding struggles may avoid some of the problems associated with self-disclosure, Pachankis (2007) explored the potential negative impacts of such concealment using a cognitive-affective-behavioral model to review the existing literature. The model illustrates how situational factors, such as stigma salience, threat of discovery, and perceived consequences of self-disclosure, can result in a cascade of cognitive, affective, and behavioral responses among individuals who are concealing stigmatized identities. Cognitive implications arising from the need to manage stigma concealment include preoccupation, heightened vigilance, and suspiciousness. Affective responses to these cognitions include shame, anxiety, and isolation.

These responses, in turn, influence behavioral responses, such as social withdrawal and additional stigma concealment efforts, thus perpetuating the cycle of distress and concealment.

Overall, it appears stigma, both external and internal, contributes to therapists' and other mental health professionals' hesitance to disclose psychological wounds. Furthermore, though such concealment may provide some relief in the short term, it is ultimately a form of avoidance that often leads to negative long-term consequences in the form of increased distress, burnout, and in extreme cases professional impairment (Adame, 2011; Cvetovac & Adame, 2017; Hankir & Zaman, 2013; King et al., 2020; Mackay, 2019; Pachankis, 2007; Sawyer, 2011; Zerubavel & Wright, 2012).

Roles and Responsibilities of a Clinical Supervisor

Clinical supervision is defined by the APA (2014) in their *Guidelines for Clinical Supervision in Health Service Psychology* as

> a distinct professional practice employing a collaborative relationship that has both facilitative and evaluative components, that extends over time, which has the goals of enhancing the professional competence and science-informed practice of the supervisee, monitoring the quality of services provided, protecting the public, and providing a gatekeeping function for entry into the profession. (p. 2)

It is such a common activity among psychologists that it is now included among the profession wide competencies expected of all APA-accredited program graduates (APA, 2015).
Regarding the supervisors' role, the *Guidelines for Clinical Supervision in Health Service Psychology* (APA, 2014) state:

> The supervisor serves as role model for the supervisee, fulfills the highest duty of protecting the public, and is a gatekeeper for the profession ensuring that supervisees meet competence standards in order to advance to the next level or to licensure. (p. 9)

The *Guidelines for Clinical Supervision in Health Service Psychology* are aspirational and designed to inform supervisors and supervisees about best practices in supervision. They are structured around seven key domains: (a) supervisor competence; (b) diversity; (c) supervisory relationship; (d) professionalism; (e) assessment; evaluation feedback; (f) professional competence problems; and (g) ethical, legal, and regulatory considerations (APA, 2014).

The supervisor competence domain emphasizes the importance of supervisors being competent in both the provision of services being provided by their supervisees and in their role as a supervisor (APA, 2014). This includes taking a clinical supervision course, which is a required part of any program following the APA's (2015a) *Standards of Accreditation for Programs in Health Service Psychology*. It also includes receiving supervision in providing supervision, which can be obtained on internship or during postdoctoral training (APA, 2014, 2015a). To maintain competence, it is recommended that supervisors continue training and education in areas related to the services they provide, as well as clinical supervision itself. Part of the supervisor competence domain includes attaining and maintaining competence in diversity (APA, 2014), something that is required of all clinical psychologists in the APA's (2017) *Ethical Principles of Psychologists and Code of Conduct*.

The diversity domain of the APA's (2014) *Guidelines for Clinical Supervision in Health Service Psychology* further underscores the significance of diversity competence and highlights the need for supervisors to be sensitive and responsive to the cultural and individual differences of both supervisees and clients. Maintaining competence involves continuous education,

adaptation, and advocacy to meet the diverse needs of supervisees and clients effectively (APA, 2014).

The supervisory relationship domain highlights the importance of the supervisory relationship as a factor in effective supervision. Supervisors are recommended to establish collaborative, respectful, and supportive relationships with supervisees, which are vital for fostering supervisee professional growth and providing high-quality client care. The professionalism domain encourages supervisors to model and promote professionalism within the supervisory relationship. This includes demonstrating ethical, responsible, and respectful behavior and a commitment to the welfare of clients, supervisees, and the public (APA, 2014), something that is also required by the *Ethical Principles of Psychologists and Code of Conduct* (APA, 2017). The assessment, evaluation, and feedback domain establishes that effective supervision involves ongoing assessment and feedback regarding the supervisee's performance (APA, 2014). The *Standards of Accreditation for Programs in Health Service Psychology* (APA, 2015a) provide additional information on how accredited programs should go about doing this.

The professional competence problems domain addresses the management of supervisees who exhibit professional competence problems. Supervisors have a crucial role in identifying, communicating, and addressing such issues in a supportive and remedial manner while maintaining client and public safety (APA, 2014, 2017). Finally, the ethical, legal, and regulatory considerations domain emphasizes supervisors' ethical and legal responsibilities. This includes adhering to any relevant state and federal laws, regulations, and professional standards; discussing informed consent and confidentiality within the supervisory relationship; and acting as a gatekeeper to the profession of psychology (APA, 2014, 2017).

J. E. Barnett and Molzen (2014) also emphasized the importance of ethical, competent, and legally sound clinical supervision in the training and professional development of mental health professionals. They highlighted the responsibility supervisors have to ensure their supervision is conducive to providing the highest quality services to clients and minimizing any potential harm. Based on a review of supervision literature, relevant laws and regulations, and professional ethical guidelines, they created a series of recommendations to assist supervisors in addressing some of the legal and ethical challenges that arise in clinical supervision. In no particular order of importance, the authors covered 16 primary responsibilities of the supervisor in providing ethical mental health supervision.

J. E. Barnett and Molzen (2014) highlighted that in order to be effective, supervisors must possess competence in both the clinical practices they supervise and in the provision of clinical supervision itself. They also emphasized the importance of integrating ethical practice and legal compliance with a focus on aspiring to the highest standards of the field in all supervisory activities. This includes addressing and integrating issues of diversity and cultural competence, careful management of boundaries, and avoidance of exploitative multiple relationships. It also includes thorough and timely documentation of all clinical services and supervision sessions, which is essential for continuity of care, accountability, and risk management.

A thorough informed consent process at the outset of the supervisory relationship is recommended. This should cover both the supervisor’s and supervisees’ expectations, responsibilities, documentation requirements, limits to confidentiality, and the evaluation processes. Supervision must be tailored to the individual needs of each supervisee, considering their strengths, challenges, and areas requiring further training, and should adapt to the

supervisee's evolving training needs, progressing from more active supervision to allowing greater autonomy as competence is demonstrated (J. E. Barnett & Molzen, 2014).

To appropriately tailor and adapt supervision throughout the year, formal and informal evaluations are essential, with clear criteria for successful completion, ongoing assessment and feedback, and opportunities for remediation if any problems are identified. Because supervisors act as gatekeepers for the profession, ensuring only those who demonstrate the necessary competence and ethical standards progress toward independent practice is vital. This means supervisors who notice professional competence concerns in supervisees have a responsibility to provide remediation and additional support to improve supervisee competence (J. E. Barnett & Molzen, 2014).

Supervisors also serve as professional role models, exemplifying ethical behavior, professional conduct, and appropriate boundary management. Beyond supervisory duties, supervisors can act as mentors to supervisees, taking a personal interest in their professional development and helping them navigate their career paths. They must foster a safe and trusting environment to enable supervisees to openly share and learn from their experiences without fear of undue criticism (J. E. Barnett & Molzen, 2014).

Supervisors should model and promote self-care and address any distress or burnout to ensure the professional competence, well-being, and effectiveness of both supervisors and supervisees. They must ensure supervisees have access to emergency support and any transitions and endings of professional relationships are managed ethically and responsibly (J. E. Barnett & Molzen, 2014).

The comprehensive approach to clinical supervision outlined by J. E. Barnett and Molzen (2014) emphasizes the complexity and responsibility inherent in supervising future mental health

professionals. It highlights the importance of supervisors' clear communication, cultural and clinical competence, and strong understanding of a wide variety of legal and ethical issues.

St. Arnaud (2017) explored the significance of the parallel process in clinical supervision, in which dynamics from the therapist–client relationship are mirrored in the supervisor–supervisee relationship, specifically in relation to the concept of the wounded healer. Through a review of the literature, he uncovered how the transference reactions of supervisees toward their supervisors can reveal significant insights into the psychological processes of their clients, potentially improving clinical outcomes. However, he also found that exploration may touch upon trainees' psychological wounds. This is due to the fact that transference may arise from the wounds of the trainee, the client, or some combination thereof.

There is a fine line between the therapeutic benefits of a healer's psychological wounds and the potential for those wounds to hinder their professional practice. Therefore, supervisors have a crucial role in enabling the exploration of a healer's psychological wounds in a supportive manner, without turning supervision into therapy. Parallel processes in supervision can serve as a valuable tool for understanding and improving therapeutic work. However, it is essential for supervisors to recognize when a supervisee's psychological wounds might be influencing the process (St. Arnaud, 2017).

St. Arnaud (2017) argued that although supervisors cannot, and should not, fulfill the role of a supervisees therapist, the supervisees psychological wounds must be addressed to the extent that they may be affecting their work with clients. Supervisors must, therefore, be able to address these concerns appropriately, fostering the supervisees professional and personal development without crossing boundaries.

In their interviews with 11 doctoral-level psychology trainees, Kozlowski et al. (2014) examined the effects of positive boundary crossing in clinical supervision from the perspective of supervisees. Positive boundary crossings are defined as events where supervisors step outside the strictest professional boundaries in ways not deemed unethical, such as socializing outside of work, supervisor self-disclosure, or sharing car rides. Kozlowski et al. found most supervisees viewed such boundary crossings positively, citing benefits such as enhanced supervisory relationships and improved clinical training. However, some supervisees reported role confusion as a result of these crossings and some reported feeling anxious about discussing positive boundary crossings with supervisors. These findings show that although supervisors need to be cautious about their boundaries, rigidly maintaining traditional boundaries may deprive supervisees of valuable mentoring or more genuine connections with supervisors. However, because of the potential for role confusion and supervisee anxiety, the researchers highlighted the importance of discussing boundary crossings within the supervisory relationship to prevent misunderstandings and to ensure both parties are comfortable with the dynamics of the relationship at all times. The authors concluded that when managed ethically and discussed openly, positive boundary crossings can potentially enhance the supervisory relationship and the training experience for supervisees. They therefore encouraged a more nuanced approach to boundary management in clinical supervision (Kozlowski et al., 2014).

Contrastano (2020) further examined the complex dynamics of boundaries and boundary crossing within the supervisory relationship. In her review of literature on the perspectives of supervisees toward supervisors' self-disclosure, she explored positive boundary crossings, self-disclosure, and role confusion within supervisory relationships. She examined how these aspects

influence both the supervisees clinical work and their professional development, highlighting the potential benefits and risks associated with supervisors being open and genuine in supervision.

Using examples from her personal experience in doctoral training programs, Contrastano (2020) illustrated how a mutual willingness to engage in self-disclosure significantly affected the supervisory process. She examined instances where boundary crossings and self-disclosure actually fostered a deeper supervisory relationship, contributing to professional growth and enhanced clinical practice. However, she also addressed the challenges and confusion that can arise from blurred boundaries and the perception of the supervisory relationship as a friendship due to positive boundary crossings.

Because of the double-edged nature of supervisor self-disclosure and boundary crossing, Contrastano (2020) emphasized the importance of maintaining ethical boundaries while still allowing flexibility to use the supervisory relationship most effectively. She suggested clear and ongoing communication about supervisory expectations and boundaries is crucial to prevent misunderstandings and manage the inherent power differential present in a supervisory relationship. She recommended further research in this area to develop more concrete guidelines that can help supervisors and supervisees flexibly manage the supervisory relationship, which, in turn, will facilitate professional development and high-quality client care.

Although not their primary focus, two of the personal narratives discussed previously regarding the phenomenon of the wounded healer, the clinical utility of wounds, and the experience of disclosure-related stigma also reflected on the crucial and complex role supervisors play in the integration of their client and therapist identities. Both Mackay (2019) and Sawyer (2011) discussed the importance of supervisors having flexible boundaries and being willing to address wounds in supervision to the extent that they affect client care without turning

supervision into therapy or compromising the supervisees privacy. Neither wanted nor felt it appropriate for supervisors to act as therapists, but both reflected on times when their psychological wounds affected their clients in some manner. Both reported it was both appropriate and important for supervisors to be willing and able to discuss psychological wounds nonjudgmentally in these situations, further highlighting the importance of flexibility and openness on the part of the supervisor.

Overall, it is clear that supervisors carry a heavy responsibility to their supervisees, clients, and the public at large. Their responsibilities are complex and multifaceted and involve fulfilling various, and sometimes conflicting, roles. These include the role of professional mentor, role model, and supporter while simultaneously serving as an evaluator of professional competence and gatekeeper to entering the field of psychology. Supervisors are tasked with balancing and managing the relationships between themselves and their supervisees, as well as the supervisees and their clients. To do this, supervisors must participate in ongoing training in clinical practice, provision of supervision, and ethical, legal, and diversity considerations. Because the supervisory working alliance is such a crucial factor in supervisee development and positive client outcomes, supervisors must also be willing and able to foster open, supportive supervisory environments in which constructive feedback can be safely exchanged while simultaneously understanding and maintaining professional boundaries (APA, 2014; J. E. Barnett & Molzen, 2014; Contrastano, 2020; Kozlowski et al., 2014; Mackay, 2019; Sawyer, 2011; St. Arnaud, 2017).

Supervisee Self-Disclosure

Supervisee self-disclosure encompasses sharing personal reactions, fears related to professional performance, and factors affecting their capacity to perform their duties. It is a skill

that must be refined, as with other clinical competencies, first within the supervisory relationship. Supervisors vary significantly in their approach to guiding students on what and when to disclose, with limited structured guidelines for balancing the relevance and necessity of such self-disclosures for client care or supervisee development (Staples-Bradley et al., 2019).

Inspired by the lack of any clear guidelines for supervisee self-disclosure in supervision, Staples-Bradley et al. (2019) reviewed the existing literature to create a set of proposed guidelines for supervisors to facilitate appropriate supervisee self-disclosure. Through the use of three personal case examples the authors highlighted that when used appropriately, supervisee self-disclosure can benefit both client care and supervisee development. They also reported barriers to self-disclosure including weak supervisory working alliances, anxiety about negative evaluations or repercussions due to disclosing, and uncertainty regarding the appropriateness of the disclosed content.

Based on their findings, Staples-Bradley et al. (2019) proposed four guidelines to assist supervisors in eliciting appropriate supervisee self-disclosure: (a) foster a positive supervisory working alliance prior to eliciting self-disclosure, (b) communicate to supervisees that a specific self-disclosure is safe, (c) clarify the purpose of any given self-disclosure, and (d) reinforce the benefits of appropriate self-disclosure to assuage any ongoing concerns of backlash due to self-disclosure in the future. These proposed guidelines emphasize the delicate balance required in clinical supervision regarding self-disclosure. The researchers advocated for a structured, empathetic approach that recognizes the developmental benefits of self-disclosure while respecting students' professional boundaries and privacy. They highlighted the importance of supervisors being able to clearly identify the reason for the self-disclosure and warned against

eliciting self-disclosure out of personal curiosity or as a test of the supervisee's willingness to disclose.

Though these guidelines serve as a starting point, the authors stated additional research is needed. They hoped the guidelines could serve as an outline for future researchers to create more concrete guidelines. The authors argued that a standardized set of guidelines regarding supervisee self-disclosure would help both supervisors and supervisees better use self-disclosure as a training tool in supervision (Staples-Bradley et al., 2019).

Guttman (2020) also addressed the complexities of self-disclosure in clinical supervision, highlighting the importance of self-disclosure for both the supervisory alliance and client treatment outcomes. Through the use of two examples from personal experiences in doctoral-level supervision, Guttman explored the interactions among self-disclosure, nondisclosure, supervisory working alliance, parallel process, and countertransference.

Her first example focused on supervisee self-disclosure. In this example, Guttman (2020) reflected on a case in which she felt silenced by her supervisor when discussing a challenging client. She discussed how this resulted in her pulling further away from the supervisor and reducing self-disclosure. In turn, she felt treatment with the client did not progress effectively, in many ways paralleling what was happening for her in supervision.

In her second example, Guttman (2020) discussed the positive impact of her supervisor's self-disclosure on her own training. His self-disclosure showed his humanness, providing reassurance that it was indeed okay to be human in this field. It also allowed her to be more connected with her emotions while with clients, fostered a better understanding of process-based treatment, and enhanced her understanding of when and how self-disclosure can be used therapeutically. Using these examples, Guttman highlighted the complex relationships among

self-disclosure, the supervisory alliance, parallel processes, and treatment outcomes. She went on to emphasize the need for further research into the topic of supervisee self-disclosure and the various factors that may affect supervisee self-disclosure.

In their study, Mehr et al. (2015) examined the interplay between various factors that may influence the likelihood of trainees in professional psychology to disclose relevant information to their supervisors. Using structural equation modeling, the researchers explored the relationships among trainee anxiety, the supervisory working alliance, counseling self-efficacy, and willingness to disclose with a sample of 201 professional psychology doctoral students.

The supervisory working alliance, measured by the Working Alliance Inventory – Supervision form, was characterized by Mehr et al. (2015) as an emotional bond and agreement on the tasks and goals of supervision. A strong supervisory working alliance was found to be associated with reduced supervisee anxiety, as measured by the Trainee Anxiety Scale, and an increased willingness to disclose, as measured by the Self-Disclosure Index and Trainee Disclosure Scale. Counseling self-efficacy, measured by the Self-Efficacy Inventory, was defined by Mehr et al. as the level of confidence a supervisee has in their counseling abilities. Higher counseling self-efficacy was found to be linked to lower levels of supervisee anxiety in supervision. The study did not, however, reveal a direct relationship between counseling self-efficacy and willingness to disclose, suggesting the impact of self-efficacy on self-disclosure may be mediated through other factors such as reduced anxiety or a stronger supervisory alliance (Mehr et al., 2015).

Though Mehr et al. (2015) hypothesized that lower levels of supervisee anxiety would predict a higher willingness to disclose, this relationship did not turn out to be statistically significant. The researchers suggested that with a larger sample size, the relationship might reach

significance and factors within the supervisory relationship other than anxiety may play a more critical role in self-disclosure. This highlights the importance of fostering a supportive supervisory environment and the need for further research into the complex factors that go into a strong supervisory working alliance (Mehr et al., 2015).

To further examine potential mediators between the supervisory working alliance and self-disclosure, Li et al. (2022) recruited a sample of 222 counseling supervisees to investigate the mediating effect of supervisee role ambiguity in the relationship between supervisee self-disclosure and supervisory working alliance. Supervisee role ambiguity, measured by the Role Conflict and Role Ambiguity Inventory, was defined as a “lack of clarity regarding the expectations for one’s role, the methods for fulfilling those expectations, and the consequences” (p. 194). The supervisory working alliance, measured by the Working Alliance Inventory-Supervisee Form, was defined as “the composition of supervisor and supervisee’s mutual agreements on the tasks and goals of supervision, as well as the shared emotional bond between the supervisor and supervisee” (p. 194).

Motivated by previous research, which has shown a stronger supervisory working alliance improves supervisee self-disclosure, Li et al. (2022) were interested in the underlying factors influencing how stronger alliances improve self-disclosure. Specifically, they examined the mediating effect of supervisee role ambiguity on both supervision-related self-disclosures and counseling-related self-disclosures, measured using the Supervisee Disclosure in Supervision Scale. Supervisee role ambiguity was hypothesized by the researchers to mediate the relationship between supervisee self-disclosure and the supervisory working alliance.

Upon conducting a path analysis, Li et al. (2022) found supervisory role ambiguity to have a significant mediating effect on the relationship between the supervisory working alliance

and supervisee counseling-related self-disclosure, with higher ambiguity being related to lower levels of counseling-related self-disclosure, although not for supervision related self-disclosures. These findings highlight the importance of providing supervisees with clarity regarding role expectations to reduce supervisee role ambiguity. By clearly communicating role expectations to supervisees, supervisors may increase supervisees' counseling-related self-disclosures, in turn increasing the effectiveness of supervision overall (Li et al., 2022).

Pakdaman et al. (2015) explored the role of clinical supervisors in managing their supervisees' countertransference, which has significant ethical implications for the development of clinical competence, among a sample of 332 clinical and counseling psychology doctoral students. The researchers found the quality of the supervisory working alliance affected both supervisees' comfort with the idea of disclosing as well as their likelihood of actually disclosing countertransference reactions.

Pakdaman et al. (2015) found supervisees' likelihood to disclose was not exclusively related to a strong supervisory working alliance, with other factors such as personal or professional ethics also playing a role. Comfort with disclosing was, however, found to directly increase the likelihood of disclosing countertransference. The type of countertransference was found to influence both comfort with and likelihood to disclose, with sexualized countertransference being the least disclosed compared to other types of countertransference, such as feelings of protectiveness or incompetence. On the other side, countertransference related to feeling mistreated or criticized was more likely to be disclosed compared to other types of countertransference. Other characteristics that influenced the likelihood of disclosure included supervisee characteristics such as theoretical orientation, with psychodynamically oriented supervisees being more likely to disclose compared to family systems or cognitive-behaviorally

oriented supervisees (Pakdaman et al., 2015). One of the hallmarks of the psychodynamic orientation is the importance of recognizing and managing the transference and countertransference that occur in the therapy relationship. Therefore, it is not surprising that students with this orientation might be more willing to disclose than are those whose orientations place emphasis on other aspects of treatment (Pakdaman et al., 2015).

Pakdaman et al. (2015) also discussed the ethical considerations related to discussing countertransference in clinical supervision. On the one hand, these include the importance of respecting supervisees' privacy and personal life and focusing on professional performance. On the other, because the ethical management of countertransference is considered a necessary clinical competence, it is crucial that supervisees disclose relevant countertransference experiences to their supervisors. It is therefore vital to ethical supervision that supervisors foster strong supervisory alliances, so supervisees feel comfortable disclosing countertransference reactions to provide clients with the best care and supervisees with the best training (Pakdaman et al., 2015).

Gibson et al. (2019) attempted to differentiate between clinically-related nondisclosure, meaning nondisclosure related to the supervisee's clinical work, and supervision-related nondisclosure, or information related to the process of supervision itself. They also endeavored to understand how the supervisory working alliance, collaborative supervision, and relational behaviors exhibited by the supervisor might affect these types of disclosures. For their study, they recruited 257 supervisees from a variety of clinical and counseling programs at both the master's and doctoral levels. The researchers used multivariate multiple regression to examine the joint contributions of the supervisors' collaborative supervision behaviors, measured by the Collaborative Supervision Behaviors Scale; relational behaviors, measured by the Relational

Behavior Scale; and the supervisory working alliance, measured by the Working Alliance Inventory-Trainee version, on supervisee nondisclosure, measured by the Supervisee Nondisclosure Scale.

Results highlighted the complex and multidimensional nature of both clinically-related and supervision-related nondisclosure in supervision. This distinction is critical for understanding the complexity of the supervisory relationship and the factors that influence supervisees willingness to disclose information. Consistent with previous research, the supervisory working alliance was found to be inversely related to supervisee nondisclosure, particularly supervision-related nondisclosure. This highlights the importance of a strong, positive relationship between the supervisee and supervisor in promoting openness and transparency in the supervision process (Gibson et al., 2019).

Collaborative supervision, defined by Gibson et al. (2019) as the extent to which supervisors and supervisees work together on supervision processes and activities, was also inversely related to supervisee nondisclosure, underscoring the value of a collaborative approach in reducing barriers to self-disclosure. Relational behaviors exhibited by supervisors, such as focusing on feelings, countertransference, and parallel processes, were inversely related to supervise nondisclosure as well, indicating supervisors who adopt an explicitly relational approach facilitate greater openness from their supervisees. This study supports previous research on the importance of the supervisory working alliance and points to the need for further research to explore why and under what circumstances supervisees choose to withhold information, even when they recognize its relevance to clinical work and supervision (Gibson et al., 2019).

Hutman and Ellis (2020) were also interested in how factors that influence supervisee nondisclosure affect both supervision-related nondisclosures and clinically-related nondisclosures. In addition to the supervisory working alliance, they were particularly interested in the impact of the supervisors perceived cultural competence on supervisee nondisclosure. In their study of 221 mental health supervisees, they examined the impact of these two factors on both supervision-related and clinically-related nondisclosures.

Consistent with previous research, Hutman and Ellis (2020) found the supervisory working alliance to be inversely related to supervisee nondisclosure, particularly supervision-related nondisclosure. Though the supervisory working alliance influenced clinically-related nondisclosures as well, the impact was significantly less. This provides further support that a strong, positive relationship between supervisor and supervisee leads to increased supervisee self-disclosure, particularly related to supervision issues, whereas a weak working alliance may result in limited supervisee disclosure.

Hutman and Ellis (2020) also found the quality of the supervisory working alliance mediated the relationship between supervisor multicultural competence and supervisee nondisclosure. These findings indicate the perceived multicultural competence of a supervisor influences nondisclosure indirectly through its impact on the supervisory working alliance. Although the relationship may be indirect, the results nonetheless indicate the importance of demonstrating multicultural competence as part of building a supportive supervisory working alliance. This will foster supervisee self-disclosure and potentially lead to better supervision outcomes, increased supervisee professional development, and higher quality client care. Based on their findings, Hutman and Ellis recommended future research to further explore how and

why cultural factors and perceived cultural competence influence the supervisory working alliance and supervisee self-disclosure.

In their study of 123 counseling supervisees, Drinane et al. (2021) specifically examined the impact of cultural concealment on supervisee satisfaction, measured by the Supervisory Satisfaction Questionnaire, and the supervisory working alliance, measured by the Working Alliance Inventory–Trainee version. Cultural concealment, defined as the nondisclosure of aspects of cultural identity and measured using a modified version of the Supervision Cultural Concealment Questionnaire, was examined in two parts: nondisclosures in relation to the supervisees' own cultural identities and in relation to their clients' cultural identities.

Using regression analyses, Drinane et al. (2021) found supervisees engage in cultural concealment both in relation to their own cultural identities and in relation to their clients' cultural identities. The dual level of concealment was found to have a significant negative impact on both satisfaction with supervision and the quality of the supervisory working alliance. This indicates concealment of cultural information can harm the supervisory relationship and process and clients may not receive the full benefit of supervision if supervisees are concealing aspects of their clients' cultural identities.

Drinane et al. (2021) highlighted the importance of supervisors fostering an environment in which supervisees feel safe and encouraged to explore both their own and their clients' cultural identities. Doing so could improve the supervisory relationship, enhance supervisee professional development, and ultimately improve client care. The findings also emphasize the complexity of cultural dynamics within clinical supervision, and the authors called for further research to explore these phenomena in greater depth, including gathering qualitative

perspectives on what drives the need to conceal cultural information during the supervisory process (Drinane et al., 2021).

Overall, there is a large body of research supporting the importance of a strong supervisory working alliance as a way to foster supervisee self-disclosure in clinical supervision. Additionally, there is strong evidence that nondisclosure in supervision can be harmful to both supervisees and their clients. Many studies emphasized the need for further research into the underlying mediators affecting the supervisory working alliance and further qualitative information regarding when, how, and why supervisees choose to self-disclose (Drinane et al., 2021; Gibson et al., 2019; Guttman, 2020; Hutman & Ellis, 2020; Li et al., 2022; Mehr et al., 2015; Pakdaman et al., 2015; Staples-Bradley et al., 2019).

Study Aims

Although research exists on the overall topic of the wounded healer and there is a significant body of evidence supporting the idea that it is crucial for psychologists-in-training to integrate any wounds they carry into their professional identities appropriately, there is little research available when it comes to if or how this woundedness is being addressed in clinical supervision. Because the research shows a history of adverse experiences, trauma, or negative interactions with mental healthcare systems are common motivating factors in choosing to pursue a career in psychology, it is essential for supervisors to be ready and able to discuss these topics appropriately in supervision. Because having such a history may be both helpful and harmful to clinicians and the clients they serve, supervisors have an ethical obligation as gatekeepers and mentors to foster a safe and appropriate environment in which supervisees feel comfortable discussing the impact of their psychological wounds on their clinical practice.

Though some research exists on the topics of supervisee self-disclosure and nondisclosure, most studies only briefly touched on self-disclosures of psychological woundedness specifically. The majority of the available research focused more specifically on self-disclosure of supervisory relationship-related topics or in-session missteps as opposed to the disclosure of personal psychological wounds. Nothing readily available delved into students' experiences discussing trauma histories specifically.

Though there is a solid foundation of research related to the experiences of psychologists, social workers, and other licensed mental health professionals disclosing psychological wounds, these studies rarely touched on the experiences of students. Past research has focused mainly on the experiences of licensed professionals who already practice independently, though many did recommend further research into the topic. Many also recommended appropriate training for supervisees and supervisors regarding the wounded healer phenomenon, though most did not include what that might entail. Thus, a gap in research exists specifically regarding the thoughts and experiences of students related to discussing their personal trauma history with clinical supervisors. The goal of this study was therefore to better understand the thoughts and experiences of supervisees related to disclosing their personal trauma history, a specific type of psychological wound that is not generally separated from others, in clinical supervision.

- Why do students want, or not want, to disclose a personal trauma history in clinical supervision?
- Why do students feel they are able, or unable, to disclose a personal trauma history in clinical supervision?

- What impact does choosing to disclose, or not disclose, personal trauma history to clinical supervisors have on their personal well-being, professional identity, and clinical competence?

Study Design

The overall goal of the study was to explore students' personal thoughts and experiences regarding the disclosure of their trauma history in the context of clinical supervision and to better understand the essence of this subjective phenomenon. The hermeneutic phenomenological approach was chosen as the most appropriate, as this type of phenomenological research is generally undertaken for the purpose of better understanding the essence of participants' lived experience of a particular phenomenon and uncovering common themes among these experiences (Creswell & Poth, 2018; Peoples, 2021).

Hermeneutic phenomenology follows six basic research principles. First, researchers must formulate a question regarding a phenomenon of interest. Next, they collect data, usually in the form of interviews. The researcher then reflects on the data and explores common themes, before beginning to describe the phenomenon and themes in writing. The researcher must maintain a strong focus on the initial research question and balance the participants' individual experiences with the overall themes observed. By following these principles, this study aimed to better understand students' thoughts and experiences related to disclosing their trauma histories in the context of clinical supervision (Creswell & Poth, 2018; Peoples, 2021).

Because of the flexible nature of the hermeneutic phenomenological approach and the complementary nature of the grounded theory, interviewing followed a grounded theory methodology. Interviews were therefore coded as they were conducted with subsequent

interviews being updated to incorporate any relevant information already obtained (Wilson & Hutchinson, 1991).

Mixed methods were chosen for this study to streamline the interview process when trying to decide how best to obtain background information relevant to the research. The initial survey was planned to include only a participation screener, demographic information, and interview scheduling information. Additional scaled questions were added following a more extensive literature review and development of final interview questions. Creating a set of scaled questions to obtain background information based on the literature review, such as the importance of the participants' trauma history on their motivation to enter the field, and relevant but closed-ended questions, such as whether or not the participants find it important to disclose trauma history at all, allowed the interviews to focus more fully on the participants' first-hand experiences in supervision saving time and energy for both the participants and researcher.

Chapter 2: Methods

Participants

A total of nine participants from APA-approved clinical and counseling psychology training programs were recruited and interviewed using a rolling recruitment method, meaning initial participants were recruited and interviewed while additional participants were still being recruited. Because of concerns about validity, two of the interviews were discarded, resulting in seven interviews being included in the final results. The two interviews that were discarded had nearly identical responses on both the survey and interview portions, with some specific and unusual language used throughout. For example, both used the word “accomondative” [sic] repeatedly during the interviews and also both identified as “Black African American” and male. The second of the two participants had significant trouble connecting to video to the point that when their camera was on, the connection was such that the video was pixelated and laggy, making it difficult to confirm their identity as separate from that of the first interviewee given their demographic similarities. Upon further investigation, both participants’ pre-interview surveys had been filled out back-to-back in a timeframe of about 15 minutes, and the .edu email addresses provided by the two participants appeared to be nonfunctional, with both participants communicating instead through Gmail accounts. Although none of these factors alone would have been enough to discard the interviews, together they raised red flags. After looking into the phenomenon, a small but significant body of research has shown instances of malingering in qualitative interviews are on the rise since the COVID-19 pandemic fast-tracked the use of virtual interview techniques (Roehl & Harland, 2022).

To ensure participants could give informed consent and answer clinical supervision questions appropriately, they were required to be over 18 years of age, enrolled in a clinical

psychology PhD or PsyD program, have completed at least 6 months of practicum or internship training under a clinical supervisor as part of their program, and identify as having experienced a traumatic even prior to beginning their program (see Table 1).

Table 1

Demographic Information

Baseline characteristic	Participants	Program information	Participants
Gender		Degree sought	
Female/Woman	4	PsyD	5
Queer/Non-binary	2	PhD	2
Male	1	Year in program	
Race		Second	1
White/Caucasian	5	Third	1
Indian/South Asian	1	Fourth	3
Black	1	Fifth	2
Age		Number of sites	
25	2	Two	2
26	1	Three	1
28	1	Four	4
29	1	Number of supervisors	
32	1	One	1
39	1	Two	2
		Three	1
		Four	3

Measures

Data collection followed a mixed methods design with a participation screener and demographic data collected at the start of the study to ensure participants met the eligibility criteria. A Likert-type scale was used to gauge the level of importance participants placed on discussing their trauma history and their level of comfort in doing so. Finally, the researcher conducted individual interviews via Zoom using open-ended, semi-structured questions regarding participants' opinions and experiences (see Appendix A) about discussing their personal trauma history with their clinical supervisors. As the interviews were conducted and coded initial themes were noted and additional interview questions were added following a grounded theory methodology. All questions were created for the purpose of the study and were reviewed and approved by the original dissertation chair, a qualitative research professor, prior to IRB approval.

Participation Screener

As part of the pre-interview survey (see Appendix B), participants were asked to complete a participation screener created specifically for the purpose of this study. The participation screener was developed based on the exclusion criteria and included three yes or no questions to establish participants met criteria:

- Are you currently enrolled in an APA-accredited PsyD or PhD program?
- Have you worked with a practicum supervisor for at least 6 months as part of your current doctoral training?
- Prior to entering graduate school, had you ever experienced an event or events that you consider to be traumatic?

If a prospective participant answered No to any of the above screening questions, it resulted in disqualification from the study due to not meeting the inclusion criteria.

Demographic Information

As part of the pre-interview survey (see Appendix B), demographic information was collected to assess the study's reliability, validity, and generalizability and give further insight into the results (see Table 1). Information collected included the following:

- Age
- Race
- Gender identity
- Degree program (PhD or PsyD)
- Current year in the program
- Total number of months spent on practicum(s)
- Total number of supervisors worked with for 6+ months, including current

Scaled Questions

As part of the pre-interview survey, participants were asked to rate the following questions on Likert-type scales (see Appendix B). Questions were created for the purpose of the study and were based on a review of the literature and study aims. Responses (see Table 2) were used to establish basic background information regarding the students' thoughts and experiences of the phenomenon, inform interview questions, and streamline the interview process.

- To what degree was your decision to become a clinical psychologist related to your trauma history? (0–5 from *completely unrelated* to *the main reason*)

- How important is it for you to feel comfortable discussing your trauma history with supervisors for PROFESSIONAL reasons? (0–4 from *not at all* to *extremely important*)
- How important is it for you to feel comfortable discussing your trauma history with supervisors for PERSONAL reasons? (0–4 from *not at all* to *extremely important*)
- How comfortable are you discussing your trauma history with practicum supervisors? (0–4 from *extremely uncomfortable* to *extremely comfortable*)
- To what extent have you experienced stigma or discrimination in the field due to your trauma history? (0–4 from *never* to *often*)

The first question was created to gather background information regarding the extent to which the participants in this study were in line with studies indicating psychological wounds often serve as motivation for starting a career in psychology. The second and third questions were created to inform follow-up interview questions regarding why participants placed a particular level of importance on disclosure, and to further tease apart whether these reasons were primarily personal, professional, or a combination thereof. The fourth question was created to inform follow-up interview questions related to what specific reasons participants felt (un)comfortable discussing trauma history. Finally, the fifth question was created to explore to what extent participants in this study were in line with studies that indicated many wounded healers have experienced backlash or stigma associated with disclosure of their wounds, and to inform follow-up interview questions regarding the type of stigma that may have been experienced.

Open-Ended Questions

To gather data regarding participants' lived experiences of disclosing and discussing their trauma history within the context of clinical supervision, five open-ended interview questions with potential follow-ups (see Appendix A) were designed for the purpose of this study. Following the initial two interviews, which occurred on the same day, an additional two questions were added following a grounded theory methodology. The goal of these questions was to allow participants to describe in their own words their experiences related to discussing their trauma history with their supervisors. Blank spaces were filled in based on each participant's responses to scaled survey questions (e.g., why do you feel that it is "somewhat important"), which were reviewed prior to their interview.

An additional two questions were added after the first two participants, whose interviews were conducted and transcribed on the same day, discussed the impact of cultural identity factors on their experiences related to disclosure. The first question was added to directly address the topic of cultural identity as it was directly mentioned by both participants. The second question was added to catch any additional thoughts not addressed by the previous questions and to ensure participants were able to fully express all thoughts and experiences related to the phenomenon given that both the first two participants had already addressed a topic the researcher had not considered asking about directly. The initial five questions were as follows:

- Why do you feel that it is _______ for your personal well-being to discuss your trauma history with supervisors?
- Why do you feel it is _______ to your professional development to discuss your trauma history with supervisors?

- What, if anything, have supervisors done that made you feel _____ discussing your trauma history?
- What thoughts or concerns do you have when considering disclosing your personal trauma history to clinical supervisors?
- What, if any, experiences of stigma have you personally experienced or witnessed related to sharing personal trauma history in clinical supervision?

Additional questions:

- How do you feel your cultural identity has impacted how you approach discussing your trauma history with supervisors?
- Is there anything you would like to add as it relates to your desire, ability, or experiences in discussing your trauma history in clinical supervision?

Procedures

The study adhered to all APA ethical standards and the researcher obtained approval from the Institutional Review Board (IRB) at National Louis University before beginning recruitment. After receiving approval from the IRB, the training department directors for eight clinical psychology graduate programs were contacted via email with a request to send the recruitment email to students in their program (see Appendix C). The eight APA-accredited clinical psychology programs that were contacted for participation included the Chicago School of Professional Psychology (CSPP), Adler University, Roosevelt University, Loyola, Midwestern University, University of Illinois Chicago (UIC), the University of North Carolina at Greensboro (UNCG), and the Florida School of Professional Psychology at National Louis University (FSPP). After initial difficulty in recruiting participants, the survey flyer (see Appendix C) was additionally posted to the social media sites, Facebook and LinkedIn, by both the researcher and

dissertation chair. Ultimately, those who participated were from the following five schools; UIC, Adler, CSPP, Roosevelt, and ISPP, all of which are located in downtown Chicago. This means the study may have limited generalizability to students in programs outside of the Chicago area.

Participants were first asked to complete a pre-interview online survey via SurveyMonkey to ensure eligibility and gather demographic and background data. As part of this survey, participants were asked to select a 6-digit personal identification number (PIN) for confidentiality purposes. All data were saved under the participants' PIN with their names and email addresses only saved in a password-protected spreadsheet, stored in a password-protected folder on the researcher's computer. Following completion of the online survey, participants engaged in Zoom interviews that were recorded for ease of later coding.

As part of the online survey, the first page participants were shown included a description of the study and an informed consent page with information regarding exclusion criteria, study aims, and logistics such as expected time commitment and the option to voluntarily withdraw. Because interviews were recorded part of the informed consent also included consent to record the interview, which was confirmed again verbally at the time of each interview. Next, participants answered participation screening questions to ensure they fit the criteria for the study, followed by a demographic questionnaire. They were then asked the Likert-type questions described above, followed by a page on which they were provided a link and asked to schedule their interview. Finally, they were taken to a debriefing page with the researcher's contact information and resources related to mental healthcare and trauma recovery. Each participants' survey results were downloaded prior to their Zoom interview and stored in a password-protected folder under the participants' selected PIN on the researchers' computer along with all other data. Interviews were recorded to a local computer drive only, as opposed to being saved to

the cloud, and were stored along with all other data in a password-protected folder on the researchers' computer. Transcripts were initially completed using firefly.ai, a HIPAA-compliant AI transcription software; following AI transcription, transcripts were reviewed by the researcher alongside audio recordings to confirm accuracy, after which they were saved under the participants' PIN in a password-protected folder on the researchers' computer and audio recordings were deleted to protect confidentiality.

Participants were interviewed via Zoom for ease of scheduling, recording, and eventual coding and were asked to be in a quiet and confidential environment to participate in the study fully. Following initial video check-in and confirmation of recording consent and procedures, the recording was started, and participants were given the option to turn off their cameras for the duration of recording, which all opted to do. Interview length ranged from 30–60 minutes, depending on the level of participant elaboration. Upon completing their interview, participants were debriefed, provided again with local resources for student mental healthcare, and emailed a $25 Visa e-gift card in appreciation of their time. Participants were initially recruited with the promise of a $20 gift card following completion of both the survey and interview. However, due to denomination requirements discovered when purchasing the gift cards after the interviews had already been completed, the amount was changed to $25, which participants were notified of via email.

Data Analysis

The overall goal of the study was to explore the experiences of psychology students regarding self-disclosure of their trauma history in the context of clinical supervision in order to better understand the essence of this subjective phenomenon. Therefore, the researcher used a

hermeneutic phenomenological approach when examining qualitative data (Creswell & Poth, 2018; Peoples, 2021).

Hermeneutic phenomenology follows six basic research principles. Researchers must first formulate a question or questions regarding a phenomenon of interest. Next, they collect data, usually in the form of interviews, on the phenomenon. Finally, the researcher reflects on the data, explores common themes, and begins to describe the phenomenon and themes in writing. Throughout the process, the researcher must maintain a strong focus on the initial research question and balance the participants' individual experiences along with the overall themes observed. By following these principles, this study was designed to better understand students' experiences of disclosing their trauma histories in the context of clinical supervision (Creswell & Poth, 2018; Peoples, 2021).

Qualitative data were analyzed by the researcher using a multi-step focusing strategy. First, transcripts were created using HIPAA-compliant AI software, after which the researcher reviewed the transcripts alongside audio recordings to ensure accuracy. The first step of coding was descriptive, with each transcript broken into a series of individual meaningful statements made by the participants in response to the open-ended interview questions. Participants' responses were initially copied verbatim from interview transcripts into an Excel spreadsheet in order to track themes. Responses were then broken down into individual meaningful statements by removing filler words and changing any specific details of their experience to more generic descriptions of the type of trauma endured. For example, if a participant had shared specific details of how they were abused, they were replaced with "experience of physical abuse." Meaningful statements were initially sorted by participant until all interviews were completed, at which point all they were compiled onto a single sheet, color coded to indicate different

participants, and sorted based on which interview question the statement was in response to (Creswell & Poth, 2018; Saldaña, 2016).

In the second step, meaningful statements were focused into a list of primary themes related to the participants' thoughts and experiences regarding disclosing psychological wounds in clinical supervision. This was done by first examining each individual participants' responses for patterns existing across their individual interview. Next by examining all seven participants' responses to each specific interview question for common themes. To reduce bias, this was primarily done by looking for synonymous terms and phrases as well as antonymous terms and phrases. For example, comments made by two different participants that disclosure is an ethical responsibility and a comment made by a third participant that nondisclosure is unethical would all be coded in the same way. In the final step, these themes were categorized into the three primary domains discussed below (Creswell & Poth, 2018; Saldaña, 2016).

Chapter 3: Results

Pre-interview survey results (see Table 2) were collected to inform the interview questions. All seven participants identified their psychological wounds as at least somewhat related to their decision to become psychologists. Similarly, all seven found it at least somewhat important for their professional development to be able to discuss their psychological wounds in clinical supervision. The majority of the participants, five of seven, also indicated discussing psychological wounds with clinical supervisors was at least somewhat important for personal reasons and that they were at least slightly uncomfortable doing so. Five of the seven participants also reported at least occasionally experiencing stigma following such a disclosure, whereas two never had.

Table 2

Pre-Interview Survey Questions & Responses

Pre-interview questions	Participant responses
To what degree was your decision to become a clinical psychologist related to your trauma history?	
Completely unrelated	0
Somewhat unrelated	0
Unsure/never considered	0
Somewhat related	6
It was my main reason	1
How important is it for you to feel comfortable discussing your trauma history with supervisors for PROFESSIONAL reasons?	
Not at all important	0
Somewhat unimportant	0
Somewhat important	4
Extremely important	3

Pre-interview questions	Participant responses
How important is it for you to feel comfortable discussing your trauma history with supervisors for PERSONAL reasons?	
Not at all important	1
Somewhat unimportant	1
Somewhat important	4
Extremely important	1
How comfortable are you discussing your trauma history with practicum supervisors?	
Extremely uncomfortable	2
Slightly uncomfortable	3
Slightly comfortable	1
Extremely comfortable	1
To what extent have you experienced stigma or discrimination in the field due to your trauma history?	
Never	2
Rarely	3
Sometimes	0
Often	2

First round, descriptive coding was used to examine the seven interview transcripts for meaningful statements related to the participants' experiences discussing their personal trauma history in clinical supervision. These meaningful statements were then focused into six primary themes and placed into three overall categories based on the research questions: factors influencing students' desire to discuss their personal trauma history in supervision, factors influencing their general willingness to discuss their personal trauma history with supervisors, and factors aside from willingness that may influence their perceived ability to disclose.

Desire to Disclose

Desire-related factors are the reasons given for why the students reported they would like to be able to discuss their personal trauma history in clinical supervision. Though the students varied in terms of how their trauma history influenced their work at their training sites, they all reported it appearing in their work in some manner, whether with clients, coworkers, or both. All seven participants reported discussing its impact with their supervisors as vital for their competence as future psychologists. Participants also indicated why it was difficult to separate the personal from the professional fully. They reported that though professional reasons were the primary factor driving why they wanted to have these conversations, personal factors also came into play. Two primary themes were observed specifically related to desire: clinical competence and burnout prevention.

Theme 1: Clinical Competence

A primary reason cited by all participants to explain why they would like to be able to disclose and discuss their personal trauma history with clinical supervisors was related to improving their clinical competence. Although the participants differed with regard to their desire to work with clients who might trigger trauma reactions, all of them discussed the importance of being able to handle the situation appropriately should it arise. One participant stated, “If you can’t talk about this with your supervisor, you’re inherently not providing the best care for clients and that’s really unfair.” Another said,

> We bring so many different things into our work, trauma being one of them . . . I think it’s very important because it does show up and it’s going to affect your work whether you like it or not.

The primary concern all participants referenced was that any biases they may have related to their trauma histories could affect their work with clients. Participants identified the concern that without a place to appropriately process the impact of their personal trauma history on their work with clients—both in the room and when conceptualizing cases—they run the risk of having personal biases interfere with ethical treatment. For example, one participant reported, "I prefer to be open with my trauma because it can help keep me in line, so my biases don't come up, and I don't get triggered, or have my judgement clouded based on my experiences." Another said, "If we're providing services to someone that has experienced something similar to us in any capacity, that can cloud our judgement and risk the ethical services we're providing."

Participants also indicated that even if they did have personal therapists, they were not always able to discuss these issues in individual therapy as there were other things to focus on, and the fact that affordable and culturally competent trauma therapists were not easily accessible to all students. For example,

> Even in my own therapy, there's a lot of stuff going on in my life that I need to talk about, so there's never enough time . . . And my therapist, I can see him get, like hesitant at times, or he's like, "I don't want to veer into supervisory territory."

Additionally, several felt supervision was a place where they wanted to learn how to appropriately use their psychological wounds to inform treatment with clients without overidentifying or crossing any other boundaries, something for which personal therapy may not be best suited. One participant stated, "Supervision is not only a place to learn these skills in therapy and assessment . . . but also a place to shape your clinical identity as it relates to lived experiences." Another said, "I think it's helpful to learn how to have those conversations in a professional way."

Other points made regarding competence included how important it is for supervisors to be aware of their students' histories so they can keep an eye out for potential biases the students may not realize and so supervisors are not taken by surprise when things come up with certain clients. Students also noted supervisors being open to supervisee self-disclosure is important as part of ethically overseeing trainees as it ensures they are aware of the things that are coming up with clients who are ultimately being seen under their license. For example, "I see it almost as an ethical obligation, by providing space in supervision you're ensuring that your graduate trainees are working through any kind of obstacle that would impede their ability to provide the best care to their clients." One student noted supervisee self-disclosure can improve supervisors' competence as well:

> I think it's also important for supervisors. I think that supervisors get a lot out of it . . . kind of like parallel with the people they're supervising . . . learning about all the different ways that trauma and mental health can pop up for us as therapists. I think that there's something happening in the room for both of us.

Theme 2: Reduce and Prevent Burnout

All seven participants indicated being able to discuss the way their own histories were coming up for them in their practicum helped to both reduce and prevent symptoms of burnout. On the flipside, all seven participants also indicated that when they were not able to do so it could actually contribute to their burnout. For example, one participant said, "Being able to talk about these things is important for your own self-care and fighting burnout." Another stated,

> I had such a hard couple of months it led to having a panic attack at work, which is very unlike me. I think if my supervisor had created more space for me to talk through some of the things I was going through during the training year that could have been diverted.

Students indicated not being able to discuss how their trauma history came up with clients resulted in more rumination about practicum during off hours and anxiety about going into practicum. In contrast, students indicated that when they were able to discuss these topics in supervision, they found it not only improved their learning, it also improved their mood and functioning outside of practicum. Students indicated the primary impact outside of practicum was intrusive or unwanted thoughts about practicum, along with problems while on site. For example,

> Not talking about it, while it avoids some potential stigma, there's also . . . I'm a little more on edge in supervision. It's just another thing contributing to my anxiety that therefore makes me more anxious in session, which is something I have to learn to navigate anyway. It almost exacerbates it if I don't talk about it.

Willingness to Disclose

Willingness factors were related to students' willingness to disclose to specific supervisors as well as their overall willingness to disclose to clinical supervisors in general. These themes were not necessarily related to the students' desire, discussed above, or perceived ability, discussed below, but were strictly related to the things that influenced a student's willingness all other things held equal.

Theme 3: Supervisory Style and Attitudes

There were two sides to this theme: the attitudes that improved students' willingness to disclose and those that decreased their willingness to disclose. In addition to specific attitudes listed in Table 3, students indicated their supervisors' nonverbal communication, incidental comments, reactions to other student self-disclosures, and reactions to clients all informed their opinion of whether or not a supervisor would be receptive to student self-disclosure. Nonverbal

communications that might indicate a supervisor is nonreceptive included freezing up, non-response to other self-disclosures, and appearing uncomfortable, stressed, or overwhelmed by the topic. For example, "If they emanate anxiety, you know, based upon their body language or something like that . . . or if they freeze up, then that's gonna make me not want to talk." Another participant stated, "I am pretty sensitive to things people say, the way they comment about things, and the phrases they use which tells me if I am safe to have those conversations."

Negative incidental comments about trauma or psychological wounds, negative reactions to other students' self-disclosures, and negative comments about clients with trauma histories all also decreased students' willingness to disclose their own trauma histories. For example, several students discussed experiences with supervisors who verbally indicated interest in supporting students' participation in self-care but did not provide support for students who actually tried to do so. One participant stated,

> I think self-care, in a lot of places is legitimate, and in a lot of places is now a tagline we say, but don't actually practice, particularly for students. For example, they sent us a list our first year that was sliding scale people, and everyone was $150 per session, it's not doable.

Others discussed situations where supervisors made comments regarding clients' trauma-related reactions that indicated they would not be receptive to self-disclosures made by students. Still others reported hearing or seeing other students suffer consequences following self-disclosure, such as being told to "go to therapy" without being given the resources to actually do so. For example,

> In a forensic setting, if clients protected themselves or deny the accusations, then supervisors would say things like, "well, that these people are very guarded, and they're

> concealing, repressing, and lying, all this stuff." And I would never feel comfortable talking to them.

On the opposite side, students indicated they were more willing to disclose to supervisors who stood behind positive comments about self-care, advocated for students who disclosed difficulties, or otherwise fostered collaborative and respectful environments. One participant reported their supervisor "held space, didn't push past the level of my comfortability with what I was sharing, and checked in, throughout the conversation, with how I was doing." Another student stated they are

> more comfortable with supervisors who are more personable and are interested in who I am as a person and as a clinician. And they ask questions about how those two things connect, or how I bring myself into the room.

Table 3 lists all the qualities reported by more than half of the participants that influenced their willingness to self-disclose. All seven participants indicated nonjudgmental reactions to self-disclosures of trauma as the primary factor that increased their willingness. The majority of the participants also reported supervisor attitudes of openness, support, warmth, genuineness, and humility would increase their willingness. For example, "When I first brought it up, she was just very non-judgmental, very supportive . . . she didn't push me to talk more, but was very much like, 'Okay, what do you need out of this conversation.'"

Most participants also reported the importance of supervisors opening the door for self-disclosure by either disclosing some form of adversity themselves or by explicitly inviting students to share more sensitive topics as part of supervision. One participant reported,

> If they are also open and willing to talk about themselves. Obviously, not to the point where it's them trauma dumping on you, but to the point where it's like, they share enough about their personal issues and struggles that like, you feel less alone.

Another stated,

> For the supervisor it's really important to say, "this is a space to process your own history and how it impacts you as a therapist, and how that might impact relationships here and the work that you do." Having that just laid out as an expectation, I think goes a long way.

The primary factor that decreased willingness was judgmental attitudes on the part of supervisors. Another common factor that decreased willingness was assumptions on the part of the supervisor. For some, the assumptions were related to the type of trauma they may have experienced. For example, a participant who had served in the military reflected on the supervisor's expectation that their primary trauma was related to their service, when in fact it was not. Others reported that following self-disclosure, supervisors were prone to overidentifying the trauma history as the root of any clinical concerns that were brought up in supervision, even when that was not the case. For example,

> I do have a diagnosis of PTSD. And I tell people that I'm a veteran, so they assume "you must have killed a lot of people in combat or had a couple of brushes with death." But my PTSD is directly related to going through abuse and repressing it, hiding it, and pushing it down.

Another said, "I would bring up something casually and she would make the entire supervision hour about that. And that made me wish I didn't even bring it up, it wasn't even really that important."

Both judgmental and assumptive reactions, along with supervisors who were overly interested in the details or other irrelevant aspects of the trauma, were reported as causing distress beyond training and in some cases as contributing to feelings of burnout. Other less outright harmful factors that decreased willingness included disinterested reactions, which indicated to students that the self-disclosure was unwelcome, as did rigid boundaries within supervision. For example,

> When I do sense, very firm boundaries . . . it models that, okay, you're not comfortable sharing, or talking more about yourself, at the same time, are you also uncomfortable with hearing about me? Because you were uncomfortable sharing about you?

Table 3

Supervisor Characteristics That Influence Student Willingness to Disclose

Increase willingness	Reported by	Decrease willingness	Reported by
Nonjudgmental	7	Judgmental	7
Open	6	Assumptions	5
Supportive	6	Disinterested	5
Warm	6	Rigid	4
Genuine	5	Pushing for details	4
Humble	5		
Appropriate supervisor self-disclosure	5		
Clear & early indication of openness	4		

Theme 4: Professionalism and Stigma

All participants indicated fear of some form of backlash, stigmatization, or appearing unprofessional should they disclose their trauma history. Some participants reported having

experienced this directly, for example, by having supervisors over-focus on their trauma history while ignoring or dismissing other educational concerns, making assumptions about its impact on them, or dismissing it as something to be covered exclusively in personal therapy. One participant stated,

> First of all, I don't need anybody's pity, especially my supervisor's, and I don't want that to be something that they think of when we work together. I have never wanted to ever be seen as unprofessional . . . it is just super important to me, for my supervisors to see me as professional, hardworking, and talented. I feel like if I don't bring up the trauma there's less opportunity for them to question me.

Other participants reported having observed backlash from supervisors against other students who did disclose trauma or other mental health concerns, which contributed to their unwillingness to share their personal trauma history. For example, one participant had a supervisor who

> immediately said "you need to go get therapy for this." Even though all I said was, this is similar to something I've experienced . . . the immediate response was that I'm doing something wrong, and I need to get therapy . . . it was really horrible.

Several participants denied directly experiencing or witnessing backlash following such a self-disclosure. Still, they held these concerns from hearing stories from others who had experienced or witnessed such backlash. One participant stated,

> Clinical psychology I think it's actually one of the fields that most stigmatizes mental health, particularly for members of the field. And I think it can create a really, really unhealthy system for people trying to come into it. And means we lose people out of the field, because we're not creating a mentally healthy system.

Ability to Disclose

Though some supervisors may exhibit all the characteristics a student needs to feel willing to disclose, there are nonetheless factors that can make it difficult for a student to ever feel fully able to discuss their trauma history in clinical supervision. These factors are often outside the control of the supervisor or supervisee, although some may be mitigated by positive supervisory experiences, clear supervisory boundaries, and supervisee personal reflection or growth.

Theme 5: Personal Identity Factors

These factors were primarily rooted in some part of the supervisor's or supervisee's cultural background or personal identity and were separate from anything the supervisor has or can do to increase students' willingness to disclose. For example,

> Both my supervisors this year were people of color, which I learned a lot from. But, unfortunately, my family to some degree . . . if there are degrees of racism . . . that was something, since I was a kid, I remember fighting about. It was just something within the context of my history that made me not want to be completely open with my supervisors.

On one side of this theme were identity factors on the part of the supervisor that may affect a student's choice to disclose. For example, one student indicated it was easier to disclose to female-presenting supervisors due to the nature of their trauma responses. Another reported it was easier to discuss trauma with other marginalized individuals who often need less context to understand the situations being described. For example,

> I've had a blend of identities, when it comes to my supervisors, and I definitely have found that those that have more marginalized identities at some point in their intersection,

have, maybe from their own experience, kind of known how they like people to address topics, so they've kind of modeled that in our relationship.

One the other side of this theme were the participants' personal identity factors that made it difficult for them to move past personal barriers to self-disclosure, even when a supervisor exhibited all of the characteristics needed for the student to feel comfortable. For example, one student reported societal norms related to masculinity made it difficult for him to open up, regardless of how receptive the supervisor might be. Another reflected that it was generally taboo in their cultural background to discuss negative experiences or emotions openly, despite these being commonly accepted parts of life. A third reflected on how her ability to disclose had changed from her first to final year of training, stating she now felt much more comfortable disclosing in part due to recognizing the importance and having gained confidence doing so and in part due to supervisors seeming more receptive to this type of self-disclosure as she became more advanced. For example, one participant said, "I was brought up in an environment where you don't talk about these things, it's better to muscle through." Another stated, "Culturally, we usually don't usually talk, super open and honest about our experiences of trauma . . . so I think sometimes I also tend to refrain from going into it."

Theme 6: Structural Factors

Although many students indicated they had experienced at least one supervisor who had the characteristics they required to be willing to disclose their trauma history, several continued to indicate discomfort in actually doing so due to the necessary role supervisors play as gatekeepers to the profession. One of the primary concerns discussed by most participants was the concern that bringing up their trauma history could make them seem incompetent. Though supervisors can mitigate this to some degree, the fact that supervisors will always, and

necessarily, have major input in students' ability to move on from that site and, ultimately, to obtain their degree, there is no way to completely eliminate this concern. For example,

> Knowing this person is going to write me a letter of recommendation, I don't want there to be a question about my own mental health. If I were to fail a year of practicum my degree could be put off a year, I would have to talk about it on internship applications, so I would rather just grin and bear it.

Another factor affecting students' ability to disclose was the structural factors in place that meant they would have to continue working with a supervisor for some period of time, which could be problematic should they react negatively to the self-disclosure. Though again supervisors can lessen these concerns to a point, the fact is that students are, for the most part, locked into the position with limited recourse. Though there is always the risk of a rupture in the supervisory relationship, ruptures related to trauma were something multiple students identified as more difficult to overcome than other ruptures. For example,

> It's one thing to get feedback like "you could do better about being concise in your notes." But it's another thing altogether to be like, "you need to do self-care" as it relates to trauma. That would not feel good.

Another concern was the importance of using supervision efficiently. One participant reflected that there was often limited time in supervision to cover a wide variety of topics. For example,

> There's 100 things to talk about. And everybody's trauma history is so much. It's like where do I even start? Even my one supervisor who was welcoming had a tendency at times to drive what we were talking about. So, I would be in a place where I just got very

> triggered in a session and would like to talk about it, she would be like, "we need to talk about this other thing or this other thing," and they were important things.

Many participants also reported awareness and concern that a clinical supervisor's role is, and should remain, distinct from that of a therapist. Though they all reported that there were clear clinical reasons for the self-disclosure of trauma history in clinical supervision, they also recognized the importance of keeping the self-disclosure focused on the clinical relevance of their trauma history. Students indicated they could use personal therapy to process the details of the trauma itself and its impact on their personal lives and would prefer to use supervision to address how it related to their work at practicum. For example,

> It's like a weird dynamic because it's like, I don't know, like you're a supervisor. But then the way that things are, it's almost supposed to feel like a therapy space where you open up, because they are therapists at the same time. But I don't want you to be my therapists and I don't want to kind of muddy those boundaries with these personal things about me.

Chapter 4: Discussion

The purpose of this study was to begin addressing a gap in the existing research regarding the experiences of clinical psychology students with disclosing their personal trauma history in clinical supervision. Although research exists on the topic of supervisee disclosure and nondisclosure within clinical supervision, no studies specifically looked at the experiences of disclosing a personal trauma history. Most focused on the factors influencing self-disclosure, with some looking at the differences between supervision-related and clinically-related self-disclosure. Although self-disclosure of trauma history is often clinically related, none of the studies detailed the specific nature of clinically-related disclosures (Drinane et al., 2021; Gibson et al., 2019; Guttman, 2020; Hutman & Ellis, 2020; Li et al., 2022; Mehr et al., 2015; Pakdaman et al., 2015; Staples-Bradley et al., 2019). Using a hermeneutic phenomenological approach, seven semi-structured qualitative interviews were conducted with psychology trainees in APA-accredited clinical psychology doctoral programs and analyzed using a multi-step focusing strategy to explore their thoughts and experiences related to self-disclosing a personal trauma history in clinical supervision.

Pre-interview survey results supported previous research indicating having a personal trauma history, which is a type of psychological wound, is a motivating factor for many to enter the field (Adame, 2011; M. Barnett, 2007; B. A. Farber et al., 2005; Mackay, 2019; Sawyer, 2011), with all seven participants indicating it was at least somewhat related to their decision to pursue the career. Similarly, survey results were consistent with research that shows being able to disclose psychological wounds to clinical supervisors is perceived by mental health professionals as important for clinical competence and, to a lesser extent, personal well-being (Brown et al., 2022; Leung et al., 2023; Mackay, 2019). Additionally, with five of seven participants reporting

at least occasional stigma and some discomfort with disclosure of psychological wounds, the survey results support concerns identified in the literature regarding the stigma mental health professionals with psychological wounds face in professional environments and the impact of this stigma (Adame, 2011; Cvetovac & Adame, 2017; Hankir & Zaman, 2013; King et al., 2020; Mackay, 2019; Pachankis, 2007; Sawyer, 2011; Zerubavel & Wright, 2012).

Given the number of professionals in the field who identify as having experienced one or more ACEs, psychological wounds, or negative mental health system interactions, there is an unavoidable overlap between therapists' personal mental health histories and their clinical practice. This overlap can be positive or negative, depending on how it is handled by the individual mental health professional and those around them. Without proper self-reflection, self-care, and supervision, mental health professionals with a history of adversity or psychological wounds run the risk of crossing from wounded healer to impaired professional (Adame, 2011; Ashley et al., 2009; M. Barnett, 2007; Dickeson & Smout, 2018; B. A. Farber et al., 2005; Hankir & Zaman, 2013; Mackay, 2019; Sawyer, 2011; Smith & Moss, 2009; Zerubavel & Wright, 2012).

Clinical supervision is an activity designed to help mental health professionals hone their clinical skills. This refining of clinical skills should include working through the impact of their psychological wounds on their clinical work. However, the reality of their perceived ability to discuss their psychological wounds in clinical supervision varies greatly (APA, 2014; J. E. Barnett & Molzen, 2014; Contrastano, 2020; Kozlowski et al., 2014; St. Arnaud, 2017). The participants in this study agreed that clinical supervision is an activity in which they would like to be able process how their personal wounds interact with their professional practice, and also had varied thoughts and experiences when it came to actually doing so. All seven participants

identified a large part of their desire to self-disclose their trauma history to supervisors stemmed from a desire to improve their clinical competence.

Part of the reason many professionals hesitate to disclose their personal histories of adversity, and many supervisors hesitate to encourage such disclosure, is professional and ethical concerns about discussing psychological wounds in clinical supervision. One of the concerns identified in the literature is the importance of maintaining the professional boundary between supervision and personal therapy and the role confusion that can arise from mixing personal and professional relationships (J. E. Barnett & Molzen, 2014; Contrastano, 2020; Kozlowski et al., 2014; Mackay, 2019; Sawyer, 2011; St. Arnaud, 2017). This boundary is particularly significant given the role of supervisors as gatekeepers to the field, necessitating some level of judgment of their supervisees' clinical competence (APA, 2014; J. E. Barnett & Molzen, 2014; St. Arnaud, 2017).

This was also something the participants in the current study were keenly aware of and that often stood as a barrier to their self-disclosure of their trauma histories. Students reported they worried any self-disclosure of their trauma history or its impact on their work could result in them being seen as unprofessional or incompetent. Given a supervisor's power and role as gatekeeper, being seen as incompetent or unprofessional could have serious implications for the students moving forward in their training. On the other hand, both previous research and this study's participants reflect that the nondisclosure of such things also risks their clinical competence, creating a catch-22 for students who feel the need to seek support regarding the impact of their trauma history on their work with clients (Brown et al., 2022; Leung et al., 2023; Mackay, 2019; Pachankis, 2007).

Other barriers to self-disclosure of trauma history reported by participants included fear of being pitied or seen as a victim, having supervisors overattribute unrelated challenges in clinical competence to the trauma history, or supervisors taking an inappropriate interest in personal and unnecessary details of the trauma history. These fears are not unfounded, even among licensed professionals; the fear of stigma, sometimes due to past experiences of stigma, is a prevalent reason why psychological wounds, trauma histories, and experiences of adversity are not disclosed (Adame, 2011; Cvetovac & Adame, 2017; King et al., 2020; Mackay, 2019; Sawyer, 2011; Zerubavel & Wright, 2012). Consistent with previous research, several of the participants in the current study had experienced instances of judgment or backlash after disclosing their trauma histories that “left a mark,” including being told to “go to therapy.” Others had not yet self-disclosed their histories out of fear that this could happen or due to having heard stories of it occurring to others in their training programs.

Another issue highlighted in the current study was students’ desire to be able to self-disclose their trauma histories to their supervisors when relevant to their clinical work and the importance they placed on being able to do so. The literature reviewed above also emphasized that many mental health professionals with personal trauma histories feel being able to self-disclose their psychological wounds is something they not only desire but view as integral to their professional competence and integration of their professional and personal identities. Without being able to openly discuss the impact of personal struggles on clinical care, they could run the risk of increased vicarious trauma, secondary traumatic stress reactions, burnout, and even professional impairment (Brown et al., 2022; Leung et al., 2023; Mackay, 2019; Pachankis, 2007). Consistent with past research, students in the present study reported being able to self-disclose their trauma history in supervision decreased their anxiety about seeing clients and

about going to their training sites overall. They also reported impacts on their clinical work when comparing situations in which they could self-disclose to those in which they could not or did not self-disclose.

In addition, students in the current study who wished to disclose their trauma history in supervision highlighted the importance of keeping the disclosure focused and relevant to their clinical work. Literature indicates personal therapy and self-reflection outside of the supervisory relationship are crucial to developing clinical competence (Hankir & Zaman, 2013; Mackay, 2019; Sawyer, 2011; St. Arnaud, 2017; Zerubavel & Wright, 2012). Therefore, students who do find themselves struggling to remain focused on the clinical implications of their trauma history in supervision may want to consider seeking additional personal therapy to process the more personal aspects. Participants in this study recognized this importance, with some having intentionally entered therapy before entering graduate school, others beginning therapy during graduate school, and some engaging in therapy services as needed or available throughout life. In support of students' mental health, it appears leaders of graduate programs need to do a better job of supporting student access to mental healthcare. Availability of therapy to students varied widely among participants, but none reported feeling the services offered through their university were sufficient, given the nature of the work.

Strengths and Limitations

The primary strength of this study was the diversity of the sample in terms of age, gender identity, racial identity, and clinical experience despite the relatively small and regionally specific sample. Additionally, although all participants were studying in the Midwest, at least four of the seven participants disclosed having grown up elsewhere and moved to the area for

school, meaning there was at least some geographic diversity with regard to participants' upbringing and childhood experiences.

The use of a hermeneutic phenomenological approach allowed the researcher to more fully explore the participants' thoughts and experiences related to the phenomenon of disclosing psychological wounds to clinical supervisors than would have been possible using a quantitative, or even alternative qualitative, study design. Additionally, the use of a rolling recruitment technique and grounded theory method enhanced the quality of subsequent interviews by allowing participants' experiences to inform the process and ensure all relevant questions were being asked.

This study also had several limitations, including the lack of an external expert review of the proposed research questions to ensure validity and reduce bias potential. Though questions were reviewed by the then-chair and multiple faculty members prior to IRB approval, it is still possible the researcher's personal biases influenced the research questions. The study also did not use a research assistant as another way to reduce potential bias in a qualitative design. It is therefore possible that the researcher's personal biases influenced the results in some manner, despite remaining vigilant regarding personal thoughts and emotions throughout the process. Additionally, although clarification was asked for throughout the interviews if at any point the researcher was unsure of the participant's meaning, it is still possible that a miscommunication occurred that could have been caught if participants had a chance to review their responses.

Another limitation was the difficulty recruiting participants, which resulted in a small and regionally specific sample that limited the generalizability of the study. The necessary decision to discard two interviews due to serious validity concerns further limited generalizability, as it resulted in an even smaller sample size than originally anticipated. Finally, although outside the

researcher's control, the unexpected dropping out of the original dissertation chair and passing of one of the original readers resulted in several abrupt committee changes that may have affected the overall study quality.

Future Research Directions and Recommendations

Future research is needed to explore how supervisors can open the door for student self-disclosure while maintaining appropriate boundaries between clinical supervision and therapy. To facilitate both supervisee professional development and high-quality client care, clear guidelines are needed for supervisors on how best to approach and manage students with histories of trauma and adversity. Clear communication of these guidelines to students is also needed for them to feel comfortable and able to identify when and how self-disclosure is most appropriate.

Related to this, further research into the impact of the overall culture and environment of the training site at which supervision is occurring could also shed light on the complex dynamics at play. Although not a significant theme, a few participants reported that feeling supported at practicum sites by peers or other non-supervising professionals can alleviate distress related to an unsupportive supervisor or that a supportive supervisor could mitigate some of the distress related to otherwise stressful clinical environments.

Another area of research could explore how graduate training program leaders can support students who are coming into their programs with a personal history of trauma and facilitate appropriate self-disclosure in supervision. Because many students indicated a lack of support, not only at their practicum and internship sites but also within their training programs, it is clear that more investigation is needed into how graduate training programs can realistically support student mental health.

Finally, though a fairly large body of qualitative research and many personal accounts from mental health professionals support the potential utility of psychological wounds, very little true experimental or quantitative research has been done on the topic. This reliance on qualitative information is partly due to the complexity of measuring the impact of healers' wounds on client outcomes along with a need for more longitudinal designs, which inherently take longer to complete and analyze. Regardless of these challenges, further quantitative research into the clinical utility of a healer's wounds would benefit the field.

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Appendix A

Interview Questions

Initial Interview Questions and Potential Follow-ups created for the purpose of the study:

- Why do you feel that it is _______ for your personal well-being to discuss your trauma history with supervisors?
    - How does discussing, or not discussing, your trauma history in clinical supervision impact your personal well-being?
- Why do you feel it is _______ to your professional development to discuss your trauma history with supervisors?
    - How does discussing, or not discussing, your trauma history in clinical supervision impact your professional development?
- What, if anything, have supervisors done that made you feel _____ discussing your trauma history?
    - How and why did that make you feel (un)comfortable?
- What thoughts or concerns do you have when considering disclosing your personal trauma history to clinical supervisors?
    - What, if anything, have supervisors done to address these concerns?
- What, if any, experiences of stigma have you personally experienced or witnessed related to sharing personal trauma history in clinical supervision?
    - How did that impact your thoughts about sharing trauma history with future supervisors?

The following two questions were added after first two interviews due to both participants discussing cultural aspects of self-disclosure and other information not initially considered by the researchers.

- How do you feel your cultural identity has impacted how you think or go about discussing your trauma history with supervisors?
    - How might the cultural identities of your supervisor(s) impact your decision to discuss trauma history with them?
- Is there anything you would like to add related to your thoughts or experiences discussing your trauma history in clinical supervision?

Appendix B

Pre-Interview Survey

1. Introduction & Informed Consent

Please print a copy of this page for your records.

Overview

You are being asked to participate in the study, "Exploring psychology graduate students' desire and ability to discuss their trauma history with practicum supervisors." The study is being conducted by Madeleine Lane, M.A., who is a student at the Illinois School of Professional Psychology at National Louis University working on a Clinical Research Project (CRP), under the supervision of CRP Chair Dr. Kristen Newberry, PsyD. The purpose of this study is to better understand graduate students' experiences of discussing their trauma history within the context of clinical supervision. This study is a requirement to fulfill the researcher's doctoral degree and will not be used for decision-making by any organization.

This page outlines the purpose of the study and provides a description of your involvement and rights as a participant.

STUDY GOALS

- To assess the level of importance clinical psychology graduate students place on being able to discuss their trauma history with practicum supervisors.
    - To explore the reasons behind this perceived importance or lack thereof.
- To assess how comfortable clinical psychology graduate students are with discussing their trauma history with practicum supervisors
    - To explore why students may or may not be comfortable with such discussions.
- To better understand graduate students' experiences of discussing their trauma history within the context of clinical supervision.

PARTICIPATION IN STUDY

In order to participate in the study, you must meet the following criteria:

1. Be at least 18 years of age
2. Currently enrolled in an APA accredited PsyD or PhD program in Clinical Psychology
3. Worked with at least one practicum supervisor for six or more months as part of clinical psychology training
4. Have experienced trauma(s) prior to entering graduate school (no details required)

Participation in the study will include the completion of two parts of the study with a total time commitment of up to 90 minutes which includes an online survey and a live video interview.

The online survey will take approximately 15 minutes and include:

- A Participant Qualification Screening
- A Background & Demographics Questionnaire
- Survey Questions related to your level of importance and comfort related to discussing trauma history with practicum supervisors (no details required)
- Scheduling of a Zoom Interview Time

The Zoom interview will take up to 1 hour and will be audio-recorded, and will include:

- Open-ended questions regarding the reasons why you feel it is or is not important to discuss your trauma history with supervisors.
- Open-ended question regarding whether you are or are not comfortable discussing your trauma history with supervisors.
- *No details of your trauma history will be required.*

STUDY RISKS AND BENEFITS

- The risks associated with this study are minimal because, even though you have reported a history of trauma, you will not be required to disclose details of your trauma as part of the study and may withdraw from the study at any time.
- You will be provided a list of support referrals at the end of the survey and following the interview which can provide you with resources to help manage any trauma-related symptoms.
- One benefit of participation is knowing your time and story may help researchers learn more about why supervisees choose to disclose or not to disclose their trauma histories to practicum supervisors.
- You will also receive a $25 Visa e-gift card emailed to the address provided upon completion of the interview.

CONFIDENTIALITY AND PRIVACY

- The information provided will be treated confidentially, which means that nobody except Madeleine Lane, M.A., and Kristen Newberry, PsyD., who is CRP Chair, will be able to tell who you are.
- Identifying information will be stored in a single password-protected Excel file which is only used for the purpose of storing Participant ID, name, interview schedule, and contact details.
- Recordings will be stored in a password-protected file to which only Madeleine Lane, M.A., and Dr. Kristen Newberry, CRP Chair, will have access.
- Recordings will be deleted upon completion of a transcript.
- Transcripts will be stored using Participant ID only in a password-protected file to which only Madeleine Lane, M.A., and Dr. Kristen Newberry, CRP Chair, will have access.
- All data other than the Participant ID Excel file will identify participants with the Participant ID only.
- The results of this study may be published or otherwise reported at conferences and employed to inform supervision practices, but participants' identities will in no way be revealed (data will bear no identifiers that could connect data to individual participants).
- The records of this study will be kept private. No words linking you to the study will be included in any sort of report that might be published.
- All raw data from this study will be destroyed three years following the completion of the study and all computer files containing data will be deleted from all storage media.

CONTACT INFORMATION

- You have the right to get a summary of the results of this study. If you would like a copy of the summary, please email Madeleine Lane at
- In the event that you have questions or require additional information, you can contact the researcher, Madeleine Lane, at
- This research study has been reviewed and approved by the Institutional Research Review Board at National Louis University. If you have any concerns or questions before or during participation that have not been addressed by the researcher, you may contact Dr. Kristen Newberry, CRP Chair at: kcarneynewbery@nl.edu, 18 South Michigan Ave., Chicago, IL, (312) 261-3122, or chair of NLU's Institutional Research Review Board: Dr. Shaunti Knauth, Shaunti.Knauth@nl.edu, (312) 261-3526, located at National Louis University, 122 South Michigan Avenue, Chicago, IL..

VOLUNTARY PARTICIPATION

- All participation is voluntary.
- If you do not participate, it will not harm your relationship with Madeleine Lane or the Illinois School of Professional Psychology at National Louis University.
- If you decide to participate, you can refuse to answer any of the questions that may make you uncomfortable without affecting your relationship with Madeleine Lane or the Illinois School of Professional Psychology at National Louis University.
- You can withdraw from the study at any time without affecting your relationship with Madeleine Lane or the Illinois School of Professional Psychology at National Louis University.

* 1. **CONSENT**

- I understand that my participation will consist of two activities, listed below and described in detail above:
  - This Online Survey (approximately 15 minutes)
  - A one-time recorded Zoom interview (approximately 1 hour and 45 minutes)
- I meet all four study criteria described above.
- I understand that participation is voluntary and may be withdrawn at any time.
- I have read the above information and understand that by checking "AGREE" below I am agreeing to participate in the study "*Exploring psychology graduate students' desire and ability to discuss their trauma history with practicum supervisors.*"

◯ AGREE

◯ DISAGREE

3. Background Information

5. Age (in years)

[ ]

6. Race/Ethnicity

[ ]

7. Gender Identity

[ ]

* 8. Degree Sought

◯ PhD

◯ PsyD

* 9. Year in Program

◯ 2nd

◯ 3rd

◯ 4th

◯ 5+

* 10. Total Number of direct supervisors you have worked with for 6+ months (including current if applicable)

◯ 1

◯ 2

◯ 3

◯ 4+

* 11. Total number of practicum sites you have worked at for 6+ months (including current if applicable)

◯ 1

◯ 2

◯ 3

◯ 4+

4. Survey

* 12. To what degree was your decision to become a clinical psychologist related to your trauma history?

Completely Unrelated to my choice of degree/career	Somewhat Unrelated	Unsure / Never thought about it	Somewhat Related	The main reason I chose this degree/career
○	○	○	○	○

* 13. How important is it for you to feel comfortable discussing your trauma history with supervisors for PROFESSIONAL reasons?

Not at all Important Professionally	Somewhat Unimportant Professionally	Somewhat Important Professionally	Extremely Important Professionally
○	○	○	○

* 14. How important is it for you to feel comfortable discussing your trauma history with supervisors for PERSONAL reasons?

Not at all Important Personally	Somewhat Unimportant Personally	Somewhat Important Personally	Extremely Important Personally
○	○	○	○

* 15. How comfortable are you discussing your trauma history with practicum supervisors?

Extremely Uncomfortable	Slightly Uncomfortable	Slightly Comfortable	Extremely Comfortable
○	○	○	○

* 16. To what degree have you experienced stigma or discrimination in the field due to your trauma history?

Never	Rarely	Sometimes	Often
○	○	○	○

5. Participant ID

Please enter below a 6-digit code that you can remember. This code will be used to track your data. You will need to enter this code when scheduling your interview and may also use it to withdraw your data from the study at any time should you wish to do so.

* 17. 6-digit Participant ID

[ ]

6. Interview Scheduling

18. Please copy and paste the link below into a new browser tab to schedule your Zoom interview.

Once complete, enter the date and time of your scheduled interview. A Zoom link will be sent to you within 24 hours of scheduling your interview.

Date / Time

Date	Time		AM/PM
MM/DD/YYYY	hh	mm	-

19. Please enter an email address which you can be reached at for scheduling purposes.

7. Debriefing

Please print a copy of this page for your records.

CONTACT INFORMATION

- You have the right to get a summary of the results of this study. If you would like a copy of the summary, please email Madeleine Lane at [redacted].
- In the event that you have questions or require additional information, you can contact the researcher, Madeleine Lane, at [redacted]
- This research study has been reviewed and approved by the Institutional Research Review Board at National Louis University. If you have any concerns or questions before or during participation that have not been addressed by the researcher, you may contact Dr. Kristen Newberry, CRP Chair at: kcarneynewbery@nl.edu, 18 South Michigan Ave., Chicago, IL, (312) 261-3122, or chair of NLU's Institutional Research Review Board: Dr. Shaunti Knauth, Shaunti.Knauth@nl.edu, (312) 261-3526, located at National Louis University, 122 South Michigan Avenue, Chicago, IL.

Support Referrals

In an Emergency
If you or a loved one is in immediate danger calling 911 and talking with police may be necessary. It is important to notify the operator that it is a psychiatric emergency and ask for an officer trained in crisis intervention or trained to assist people experiencing a psychiatric emergency.

National Suicide Prevention Lifeline
Call or text **988** at any time, 24 hours, 7 days a week. The Lifeline provides 24/7, free, and confidential support for people in distress, prevention and crisis resources for you or your loved ones, and best practices for professionals.

National Alliance on Mental Illness (NAMI)
https://www.nami.org/
info@nami.org

NAMI Crisis Text Line
Text NAMI to 741741 [24 hours, 7 days a week] Connect with a trained crisis counselor to receive free, 24/7 crisis support via text message.

NAMI HelpLine
1-800-950-NAMI (6264) [M-F 10 am – 6pm ET] The NAMI HelpLine can be reached Monday through Friday, 10 am–6 pm, ET. The NAMI HelpLine is a free service that provides information, referrals, and support to people living with a mental health condition, family members and caregivers, mental health providers, and the public.

PTSD: National Center for PTSD
https://www.ptsd.va.gov/index.asp
ncptsd@va.gov

Trauma: Evidenced-Based Advice From the APA
https://www.apa.org/topics/trauma/stress
https://www.apa.org/topics/psychotherapy/psychologist-therapy
https://www.apa.org/ptsd-guideline/patients-and-families

Veterans Crisis Line
A free, confidential resource for all service members, including members of the National Guard and Reserve, and Veterans, even if not enrolled in VA benefits or health care.
Call: 988 and press 1
Text: 838255
Chat Online: https://www.veteranscrisisline.net/

Appendix C

Recruitment Email and Flyer

Hello,

My name is Madeleine Lane, I am currently a doctoral student in the Clinical Psychology program at the Illinois School of Professional Psychology at National Louis University (ISPP at NLU). I writing to invite you to be part of my Clinical Research Project (CRP), and/or to share this email with anyone you know that may be eligible and interested in participating. The study "*Exploring psychology graduate students' desire ability to discuss their trauma history with practicum supervisors"* is being conducted by myself, Madeleine Lane, M.A., under the supervision of CRP Chair Dr. Kristen Carney-Newberry, PsyD, as one of the requirements to obtain my doctorate in Clinical Psychology.

The purpose of this study is to better understand the level of interest and comfort Clinical Psychology graduate students have with regard to discussing their trauma histories with practicum supervisors as part of their clinical training and explore potential reasons behind these levels of interest and comfort.

To participate you must meet the following criteria:

1. Be at least 18 years of age
2. Currently enrolled in an APA accredited PsyD or PhD program in Clinical Psychology
3. Worked with at least one practicum supervisor for six or more months as part of clinical psychology training
4. Have experienced trauma(s) prior to entering graduate school (*you will not be required to disclose the type or details of your trauma for any portion of this study*)

This includes an online survey and a Zoom interview; participation will include completing these two parts over the course of two sessions with a total estimated time commitment of up to two (2) hours. The online portion of the study takes an estimated 15 minutes to complete. The Zoom interview will take up to 1.5 hours and will be audio-recorded.

If you are interested in participating in this study, please click on the link below or see the attached flier to complete the online survey and schedule a Zoom interview.

Link to survey:

This project has been reviewed and approved by the Institutional Research Review Board at National Louis University. If you have any questions about the project, survey, or interviews, you may contact me at or Dr. Carney-Newberry at kcarneynewberry@nl.edu.

Thank you,

Madeleine Lane, M.A.,

Doctoral Student

Clinical Psychology Program

Kristen Carney-Newberry, PsyD,

Core Faculty and CRP Chair

Clinical Psychology Program

The Illinois School of Professional Psychology at

National Louis University

18 South Michigan Ave

Chicago, IL

Recruitment Flyer

Exploring psychology graduate students' desire and ability to discuss personal trauma history with clincal supervisors

The Illinois School of Professional Psychology at National Louis University is looking for volunteers to participate in a research study exploring psychology graduate students experiences of discussing past trauma with clinical supervisors.

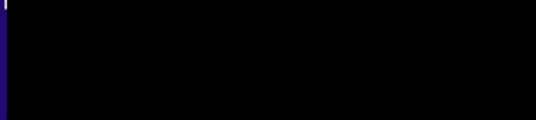
Participants must be:

- Currently enrolled in a Ph.D. or Psy.D. program in Clinical Psychology
- Have a personal history of traumatic experience(s) prior to entering graduate school (no details required)
- Worked for a minimum of six (6) months with a single practicum supervisor as part of your clinical psychology training.

Participation includes:

- working with a doctoral student
- a total time commitment of up to 1.5 hours for a survey and interview
- a $25 visa gift card upon completion of the interview

If you are interested in participating, please visit:



This study is being conducted by Madeleine Lane, M.A., a 4th-year doctoral student at ISPP at NLU, overseen by CRP Chair Kristen Newberry, PsyD.

If you have any questions, please feel free to contact Madeleine at or Dr. Newberry at kcarneynewberry@nl.edu