COUNSELOR POSTTRAUMATIC GROWTH LINKED TO HARMFUL CLINICAL SUPERVISION

by

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ABSTRACT

TRISTIN L. WHITE. Counselor posttraumatic growth linked to harmful clinical supervision. (Under the direction of DR. JOHN R. CULBRETH)

Clinical supervision is the primary method to educate and train professional counselors (Baltrinic & Wachter Morris, 2020). While clinical supervision tends to be positive and constructive, harmful clinical supervision occurs. As defined by Ellis et al. (2014a), harmful clinical supervision includes any inappropriate action or inaction by the supervisor that causes psychological, emotional, or physical harm or trauma to the supervisee. Research on harmful clinical supervision is growing (Cook & Ellis, 2021; Ellis et al., 2014a, 2015), but the focus remains on how counselors are traumatized by these experiences (Ellis et al., 2017; McNamara et al., 2017). This qualitative study takes a novel approach using the lens of Tedeschi and Calhoun's (1996) theory of posttraumatic growth to explore the positive effects of harmful clinical supervision. A sample of 12 licensed counselors completed semi-structured interviews to share their experiences. Five main themes emerged through data analysis: Confusion, Support and Encouragement, Safety and Protection, Financial Security, and Professional Duty. These findings align with the five growth categories described by Tedeschi and Calhoun, but an additional category, Professional Duty, was also identified. This study answers the research questions by providing insight into the context and process of counselor posttraumatic growth. Implications for the profession, study limitations, and suggestions for future research are discussed.

DEDICATION

For my beloved wife, DeAn White, because you have stood by me and sacrificed so much. The way out is through…

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TABLE OF CONTENTS

LIST OF TABLES xi

LIST OF FIGURES xii

CHAPTER 1: INTRODUCTION 1

Theoretical Framework 9

Need for the Study 12

Purpose of the Study 13

Research Question 14

Research Design 14

Assumptions 15

Delimitations 15

Operational Definitions 16

Associate Counselor 16

Licensed Counselor 16

Clinical Supervision 16

Harmful Clinical Supervision 16

Posttraumatic Growth 16

Summary 16

Organization of the Study 17

CHAPTER 2: LITERATURE REVIEW 19

Posttraumatic Growth Theory 19

Trauma 23

Posttraumatic 25

Growth 26

Research on Posttraumatic Growth 27

Clinical Supervision 30

Summary 39

CHAPTER 3: METHODOLOGY 41

Research Question 41

Research Framework 41

Qualitative Methods 41

Phenomenological Design 42

Hermeneutic Approach 43

Methods 43

Participants 43

Sampling and Recruitment 44

Data Collection Procedures 45

Instrumentation 46

Screening Email 46

Semi-Structured Interview 46

Data Analysis 47

Verification Procedures 48

Subjectivity Statement 49

Risks, Benefits, and Ethical Considerations 51

Summary 51

CHAPTER 4: FINDINGS 53

Participants 53

Kadie 54

Felicity 54

Jenny 54

Eleanor 54

Janice 54

Kate 55

Hendrick 55

Peter 55

Isabela 55

Barbara 56

Lori 56

Katherine 56

Themes 56

Theme One: Confusion 57

Theme Two: Support and Encouragement 61

Walk with Me 61

Hard Work 64

Professional Development 65

Theme Three: Safety and Protection 67

Physical 67

Emotional 70

Administrative 71

Theme Four: Financial Security 74

Theme Five: Professional Duty 77

Types of Harmful Clinical Supervision 80

Categories of Posttraumatic Growth 81

Summary 83

CHAPTER 5: DISCUSSION 85

Connecting Themes to Relevant Literature 85

Confusion 86

Support and Encouragement 87

Safety and Protection 88

Financial Security 90

Professional Duty 91

Context and Process of Counselor Posttraumatic Growth 91

Contributions 94

Implications 94

Limitations 96

Future Research 97

Conclusion 99

REFERENCES 100

APPENDIX A: INSTITUTIONAL REVIEW BOARD APPROVAL 128

APPENDIX B: RECRUITMENT EMAIL 130

APPENDIX C: INFORMED CONSENT 131

APPENDIX D: SCREENING EMAIL 134

APPENDIX F: PARTICIPANT DEMOGRAPHICS 137

LIST OF TABLES

TABLE 1: Harmful Clinical Supervision Categories Represented in the Data…….81

TABLE 2: Growth Categories Represented in the Data……83

TABLE 3: Participant Demographics……..133

LIST OF FIGURES

FIGURE 1: Path from Harmful Clinical Supervision to Posttraumatic Growth……...93

CHAPTER 1: INTRODUCTION

Clinical supervision is a fundamental part of professional counselor growth and development. As a signature pedagogy (Shulman, 2005), clinical supervision is the primary instructional strategy to educate counselors and develop counselor competence (Baltrinic & Wachter Morris, 2020). Through clinical supervision, associate counselors hone their skills (Bernard & Goodyear, 2019), while supervisors instill the ethical standards and practices of the profession (Beddoe, 2017). In addition, national counseling organizations frequently reference and promote supervision as a guiding practice. For example, the word *supervision* appears in The Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards and the American Counseling Association (ACA) code of ethics 68 and 37 times, respectively (ACA, 2014; CACREP, 2021). At the state level, licensing boards mandate associate counselors receive clinical supervision during a period of supervised practice before obtaining independent licensure (Field et al., 2019; Henriksen et al., 2019). Associate counselors are personally responsible for finding and contracting with a supervisor to provide clinical supervision during their supervised practice (Ellis et al., 2017a). While some counselors receive supervision as part of their employment at an agency or counseling practice, others must personally pay out-of-pocket for this service. Consequently, clinical supervision is the next step to becoming a professional counselor for almost 14,000 master-level graduates from accredited counseling programs each year (CACREP, 2019). Despite this, research focusing on the clinical supervision of associate counselors is limited (Cook & Ellis, 2021; Crockett et al., 2010).

Understanding the intricacies of supervision requires a definition. In 1992, Bernard and Goodyear suggested a definition of supervision that has become widely accepted, despite some dissent (Milne, 2007). The most recent iteration (Bernard & Goodyear, 2019) is both broad and specific, describing supervision as an intervention occurring within a relationship between a senior (supervisor) and more junior (supervisee) member of the same, or closely related, profession. This relationship enhances the supervisee's professional skills while ultimately acting as a gatekeeper to the profession. The specific elements of *intervention*, *relationship*, and *same profession* are nuanced and need further clarification.

To describe supervision as an *intervention* speaks to it being a specific action or process (Merriam-Webster, 2022b). The supervisor conveys skills and knowledge while focusing on the professional needs of the supervisee in relation to their work with clients (Corey et al., 2021). By regularly evaluating the supervisee, the supervisor targets areas needing improvement and provides direction and correction of supervisee practice (Powell, 2004). Through this process, the supervisor works to ensure competent, professionally accountable client care by supervisees who are newer to the counseling profession (Martin & Turner, 2020).

Supervision occurs within a dynamic *relationship* between the supervisor and the supervisee (Chidiac et al., 2017) and is typically experienced for the first time by counselor trainees in their educational program. The supervisory relationship is the foundation of the supervisory process (Corey et al., 2021) and changes with the growth and development of both individuals involved (Ellis, 2010). The supervisor and supervisee share responsibility in making the relationship successful, but the supervisor

ultimately carries a greater obligation due to their status, years of training, and professional experience (Cook et al., 2018).

While a supervisor's professional history is that of a counselor and may still work with clients, the supervisor no longer functions as a therapist when taking on the supervisor role with the supervisee. Instead, the supervisor works with a counselor who shares a common educational background in theory and practice. As such, the supervisory relationship may resemble some aspects of a therapeutic relationship between counselor and client, but the focus is decidedly different. According to Martin and Turner (2020), three main features of a therapeutic relationship are similar to the characteristics of a supervisory relationship. First, a therapeutic relationship focuses on the relationship between the counselor and client and the client's relational distress. However, in a supervisory relationship, the focus is on the supervisee's relationship with the client and the supervisee's professional developmental needs. Second, in terms of boundaries and disclosure in the supervisory relationship, Martin and Turner describe boundary fluidity and a larger volume of disclosure instead of critically important, rigid boundaries and limited therapist disclosure found in therapeutic relationships with clients. Finally, due to the possibility of slipping back into a counselor role, the supervisor must take precautions to maintain the appropriate structure and focus of the supervisory relationship. If the supervisor fails to be vigilant, the relationship is at risk of failure or causing harm to the supervisor, supervisee, and the supervisee's clients.

Supervision provided by members of the *same profession* serves "a professional socialization function" (Bernard & Goodyear, 2019, p. 12). Through supervisor modeling and specific instruction, supervisees develop their professional identity. For this to occur,

supervisees should receive the majority of their supervision from the same profession supervisor (Bernard & Goodyear, 2019; Borders et al., 2014). While same profession supervision is often required for state licensure (Field et al., 2019), some concessions may be allowed for a percentage of supervision provided by similar or closely related professions (e.g., counseling, psychology, social work) (Henriksen et al., 2019). To bolster this allowance, research indicates cross-disciplinary supervision can provide a perspective that is both different and helpful for supervisee professional growth (Bedford et al., 2020; Ellis, 2010).

Understanding supervision also requires differentiating between the two main types, administrative and clinical supervision. Administrative supervision focuses on promoting, coordinating, and evaluating clinical programs and services. Managerial tasks (e.g., hiring and firing staff, implementing policies and procedures, record management, employee performance evaluations) make up the bulk of administrative supervision (Tromski-Klingshirn & Davis, 2007). Administrative supervision is commonly associated with all types of non-mental health professions. Conversely, clinical supervision centers on counselor professional growth and development, clinical skills, interventions, and client welfare. Clinical tasks (e.g., review and approval of case notes, assessments, and treatment plans; observation and critique of service delivery; completion of licensing requirements) are the responsibility of a clinical supervisor (i.e., an independently licensed counselor) (Powell, 2004; Tromski-Klingshirn & Davis, 2007). Clinical supervision is typically associated with physical or mental health professions.

While not ideal, many supervisors provide both administrative and clinical supervision to supervisees. This situation describes *dual-roled supervision* and usually

results from limited staff or cost efficiency attempts (Kreider, 2014). One of the main drawbacks to dual-roled supervision is combining two evaluative supervisory roles (Tromski-Klingshirn, 2007). First, the supervisor holds the supervisee to task regarding their responsibilities as an employee while simultaneously asking them to be open and honest while discussing their flaws and failures as a counselor. This situation results in the supervisee having reasons to share and withhold information from the supervisor (Mehr et al., 2010). Despite potential problems, dual-roled supervision is common. Tromski-Klingshirn and Davis (2007) noted almost half of the supervisees in their study reported receiving supervision in this manner.

The process and requirements to become a supervisor varies from state to state and by mental health profession. In 2000, Sutton's examination of national counseling supervisor requirement trends from 45 states and the District of Columbia found only minimal requirements for counseling experience and training, and only three states offered a specific supervisor credential. Almost 20 years later, Field et al. (2019) found that requirements in all states and the District of Columbia had expanded significantly. Counselor supervisors were now required to be fully licensed, accrue years of post-licensure experience, attend numerous hours of supervision specific training, prepare and follow supervision contracts, abide by professional ethical codes, and earn an advanced supervisor credential.

Along with efforts to standardize the preparation and training of the supervisor, it was also necessary to establish a baseline of what constitutes *minimally adequate clinical supervision*. To do this, Ellis et al. (2014a) used a consensus validation approach to combine common supervision requirements and standards across multiple helping

professions (counseling, psychology, social work). The results describe a supervisor who is (a) educated and competent in counseling skills; (b) holds a supervisory credential; (c) utilizes a supervision contract; (d) routinely reviews supervisee's counseling sessions to provide fair, evaluative feedback; (e) promotes supervisee growth and development; (f) maintains supervisee confidentiality; (g) attends to multicultural and diversity issues; (h) monitors the power differential in the relationship; and (i) provides at least one hour of face-to-face supervision per week. While extensive, Ellis et al. maintain these qualifications are the "bare minimum" necessary for supervision and likely do not meet the complete standards of any single helping profession. Needless to say, if a supervisor is "unable or unwilling" to provide minimally adequate clinical supervision, the supervisor is, by default, providing *inadequate clinical supervision* (Ellis et al., 2014a, p. 439).

Given the importance of clinical supervision to educate and train counselors, it would follow that supervision is always conducted ethically and professionally. Unfortunately, because clinical supervision involves human beings in relationships, harmful experiences occur. As described by Ellis et al. (2014a), *harmful supervision* includes two key components

> (a) that the supervisee was genuinely harmed in some way by the supervisor's inappropriate actions or inactions, or
>
> (b) the supervisor's behavior is known to cause harm even though the supervisee may not identify the action as harmful (p. 440).

Within these components is the concept of a supervisee being "harmed." While it is impossible to account for every possible situation, Ellis et al. define harm as any action

by the supervisor that causes “psychological, emotional, and/or physical harm or trauma to the supervisee” (p. 441). Additionally, harm can occur on more than one occasion, or be part of an ongoing situation; happen in individual or group supervision; and with one or more supervisors (Ellis et al., 2014a). This description of harm is inherently subjective, as it requires the supervisee to evaluate not only the actions of the supervisor but also their response to those actions. Furthermore, while it may seem obvious what actions could or would cause harm, Ellis et al. acknowledge the possibility of a supervisee being unaware that a supervisor's actions are harmful. Because some dynamics of the relationship may be more covert, supervisees may find it difficult to recognize and even more difficult to address (Ammirati & Kaslow, 2017).

To provide more clarity, Ellis et al. (2014a) attempted to differentiate *inadequate supervision* (e.g., failing to spend adequate time in supervision, neglecting to monitor and evaluate supervisee client care, disregarding supervisee skill development) from *harmful supervision* (e.g., sexual improprieties, aggressive or abusive behavior, supervisee boundary violations, macro- and microaggressions, public humiliation). Through a two-staged study, Ellis et al. (2014b) developed and tested the Inadequate and Harmful Supervision Descriptor Ratings scale. When administered, results indicated 90% of supervisees reported at least one of the characteristics of inadequate supervision, while 28% reported the more serious harmful supervision.

While all supervisors have the capacity to cause harm (Ammirati & Kaslow, 2017; Borders, 2017; Ladany, 2014), determining the prevalence of harmful clinical supervision is difficult. One of the reasons for this is the low number of complaints filed against mental health professionals (Van Horne, 2004) and an even smaller number are

supervision specific (Pope & Vetter, 1992). In addition, complaint allegations are often combined into categories. For example, of the 5,626 counselor liability insurance claims reported during a five-year period (2014–2019), 13% included allegations related to the 2014 ACA Code of Ethics Section F: Supervision, Training, and Teaching (CNA/HPSO, 2019). Unfortunately, without delineating the category further, the number of supervision-related allegations is unknown.

Another reason harmful clinical supervision remains hidden is the lack of reporting. Because clinical supervision is a required component of supervised practice leading to full licensure, associate counselors can be in a position to accept harmful supervision rather than having no supervision. Kiewitz et al. (2016) described this as avoidance-based behavior in the form of silence. To avoid further harmful supervision, the supervisee withholds information. By remaining silent, the supervisee also avoids supervisor retaliation (e.g., the supervisor will not complete required documentation for the licensing board or provide a recommendation letter) (Cook et al., 2018). This willingness to suffer in silence suggests associate counselors understand their career as professional counselors is in jeopardy without clinical supervision.

For those counselors who have experienced harmful clinical supervision, research and commentary tend to focus on how the lasting, adverse effects of these experiences have stunted or derailed the counselor's career (Ellis et al., 2017; McNamara et al., 2017). The literature on harmful clinical supervision overwhelmingly focuses on the adverse effects and does not account for any positive results (Anonymous, 1991; Ellis, 2017b; Ellis et al., 2017; McNamara et al., 2017; Miller & Larrabee, 1995). This negativity bias gives the impression that supervisee impairment or lasting detriment are the only possible

results of harmful clinical supervision. While not negating the counselor's experiences, this study focused on how harmful clinical supervision can also foster positive, life-changing experiences known as posttraumatic growth. By shifting the focus to posttraumatic growth, this study helps illuminate the critical individual and contextual factors that make supervisees more growth oriented. Finally, this study contributes to the literature on clinical supervision as no studies have focused on harmful clinical supervision in counseling and posttraumatic growth.

Theoretical Framework

In nature, plants that require fire to complete their reproductive cycle are called pyrophytes. These types of plants can persist after an experience that seriously harms or kills other plants (WorldAtlas, 2021). The destructive nature of fire, while a significant trauma, actually promotes new growth and is a vital part of the ecosystem. Without the shock and distress of fire, pyrophytes cannot thrive. In contrast, humans tend to avoid pain and suffering. To experience trauma means going through significant hardship. Not only does this type of experience have a negative connotation, but it is often viewed as a precursor to maladaptive functioning (Captari et al., 2021). But some individuals experience traumatic events, and while they do describe significant discomfort, they also report the trauma has led to positive or life-changing results. Like pyrophytes, these individuals can transform trauma into growth and change for the better.

With this concept in mind, the research lens for this study follows the theory of posttraumatic growth. Coined by psychologists Richard Tedeschi and Lawrence Calhoun in 1995 at the University of North Carolina at Charlotte (UNCC), posttraumatic growth is “positive psychological changes experienced as a result of the struggle with traumatic or

highly challenging life circumstances" (Tedeschi et al., 2018, p. 3). The resulting changes can occur in multiple life areas and are usually stable and permanent. Posttraumatic growth should not be confused with changes associated with normal human development or the similar-sounding concepts of resilience (general resistance to trauma) and recovery (the process of returning or combating an actual or perceived problem). Posttraumatic growth is inherently different because it focuses on changes in how individuals think, feel, and behave "because the events they have experienced do not permit them to return to baseline functioning" (Tedeschi et al., 2018, p. 5). Instances of posttraumatic growth reflect a fundamental change and are a direct result of trauma.

As a constructivist perspective, posttraumatic growth theory suggests individuals actively create meaning in their lives through their experiences (Joseph, 2011). Individuals find patterns and make meaning, which in turn helps them organize and understand the world. Over time, fundamental beliefs about the world are constructed and held. For example, when an individual experiences a trauma challenging these fundamental beliefs, the individual comes to a crossroads; they must decide how to incorporate this new experience into their worldview (Baumann, 2018). Because trauma is typically out of the ordinary and does not fit what an individual expects to happen, there is often a struggle to understand and make meaning of the event (Silverstein et al., 2016). This mental and emotional struggle defines meaning, and changes become stable and permanent (Tedeschi & Blevins, 2015).

While posttraumatic growth theory and research are relatively new, the concept is not. The UNCC Posttraumatic Growth Research Group noted the theme of posttraumatic growth occurring throughout spiritual and religious traditions, literature, and philosophy

(UNCC, 2014). Perhaps one of the better-known quotes to reference the concept of posttraumatic growth is by philosopher Friedrich Nietzsche, “What does not kill me, makes me stronger” (Nietzsche, 1990/1889).

Despite being a familiar concept, posttraumatic growth is challenging to measure because it is both personal and subjective. Prior to Tedeschi and Calhoun (1996) developing the Posttraumatic Growth Inventory (PTGI), the three general areas of growth were: changes in relationships with others, philosophy of life, and views of the self (Tedeschi & Calhoun, 1995). Using quotes from previous research participants (Tedeschi & Calhoun, 1988), the PTGI includes 21 items rated on a Likert-type scale to measure five growth categories: (a) relating to others, (b) new possibilities, (c) personal strength, (d) spiritual change, and (e) appreciation for life.

The growth category *relating to others* encompasses positive change in relationships, including personal attitudes or behaviors in the relationship. Some examples include changing life priorities, spending more time with family or friends, telling others how much they are loved (Shakespeare-Finch & Barrington, 2012), and moving on from relationships that are no longer supportive (Krosh & Shakespeare-Finch, 2016). *New possibilities* describe how individuals can recognize new possibilities in their lives, take a different life path, or develop new interests or habits. This type of growth is often reported by those who have experienced life-threatening illnesses like cancer (Costa & Pakenham, 2012; Morris et al., 2011). The category of *personal strength* refers to experiences of “increased self-reliance…sense of strength and confidence, and a perception of self as survivor or victor rather than ‘victim’” (Tedeschi et al., 2018, p. 27). With this survivor perspective, individuals often experience behavioral changes, such as

focusing on personal betterment or learning new skills (Shakespeare-Finch & Barrington, 2012). The growth category *of spiritual change* targets the experiences of religious, agnostic, or atheist people and those from other cultures who endorse broader spiritual or existential changes (Calhoun et al., 2010; Tedeschi et al., 2017). Examples of this growth category include deeper faith in God, improved interpersonal connections, and harmony with nature. Finally, *appreciation for life* includes experiences of increased awareness and gratitude for what life can offer. This growth category describes experiences of noticing and appreciating everyday things that were previously taken for granted (e.g., a sunrise, enjoyable food, physical mobility) (Tedeschi & Calhoun, 1996).

In summary, posttraumatic growth theory is the theoretical lens for this study because it offers a framework for understanding how some individuals can recognize positive changes after experiencing significant trauma. Posttraumatic growth theory posits that traumatic events trigger a cognitive process of evaluating core beliefs and integrating new information. This process assists individuals move through adversity and recognize positive changes in how they view and experience the world.

Need for the Study

Given the importance of clinical supervision to educate and train new counselors, research is vital to understand how counselors experience supervision and are affected by the process. For example, research on harmful clinical supervision occurrence rates is growing (Cook & Ellis, 2021; Ellis et al., 2014a, 2015), but the focus remains on how counselors are traumatized by the experience. Unfortunately, the vast majority of literature on harmful clinical supervision continues to have a negativity bias (Anonymous, 1991; Ellis, 2017b; Ellis et al., 2017; McNamara et al., 2017; Miller &

Larrabee, 1995). This study seeks to fill the gap in literature on harmful clinical supervision by calling attention to the possibility of posttraumatic growth. As no research to date focuses on counselors who have experienced posttraumatic growth linked to harmful clinical supervision, this study will shed light on the phenomenon and provide a starting point for future research.

It is also foreseeable that this study could provide positive, practice implications and benefits to the counseling profession. If counseling programs educate students about harmful clinical supervision, those students are more likely to recognize and address harmful supervision when they experience it. By beginning the discussion early in counselor education and development, harmful clinical supervision would no longer be a taboo topic that is ignored. Counselors would be empowered to speak out about inappropriate or unethical practices and report those supervisors that fail to provide minimally adequate supervision or engage in harmful clinical supervision. With increased reporting, a clearer understanding of the scope of the problem and remediation is possible.

Purpose of the Study

The purpose of the study is to describe the lived experiences of counselors who report posttraumatic growth linked to harmful clinical supervision. This study will explore the context and process of counselor posttraumatic growth. Through this study, a gap in the current literature will be addressed and serve as a starting point for future research.

Research Question

The primary question for the study is: What are the lived experiences of counselors who report posttraumatic growth linked to harmful clinical supervision? Two additional questions are: (a) in what context does posttraumatic growth occur? and (b) what is the process of counselor posttraumatic growth?

Research Design

This study is a qualitative exploration of counselor experiences of posttraumatic growth linked to harmful clinical supervision. The purpose of the study is to gain a deeper understanding of how harmful clinical supervision can foster posttraumatic growth in counselors. This study will utilize a phenomenological research design with semi-structured interviews to answer the research question. Phenomenology is the study of individual consciousness from the first-person point of view (Vagle, 2018) that assists the researcher in learning and describing what individuals experience and how they experience it (Moustakas, 1994). Because this study will focus on a phenomenon a specific group of individuals shares, phenomenology is an appropriate tool to increase the depth and breadth of the researcher's understanding (Creswell & Poth, 2017; Moustakas, 1994).

This study will also employ a hermeneutic approach to phenomenology. The basic tenet of this approach involves the way an individual experiences the world around them (Creswell & Poth, 2017). Rather than being a “blank slate” from the beginning, an individual's experience of the world is full of meaning. This meaning is due to the interpretation of the world through the individual's existence and relationships with others (Vagle, 2018). It is impossible to view the world before examining experiences because

no one was there to experience it. Consequently, every experience a person has ties directly to their relationship with others. Because this study will focus on counselors and their experiences in supervisory relationships, a hermeneutic approach is fitting.

Assumptions

Assumptions of this study:

- Participants will voluntarily participate.
- Participants will have experienced harmful clinical supervision linked to posttraumatic growth.
- Participants will have similar experiences of harmful clinical supervision linked to posttraumatic growth.

Delimitations

Factors the researcher can control in this study:

- The researcher determined the criteria for participation:
    - Participants must be counselors credentialed as Licensed Clinical Mental Health Counselor (LCMHC) or Licensed Clinical Mental Health Counselor Supervisor (LCMHCS) by the North Carolina Board of Licensed Clinical Mental Health Counselors (NCBLCMHC).
    - Participants must have at least five (5) years of post-licensure counseling experience.
    - Participants must self-report experiencing harmful clinical supervision.
- The researcher developed an interview protocol and conducted it equally with all participants.
- The researcher completed participant interviews until data saturation.

Operational Definitions

Associate Counselor

An individual who is provisionally licensed by a state regulatory board and required to complete supervised practice with an independently licensed counselor (clinical supervisor).

Licensed Counselor

An individual who has completed all the state regulatory board requirements and holds an unrestricted, independent counseling license.

Clinical Supervision

An intervention occurring between a licensed counselor (supervisor) and an associate counselor (supervisee) and focuses on supervisee professional growth, skill development, and client welfare.

Harmful Clinical Supervision

Any inappropriate action or inaction by the supervisor causing psychological, emotional, and/or physical harm or trauma to the supervisee.

Posttraumatic Growth

Positive psychological changes experienced by an individual as a result of the struggle with a traumatic event.

Summary

This chapter introduces the phenomenon of counselors who experience harmful clinical supervision linked to posttraumatic growth. While supervision is the primary intervention to educate and train counselors and typically follows ethical and professional standards, instances of inadequate and harmful clinical supervision occur. Current

research focuses on harmful clinical supervision's lasting, adverse effects while downplaying or ignoring positive outcomes. Because some growth is only possible through suffering, this study focuses on posttraumatic growth resulting from harmful clinical supervision in counselors. As such, posttraumatic growth theory is the theoretical framework guiding this study and providing a lens for interpreting and contextualizing the data. The aim of this study is to contribute to the literature on clinical supervision by offering insights from counselors who experience posttraumatic growth linked to harmful clinical supervision. This study will highlight in what context posttraumatic growth occurs and the process of counselor posttraumatic growth. The results from this study will assist counselors, counselor educators, counselor supervisors, and counselor supervisees by describing a largely undocumented phenomenon, and providing positive, practical implications and benefits to the counseling profession.

Organization of the Study

This dissertation is made up of five chapters. Chapter one introduces the overarching topic and suggests a focus for the study. This chapter also provides an overview of relevant literature, operational definitions, research questions, assumptions, limitations, and delimitations. Chapter two offers an exploration into the development of posttraumatic growth theory, including a review of literature pertinent to this study. This chapter also includes greater detail about the counseling profession, how counselors utilize clinical supervision, and current research on harmful clinical supervision. Chapter three includes a description of the methodology and includes information about the researcher, participants, instruments, data collection procedures, and data analysis. Chapter four summarizes participant demographic information and study findings in the

form of themes and subthemes. Finally, chapter five provides a discussion of the study findings and their connection to current literature. This chapter ends by providing contributions and implications of the findings, limitations of the study, and suggestions for further research.

CHAPTER 2: LITERATURE REVIEW

This chapter begins with an examination of the theoretical framework of this study, posttraumatic growth theory. This includes a discussion of the seven principles of growth, specific elements of the current theoretical model, how posttraumatic growth can be both a process and outcome, and the context surrounding the term posttraumatic growth. Finally, specific research relevant to posttraumatic growth and clinical supervision is discussed.

Posttraumatic Growth Theory

A theoretical model for posttraumatic growth was developed by Tedeschi and Calhoun in 1995 to outline the "general psychological processes that lead to growth" and determine key concepts for further research and clinical practice (Tedeschi et al., 2018, p. 41). The model incorporates the theoretical constructs of coping, creativity, and change into seven principles that describe the growth process through a cognitive framework (Tedeschi & Calhoun, 1995). The first three principles center growth on *schema change.* In relation to psychology, schema is how an individual organizes knowledge about concepts in order guide cognitive processes and future behavior (APA, 2022c). Accordingly, an individual's schema is a blueprint of how the world works. When this blueprint is challenged by a traumatic event, the individual evaluates how this new experience fits their core beliefs about the world. As the individual incorporates this new knowledge from the trauma experience, schema change occurs. A revised and updated blueprint is developed, which can lead an individual to growth and change. Principle four suggests that different types of trauma produce different types of growth. For example, the particular growth following a divorce would be different from growth related to experiencing a natural disaster. The fifth principle indicates that personality

characteristics (i.e., optimism, hardiness, locus of control, self-efficacy) contribute to a greater likelihood of growth. Principle six states that "growth occurs when trauma assumes a central place in the life story" (Tedeschi & Calhoun, 1995, p. 85). This principle is based on the narrative approach (McAdams, 1993) that assists individuals to cognitively "rework" their trauma experience. Finally, principle seven posits that wisdom is a product of growth.

Since its inception, the theoretical model of posttraumatic growth has gone through multiple revisions. These revisions include the addition of antecedents, the different ways individuals experience posttraumatic growth, social support, additional challenges, self-disclosure, and cultural elements (Calhoun et al., 2010; Calhoun & Tedeschi, 1998, 2006, 2013; Tedeschi & Calhoun, 2004). However, the central ideas of posttraumatic growth regarding core beliefs remain the same. In the most recent version of the model (Tedeschi et al., 2018), two distinct pathways diverge regarding assumptive core beliefs: on one path beliefs are challenged, on the second path beliefs provide context for the traumatic event. According to the model, after a period of rumination, an individual reaches a tipping point when core beliefs change, and growth is possible.

Rumination is a cognitive process involving excessive, repetitive thoughts (APA, 2022b) and presents as either intrusive or deliberate (Han et al., 2021). Intrusive rumination is involuntary, often causing significant distraction or emotional distress, and is a normal part of an initial trauma response (Tedeschi et al., 2018). On the other hand, deliberate rumination is purposeful reflection on ideas or events to gain understanding (Freedle & Kashubeck-West, 2021). Both forms of rumination can occur after a traumatic

event, but intrusive rumination typically fades over time (Calhoun et al, 2000) and is often replaced, or accompanied by, deliberate rumination (Tedeschi et al., 2018).

Deliberate rumination is positively associated with posttraumatic growth (Cann et al., 2011; Morris & Shakespeare-Finch, 2011), including connections to meaning-making within the posttraumatic growth theoretical model. According to theories on meaning-making, it is an intrapersonal process reflecting the idea that life has purpose, makes sense, and has significance (Martela & Steger, 2016). When an individual moves to the point of deliberate rumination, they are also able to engage in meaning-making (Cameron et al., 2022). While posttraumatic growth is not a predictable outcome of the meaning-making process, given the right conditions, it can be a common outcome (Calhoun et al., 2010).

Depending on the point of view, posttraumatic growth can be both a process and an outcome (Tedeschi et al., 2018). When an individual examines specific aspects of their life and completes a positive reappraisal, posttraumatic growth is a process. In situations where an individual asserts that their life has changed after trauma in both a lasting and positive way, posttraumatic growth would be an outcome. The process of posttraumatic growth begins with a significant encounter with a highly challenging event. In response, the individual must examine and confront their assumptions or core beliefs about the world. Consequently, the individual experiences mental and emotional struggles that lead to distress and intrusive, unpleasant rumination. This process continues to direct and deliberate ruminating about the traumatic events and the eventual realization of the posttraumatic growth experience. When an individual identifies the experience of posttraumatic growth, they have reached the outcome of posttraumatic growth. This

outcome is composed of positive changes that result from a complex blend of cognitive, emotional, and social processes (Tedeschi & Blevins, 2015). Posttraumatic growth often presents as a stable or permanent change. Upon recognizing that the trauma experience and process have made a lasting and significant change for the better in their lives, posttraumatic growth as an outcome is realized.

Despite ongoing research on the phenomena, multiple measures to test for it, and agreement that growth after trauma is possible, there continue to be fundamental questions about the existence of posttraumatic growth. Described as "illusionary posttraumatic growth," its advocates claim it to be basic self-deception and a way for an individual to cope with particularly difficult or adverse circumstances (Boals & Schuler, 2018, 2019; Boehm-Tabib, & Gelkopf, 2021; Jayawickreme, & Blackie, 2014). This "illusion" follows the logic of ego defense mechanisms in that individuals are virtually unable to have an objective view of themselves. Instead, individuals tend to project a favorable or positive self-image to defend against the fear, anxiety, and pain associated with their actual selves (Pat-Horenczyk et al., 2015). These two faces, one reality and one illusion, are described by Maercker and Zoellner (2004) as the Janus-faced model. Janus, a Roman deity and god of beginnings and endings, is typically portrayed with two faces, looking in opposite directions. Maercker and Zoellner contended that there are two opposing types of posttraumatic growth: constructive and illusionary. Constructive posttraumatic growth is self-transcending and a direct result of successfully dealing with a traumatic event. Because it is "real," constructive posttraumatic growth is also long-lasting. On the other hand, illusionary posttraumatic growth is a short-lived self-deception that often results in maladaptive functioning. An individual is only fooling

themselves to avoid the pain associated with the traumatic event, and this façade is ultimately doomed to failure.

When Tedeschi and Calhoun introduced the term posttraumatic growth in 1996, it was the culmination of research on the "potential positive impact of the struggle with stressful events" (Tedeschi et al., 2018, p. 8). Their earlier work used "perceived benefits" as the descriptor and joined an increasing variety of terms to describe the phenomena: stress-related growth, positive psychological changes, thriving, construing benefits, adversarial growth, flourishing, positive by-products, discovery of meaning, positive illusions, drawing strength from adversity, positive reinterpretation, and transformational coping (Tedeschi & Moore, 2021). As Tedeschi and Calhoun refined their work, it was vital to identify a term to accurately reflect the positive, transformative nature of the phenomena. To provide context for the term posttraumatic growth, the concepts of *trauma*, *posttraumatic*, and *growth* are described and explored below.

Trauma

When defined in relation to mental health, trauma is a deeply distressing or disturbing experience (Merriam-Webster, 2022d). According to the American Psychological Association (APA) (APA, 2022d), examples of trauma include "terrible event(s) like an accident, rape, or natural disaster" (n.p.). Unfortunately, trauma is not a rare occurrence. The National Institute of Mental Health estimates that about 60% of men and 50% of women will experience at least one significant trauma in their lifetime (NIMH, 2017).

As a result of this prevalence, the APA has described trauma in each edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) since 1980. The DSM-III

(1980) includes trauma in the diagnostic criteria for post-traumatic stress disorder (PTSD). Specifically, the manual describes how a traumatic event would "generally be outside the range of usual human experience" and "evoke significant symptoms of distress in most people" (APA, 1980, p. 236.). In 1994, the DSM-IV went further to include anyone who "experienced, witnessed, or was confronted with an event…that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others… [resulting in] intense fear, helplessness or horror" (APA, 1994, pp. 427–428). Finally, in the DSM-5 (2013), the description of a traumatic event is notably brief: "exposure to actual or threatened death, serious injury, or sexual violence" (p. 271). These revisions have allowed a more comprehensive, yet narrow, view of trauma.

While the way trauma is defined clinically has changed over time, posttraumatic growth theory offers a more inclusive definition. Calhoun and Tedeschi (2004) explained that trauma is not defined by the event but rather by "its effect on schemas, exposing them to reconstruction" (p. 100). This view of trauma includes a wide variety of circumstances, if the events significantly challenge or invalidate the essential components of an individual's assumptive world (Calhoun & Tedeschi, 2006). Trauma's subjective and objective qualities are of interest through this lens and are defined as "a highly stressful and challenging *life-altering* event" (Tedeschi et al., 2018, p. 4).

However, stressful and challenging events should not be confused with everyday stressors (Hitter et al., 2017). Traumatic events are those of a significant magnitude. They are remarkable not only because they are undesirable but because they are extreme. Tedeschi et al. (2018) refer to these events as "seismic" and liken them to earthquakes that rock or destroy a building's foundation. Traumatic events produce anxiety, fear, and

uncertainty about the future. They often include sizable losses (i.e., loved ones, way of life, a basic understanding of how the world works) and lasting impact (Captari et al., 2021).

Lastly, it is essential to consider that a traumatic event can be more than just one discrete point in time. Some traumas, like prolonged illnesses, wartime combat, or natural disasters and their aftermath, can extend over several days, weeks, or longer. In these circumstances, Tedeschi and Moore (2021) suggested that it can be difficult to distinguish the traumatic event phase from the posttraumatic phase and what changes or challenges an individual might experience.

Posttraumatic

Posttraumatic refers to the period of time or circumstances that occur after a traumatic event (Merriam-Webster, 2022c). Accordingly, posttraumatic growth focuses on changes an individual experiences after a traumatic event rather than those occurring before or during the event (Tedeschi & Calhoun, 1996). The timeframe in which posttraumatic growth develops usually extends in terms of days, weeks, and even years. As Tedeschi et al. (2018) explained, an individual typically reacts instinctually and without careful consideration immediately following a traumatic event. As time elapses, that same individual experiences a sense of distance and safety from the event. This change in perspective over time allows the individual to see the traumatic event from a different angle and in relation to other life experiences.

As each individual works through trauma at their own pace, an ideal or definitive timeframe that fosters posttraumatic growth is difficult to pinpoint. As a result, Calhoun and Tedeschi (2013) often describe this period of time as part of the "posttraumatic

journey." The word *journey* evokes a longer than average trip, taking a roundabout way to get from point A to point B (e.g., Homer's *The Odyssey*). While most individuals can navigate this journey without professional mental health services (Tedeschi & Calhoun, 2006), others need and actively seek out this type of assistance.

In clinical practice, Calhoun and Tedeschi (2013) described the professional stance of "helping people who are coming in for assistance in coping with trauma and its aftermath *expert companionship*" (p. 23). During the posttraumatic time period, mental health professionals act as facilitators of growth and the growth process. As trusted companions, these same professionals offer expertise in nurturing others, at a pace that is comfortable to the individual (Calhoun & Tedeschi, 2013).

Growth

The word *growth* has many definitions (Merriam-Webster, 2022a), but none adequately describes the growth associated with posttraumatic growth. The transformation that can occur in the wake of a traumatic event involves positive changes in an individual's cognition and emotional life. These, in turn, often result in significant behavioral changes and a transformative life experience. However, this growth should not be confused with the normative development associated with expected periods of change in an individual's life. According to Calhoun and Tedeschi (2013), unexpected and unplanned traumatic events spark posttraumatic growth. These events are non-normative and "do not permit (the individual) to return to baseline functioning" (Tedeschi et al., 2018, p. 5). Because an individual's baseline functioning has changed, posttraumatic growth differs from similar concepts such as resilience (resistance to trauma) and recovery (the process of returning or combating an actual or perceived problem)

(Tedeschi et al., 2018). Consequently, posttraumatic growth is a unique experience that only manifests after trauma.

Research on Posttraumatic Growth

The human tendency is to focus on the negative. Often called a negativity bias (Brooks et al., 2021), its origins have connections to human survival (i.e., recognizing danger maintains safety). This negativity bias appears in research as well. The pathogenic perspective, which centers on disease development and psychological disorders, has consistently guided research for years (Calhoun & Tedeschi, 2006). For example, in the case of PTSD, this focus contributes to it being the most widely studied stress-related disorder (Barton et al., 2013). In a simple search using all the available databases through the University of North Carolina at Charlotte library, the term PTSD in scholarly journals resulted in almost 158,000 hits. Comparatively, the term posttraumatic growth resulted in only 10,400 hits. There may be multiple reasons for this vast discrepancy, but one explanation could be the research perspective of PTSD versus that of posttraumatic growth; one focuses on problematic functioning after trauma, while the other considers the positive results.

Due to its position within the domain of positive psychology (Seligman & Csikszentimihalyi, 2014), research on posttraumatic growth naturally favors a salutogenic perspective (focus on health and well-being) (David et al., 2022). This perspective is also consistent within the counseling field. Counselors, as opposed to other mental health professions, have a unique identity that focuses on client wellness (Fetter & Koch, 2009; Herlihy et al., 2018) within a therapeutic relationship (Vilkin et al., 2022). *Wellness* is a broad term that includes a holistic view of health where the mind, body, and spirit

function at optimum levels (Archer et al., 1987). Accordingly, wellness models (Myers & Sweeney, 2005; Myers et al., 2000), as opposed to the medical or illness model of mental health, include a collaborative, strength-based approach (Myers, 2003). Counselors actively assist clients in recognizing and utilizing their strengths to practice wellness and strive for self-actualization (Sylvestro et al., 2021). Through a professional, therapeutic relationship, counselors capitalize on client strengths and promote positive client outcomes (Cochran & Cochran, 2015).

Research on positive outcomes like posttraumatic growth is rapidly increasing. To assist this process, multiple instruments are available to specifically measure for posttraumatic growth including the Posttraumatic Growth Inventory (PTGI) (Tedeschi & Calhoun, 1996), Posttraumatic Growth Inventory Short Form (PTGI-SF) (Cann et al., 2010), and the Posttraumatic Growth Inventory Expanded (PTGI-X) (Tedeschi et al., 2017). Other measures commonly used include the Stress-Related Growth Scale (SRGS) (Park et al., 1996), Stress-Related Growth Scale Short Form (SRGS-SF) (Cohen et al., 1998), and Stress-Related Growth Scale Revised (SRGS-R) (Boals & Schuler, 2018). All of these utilize statement items rated on a Likert-type scale with a simple scoring process. Despite this abundance of quantitative measures, a significant proportion of research on posttraumatic growth research continues to be qualitative. While possibly more time consuming, qualitative measures that include semi-structured interviews with open-ended questions are particularly well-suited to capture the unique voices and thick descriptions (Moustakas, 1994) of positive, personal experiences after trauma.

Posttraumatic growth research is varied and crosses multiple disciplines. While focusing heavily on mental health professions (e.g., psychology, counseling, social

work), there are also studies in the fields of medicine, religion, sociology, and sports (Jayawickreme et al., 2021). Because posttraumatic growth is multifaceted, studies show the varied dimensions that make up the concept. A small sampling of this research includes trauma type-specific posttraumatic growth (Silverstein et al., 2016), vicarious trauma (Foreman et al., 2020), multiple traumas (Brooks et al., 2021), addiction (Ogilvie & Carson, 2022), childhood sexual abuse (Hitter et al., 2017), bereavement (Lumb et al., 2017), attachment (Captari et al., 2021), coaching business executives (Joseph, 2018), training and administrative supervision (Coleman et al., 2021), grief (Williams et al., 2021), mental health recovery (Llewellyn-Beardsley et al., 2019), suicide-loss survivors (Levi-Belz et al., 2021), PTSD symptoms (Yazici et al., 2021), personality and trauma dynamics (Shuwiekh et al., 2017), religion (Lehmann & Steele, 2020), and a theoretical model on the long-term consequences of abusive supervision (Vogel & Bolino, 2020).

While no research currently focuses on counselor posttraumatic growth linked to harmful clinical supervision, some literature does examine vicarious posttraumatic growth in counselors and counselor trainees. Due to the nature of the counseling profession, counselors are often exposed to the traumatic experiences of their clients. This vicarious traumatization has both negative and positive psychological consequences (Schauben & Frazer, 1995). To explore the impact of vicarious traumatization on professional development in counselors, Foreman et al. (2020) conducted semi-structured interviews with nine counselor trainees who were part of a previous mixed methods study about vicarious trauma (Foreman, 2015). The data resulted in nine domains, the majority of which shared similar experiences and views commonly associated with trauma. The responses also included elements strongly associated with posttraumatic growth,

including a change in outlook on life, greater appreciation of family and friends, and renewed focus on important life tasks. These results were similar to research by Skovholt and Ronnestad (2003) that described counselor trainees' first clinical experiences as a "catalyst for novice stress" (p. 45). Stressful experiences early in counselor training are linked to experiencing doubts about professional competence and career choice (Lu et al., 2017), as well as challenges to perceived counselor self-efficacy (Howard et al., 2006).

Within other mental health professions (e.g., psychologists, social workers), recent research on experiences of posttraumatic growth has centered on the Covid-19 pandemic. Ledesma and Fernandez (2022) used a qualitative approach to examine how practicing psychologists were affected by the pandemic. Because the pandemic provided a "unique context for psychotherapists as they are in a shared traumatic reality with the client" (p. 525), there was concern that additional pressure and psychological distress will affect the ability of therapists to provide client services. Online interviews of eight licensed psychologists working in a group clinical setting were analyzed using narrative analysis methods. The results included four chapters in the shared participant narrative: 'thrown up in the air,' struggling to find their roots, gaining stability, and 'finding a new rhythm.' Covering a nine-month period, the progression of experiences through these chapters highlights significant personal and professional growth. These results are similar to other studies of mental health workers in a shared traumatic reality (Baum, 2014, 2021; Lavi et al., 2017; McTighe & Tosone, 2015).

Clinical Supervision

Bernard and Goodyear (2019) described supervision as an intervention occurring within a relationship between a senior (supervisor) and more junior (supervisee) member

of the same, or closely related, profession. This relationship enhances the supervisee's professional skills while ultimately acting as a gatekeeper to the profession. Clinical supervision is essential for counselor education, growth, and professional development (Martin & Turner, 2020). Due to its importance, research on clinical supervision is plentiful.

Two broad but related categories, supervisor competencies and evidence-based or best practices, are relevant in clinical supervision research (Borders, 2014; Watkins, 2020). While supervisor competencies outline what supervisors should know, best practices describe what supervisors should do (Falender et al., 2014). This research contributes to the recognition of clinical supervision as a distinct specialty (Borders et al., 2014), with dedicated clinical supervision journals and regulatory boards offering supervisor credentials that attest to specific knowledge and competencies (Falender & Shafranske, 2021). Additionally, this research provides evidence that the supervisory relationship, also known as the supervisory alliance (Watkins, 2014) or supervisory working alliance (Bordin, 1983), is key to the overall effectiveness of supervision and the growth and development of the supervisee (Falender & Shafranske, 2021; Stoltenberg & McNeil, 2010).

Similar to the therapeutic alliance between a counselor and client, the supervisory alliance is a multidimensional relationship between the supervisor and supervisee (Bernard & Goodyear, 2019). Research supports the connection between a solid supervisory alliance and greater supervisee satisfaction with supervision (Ghazali et al., 2016; Son & Ellis, 2013). Despite this connection, supervisor actions or inactions can jeopardize the supervisory alliance (Ellis, 2014; Ramos-Sanchez et al., 2002).

In 2001, the *Journal of Counseling Psychology* published several articles concerning negative or conflictual supervision, two of which examined the trainee's perspective on such events. In the first study, Gray et al. (2001) conducted in-depth interviews with 13 counseling psychology students in master's and doctoral level programs who reported counterproductive events in individual supervision. All participants described at least one counterproductive event, the most common involving the supervisor dismissing the trainee's thoughts and feelings or being unempathetic. Consistent with previous research (Ladany et al., 1996), participants typically did not disclose the counterproductive event to their supervisor. Additionally, most participants found ways to justify or even defend their supervisor's actions. The second study by Nelson and Friedlander (2001) was also qualitative but sought to explore the detrimental effect of negative supervision on training in master's and doctoral level programs. Of the 13 participants, a majority endorsed a sense of powerlessness associated with negative supervision, often resulting in confusion and uncertainty about the supervisory relationship. Like Gray et al., participants rarely resolved the conflict with their supervisor, often citing fear of additional conflict.

In response to the studies by Gray et al. (2001) and Nelson and Friedlander (2001), Ellis (2001) proposed making a distinction between bad supervision and harmful supervision. Referencing earlier work by Ellis et al. (2000), Ellis suggested that bad supervision occurs when the supervisor is "unable or unwilling to meet the supervisee's training needs as an emerging professional." In contrast, harmful supervision results in "psychological, emotional, or physical harm or trauma to the supervisee" (p. 402). While the difference between bad and harmful supervision may constitute a fine line, Ellis

describes the distinguishing feature as *the effect on the supervisee*. In addition to psychological trauma, supervisees experience personal and professional functional impairments, loss of self-confidence, and a negative impact on their general mental and physical health (Ellis et al., 2000).

As research on harmful supervision continued to increase (Goodyear et al., 2005), Ellis's (2001) framework and definitions required a substantial update and revision. Specifically, the term "bad supervision" was vague, lacked a theoretical base, and did not account for the current multidimensional construct of supervision (Ellis et al., 2014a). Consequently, Ellis et al. (2014a) presented results from two separate studies designed to empirically test a revised framework of supervision and provide initial data on supervision from the supervisees' perspective. In the first study, bad supervision became *inadequate clinical supervision*, and the objective criteria for both inadequate and harmful clinical supervision were developed. Additionally, because of the change to inadequate clinical supervision, Ellis et al. needed to describe what constitutes *minimally adequate clinical supervision*.

Using a consensus validation approach to combine common supervision requirements and standards across multiple helping professions (counseling, psychology, social work), Ellis et al. (2014a) described a supervisor who is (a) educated and competent in counseling skills; (b) held a supervisory credential; (c) utilized a supervision contract; (d) routinely reviewed supervisee's counseling sessions to provide fair, evaluative feedback; (e) promoted supervisee growth and development; (f) maintained supervisee confidentiality; (g) attended to multicultural and diversity issues; (h) monitored the power differential in the relationship; and (i) provided at least one hour

of face-to-face supervision per week. While extensive, Ellis et al. maintained these qualifications constitute the "bare minimum" needed for supervision and likely do not meet the complete standards of any single helping profession. If a supervisor is "unable or unwilling" to provide minimally adequate clinical supervision, the supervisor is, by default, providing *inadequate clinical supervision* (Ellis et al., 2014a, p. 439).

Furthermore, Ellis et al. (2014a) took additional steps to incorporate subjective and objective perspectives of inadequate clinical supervision, resulting in *self-identified* and *de facto* inadequate supervision (SIIS and DFIS). For example, if a supervisee reads the definition of inadequate supervision and realizes that they have received this type of supervision, SIIS occurs. On the other hand, de facto inadequate supervision (DFIS) involves a supervisor's professional or ethical standards, applicable laws (Giddings et al., 2007; Greer, 2003), or failure to meet the new criteria of minimally adequate supervision. A supervisee does not have to recognize their supervision as inadequate. The supervisee's description of their supervisor's actions or inaction determines when DFIS occurs.

Ellis et al. (2014a) also outlined the timeframe, frequency, type, and mode of inadequate clinical supervision. Although inadequate supervision usually exists in an ongoing relationship consisting of weeks, months, or even years of scheduled events, Ellis et al. contended that only "one truly inadequate session or incident" is required (p. 440). All types of supervision (individual, group, supervisor supervision, or with more than one supervisor) can be inadequate, along with a supervisory relationship that is poor quality or results in harm experienced by the supervisee's client.

A revision of Ellis's (2001) definition of harmful clinical supervision was necessary to be compatible with the current research of Ellis et al. (2014a). The new definition includes actions or inaction by the supervisor known to cause harm via consensus within the counseling profession. Ellis et al. defined harmful clinical supervision as "supervisory practices that result in psychological, emotional, and/or physical harm or trauma to the supervisee" (p. 440). Just as subjective and objective perspectives were applied to inadequate clinical supervision, harmful clinical supervision can also be self-identified (*self-identified harmful supervision* [SIHS]) or meet the criteria for harmful clinical supervision based on a description of supervisor actions or inactions (*de facto harmful supervision* [DFHS]).

Ellis et al. (2014a) stated that the essential components of harmful clinical supervision are

> (a) the supervisee was genuinely harmed in some way by the supervisor's inappropriate actions or inactions, or
>
> (b) the supervisor's behavior is known to cause harm even though the supervisee may not identify the action as harmful (p. 440).

Consequently, harmful clinical supervision can result when a supervisor acts inappropriately, with malicious intent, or due to negligence. In addition, if a supervisor's actions violate ethical standards of the profession or standards of ethical practice and care, they can also be deemed harmful clinical supervision (Dye & Borders, 1990; Landay et al., 1999).

While the essential components of harmful clinical supervision outlined by Ellis et al. (2014a) include the supervisee experiencing genuine harm, the authors strived to

clarify that harmful clinical supervision does not include those instances when the supervisee receives constructive supervision. Supervisees often process painful or stressful issues; receive sincere but painful, constructive supervisor feedback regarding professional competencies; or receive a necessary reprimand to protect client welfare (Nelson et al., 2008). The educational and ethical stance of clinical supervision is to provide honest, respectful, and meaningful assistance *in the supervisee's best interest* (Bernard & Goodyear, 2019)**.**

Ellis et al. (2014a) refrained from making an exhaustive list of harmful clinical supervision examples but is consistent with the general descriptions first offered by Ellis (2001). These include sexual intimacy or improprieties (e.g., Celenza, 2007; Lamb et al., 2003), physically, emotionally, or psychologically aggressive or abusive behaviors; supervisee boundary violations (e.g., forcing emotional intimacy, revealing supervisee personal information to their clients; Koenig & Spano, 2003); using power for personal gain or at the expense of the supervisee; macro- and microaggressions (e.g., racism, homophobia; Burkard et al., 2009; Sue et al., 2007); public humiliation or deriding; demeaning, critical, or vindictive behavior; exploitative multiple relationships (Gottlieb et al., 2007), and failing to take action that results in supervisee or client harm.

According to Ellis et al. (2014a), the effects of harmful clinical supervision incidents vary greatly in scope and duration. Common symptoms include psychological trauma (e.g., general mistrust, debilitating fears, excessive guilt and shame, and self-derogation), loss of self-confidence, and functional impairment in personal life or professional responsibilities, duties, and skills. Even after engaging in professional

counseling services to process harmful incidents, the effects of harmful clinical supervision can last days, weeks, or even years.

The depth and breadth of research on clinical supervision includes a focus on the importance of the supervisory relationship and differences between inadequate clinical supervision and harmful clinical supervision. Because clinical supervision is a required part of counselor professional practice, understanding both shared and varied experiences of practitioners is in line with the governing ethical standards of the profession (ACA, 2014). By researching clinical supervision, advancements in the field are possible, including supervision strategies that target growth and development.

In response to the likelihood of trauma counselors experiencing vicarious trauma (Ludick & Figley, 2017) and the lack of supervision strategies to promote counselor vicarious posttraumatic growth (Knight, 2013, 2018), Deaton et al. (2021) surveyed enabling factors of vicarious posttraumatic growth (i.e., social support, self-care, meaning-making, empathy) to develop corresponding supervision strategies. These strategies (engaging emotional support within the supervisory relationship, identifying a self-care plan to include social interests and meaning making, facilitating meaning making within clinical work, and assessing levels of empathy for vicarious posttraumatic growth facilitation) were implemented at a university-based counseling center with one supervisee. A retrospective case analysis was presented with several lessons learned. Specifically, supervisors should: (a) engage supervisees in ways that elicit emotional support, such as debriefing session, (b) provide self-care opportunities at work or allow time during the work week for self-care, (c) facilitate meaning making during supervision through reframing, and (d) regularly assess levels of counselor empathy. Deaton et al.

suggested that by promoting positive growth opportunities, counseling supervisors are engaging in ethically responsible supervision.

For both clinical and administrative professionals working in the field of complex psychological trauma, there is a high risk of vicarious traumatization. To mitigate this risk, Coleman et al. (2021) conducted face-to-face, qualitative interviews with 21 participants who work on mental health teams for the National Health Service (NHS). Through coding and data analysis, five main themes were identified (called to the work, connection, separation and oneness, into and out of darkness, chaos into meaning, and reparation not repetition) that centered around and connected to the larger theme of expansion and growth. These findings are similar to other research in the field of trauma-focused work regarding professionals who experience significant positive benefits they attribute to their work (Guhan & Leibling-Kalifani, 2011; Pearlman & MacIan, 1995; Stamm, 2002). Implications include targeted training and administrative supervision to proactively address vicarious traumatization.

Outside of mental health professions, research on supervision uses vastly different terminology to describe and report incidents of negative or harmful supervision. For example, in business management, administration, human resources, leadership, and organizational behavior, a ubiquitous term is *abusive supervision* (Fisher et al., 2021; Kiewitz et al., 2016; Mackey et al., 2017; Martinko et al., 2013; Tepper, 2000; Vogel & Bolino, 2020; Vogel et al., 2015). Research by Tepper (2000) referred to abusive supervision as "subordinates' perceptions of the extent to which their supervisors engage in the sustained display of hostile verbal and nonverbal behaviors, excluding physical contact" (p. 178). Although Tepper's 15-item scale to identify abusive supervision

continues to be the method of choice in current research, a review by Fischer et al. (2021) noted “significant conceptual and psychometric limitations that undermine the accuracy and precision of the measurement” (p. 3). Even without an effective measure to identify abusive supervision, most work cultures actively avoid or discourage hostile behavior among co-workers or supervisors and their supervisees. A notable exception to this are hypercompetitive work environments (a so-called “win-or-die” culture; Matos, 2017) that encourage hostile or dominate behaviors leading to “toxic leadership” (Matos et al., 2018). While mental health professions are not immune to incidents of hostile verbal and nonverbal behavior, this behavior is typically client behavior directed at staff or other clients (Maagerø-Bangstad et al., 2019; Odes et al., 2021).

The literature on harmful clinical supervision and its impact on the counseling profession speaks to its current relevance. However, a deeper understanding of how counselors may benefit from harmful clinical supervision represents a significant gap in the literature. Because of the unique focus of the counseling profession on wellness and a positive view of growth and development, it logically follows that posttraumatic growth is the frame and lens for this examination.

Summary

This chapter provided a detailed examination of posttraumatic growth theory, including how this framework guides the current study and offers a specific lens to view the research questions. Because posttraumatic growth is a complex phenomenon situated within the domain of positive psychology, the principles of growth were outlined along with the specific elements of the current theoretical model. The terms trauma, posttraumatic, and growth were described to provide needed context in how

posttraumatic growth came to be named. Finally, specific research relevant to posttraumatic growth and clinical supervision were discussed.

CHAPTER 3: METHODOLOGY

The aim of this qualitative study was to explore the lived experiences of counselors who report posttraumatic growth linked to harmful clinical supervision. Additionally, this study sought to understand in what context posttraumatic growth occurs and the process of counselor posttraumatic growth. This chapter contains multiple subsections. The first subsection describes the overarching research question and two additional questions that guide this study. The following subsection outlines the research framework of this study, including the design and approach. The third subsection describes the specific methods of this study, including the participants, sampling and recruitment, data collection procedures, instrumentation, data analysis, and verification procedures. Finally, the last subsection discusses the study participants' possible risks, benefits, and ethical considerations.

Research Question

The primary question for the study was: What are the lived experiences of counselors who report posttraumatic growth as a result of harmful clinical supervision? Two additional questions were: (a) in what context does posttraumatic growth occur? and (b) what is the process of counselor posttraumatic growth?

Research Framework

Qualitative Methods

Although quantitative measures for posttraumatic growth are plentiful, there are several reasons why qualitative research methods were a better fit for this study. First, qualitative research tends to ask questions rather than test hypotheses. When using qualitative research methods like semi-structured interviews, participants are not limited

to predetermined responses. Instead, participants describe their unique experiences in their own words. Consequently, qualitative approaches can help researchers learn additional ways posttraumatic growth is experienced, including ways standardized scales currently do not measure. Second, because qualitative research offers a rich collection of data with thick descriptions (Moustakas, 1994), this information could assist in understanding foundational elements of growth or highlight an entirely new perspective in viewing the phenomena. Third, by collecting unique personal experiences, qualitative research can point out "individual, cross-cultural, and developmental differences in the way people perceive and express posttraumatic growth" (Tedeschi et al., 2018, p. 83). Finally, by using qualitative methods like neutral, open-ended questions (e.g., how have you changed since the event?), participants might spontaneously recognize their posttraumatic growth. This type of revelation could then assist researchers in developing hypotheses for future studies.

Phenomenological Design

Vagle (2018) describes phenomenological research as a way to find common meaning among a group of individuals and their lived experiences of a phenomenon. This study aimed to explore the experiences of counselors who report posttraumatic growth linked to harmful clinical supervision. Therefore, a phenomenological approach was appropriate for this study. Moustakas (1994) described the researcher's role in reducing individual experiences with a phenomenon down to an objective description, or essential essence, which is shared by those who experience the phenomenon. The researcher is tasked with answering two overarching questions: what has the individual experienced in terms of the phenomenon, and what context has influenced the individual's experience of

the phenomenon (Moustakas, 1994). As a researcher with experience with the phenomenon, measures were required to bracket and bridle those personal experiences and set them aside to focus on the participant's experiences (Vagle, 2018). Through this mindful attention, the researcher could see the participant's view and experience with the phenomenon.

Hermeneutic Approach

A hermeneutic approach to phenomenology was employed in this study. Simply stated, a hermeneutic approach involves interpretation (Smith & Nizza, 2022) through constant revision (Peoples, 2021). Each interpretation is further revised with each new experience. Subsequently, when an individual experiences the world around them, their experience is full of meaning. This meaning grows from interpreting the world through the individual's existence and relationships with others (Creswell & Poth, 2017; Vagle, 2018). Consequently, every experience a person has ties directly to their relationship with others. Because this study focused on counselors and their experiences in supervisory relationships, a hermeneutic approach was fitting.

Methods

Participants

A total of 12 counselors volunteered to participate in this study. Participants held the credential of Licensed Clinical Mental Health Counselor (LCMHC) (n = 4) or Licensed Clinical Mental Health Counselor Supervisor (LCMHCS) (n = 8) by the North Carolina Board of Licensed Clinical Mental Health Counselors (NCBLCMHC). Because this study was interested in posttraumatic growth linked to harmful clinical supervision, time must have elapsed for the counselors to process these experiences and understand

how they were transformed. Therefore, participants had to have at least five years of professional experience post-licensure (M = 10.9, SD = 5.6) and self-report experiencing harmful clinical supervision (n = 12). Additional information on participant demographics will be discussed in the next chapter and illustrated in Appendix F.

Sampling and Recruitment

Purposeful sampling is a method of choosing participants because they have experience or knowledge of a phenomenon (Ravitch & Carl, 2021). For this study, purposeful sampling was used to recruit participants from the NCBLCMHC email directory of 8,447 LCMHC and LCMHCS counselors. An email invitation to participate (Appendix B) was sent to all members and included information about the purpose and scope of the study, eligibility requirements, estimated time commitments, and other information necessary to facilitate informed consent. If interested in participating, counselors followed a link to the informed consent (Appendix C) on DocuSign, a web-based electronic signature platform. Once the researcher received the signed informed consent (n = 30), a screening email (Appendix D) was sent asking interested counselors the following eligibility questions: (1) What license do you hold with NCBLCMHC? (2) How many years have you been licensed? and (3) *Harmful clinical supervision* is defined as any inappropriate action or inaction by the supervisor causing psychological, emotional, and/or physical harm or trauma to the supervisee. Have you experienced harmful clinical supervision? Additionally, the following demographic questions were asked: (1) What is your age? (2) How do you identify in terms of gender? (3) How do you describe yourself in terms of ethnicity/ race? (4) How do you describe your sexual orientation? (5) What is the highest degree you completed? and (6) What is your degree

discipline? Counselors who responded to the screening email (n = 21) and met eligibility criteria (n = 14) completed an interview with the researcher (n = 12).

Although snowball sampling might have increased the number of participants and total sample size, some concerns regarding oversampling were noted in the literature accessing "hidden" (minority or traumatized) populations (Waters, 2015). Additionally, Eliason (2016) also highlighted areas where researchers who are "inside" (or a member of) the population of interest may encounter difficulties in separating and bracketing experiences. As previously indicated, because the researcher is a licensed counselor who has experienced harmful clinical supervision, extra care in recruiting participants was warranted to increase trustworthiness.

Data Collection Procedures

Once the Institutional Review Board at the University of North Carolina at Charlotte approved the study (Appendix A), the researcher contacted prospective participants using the NCBLCMHC email directory. The email request contained information about the purpose and scope of the study, eligibility requirements, estimated time commitments, and other information necessary to facilitate informed consent. If interested in participating, counselors followed the link to the informed consent on DocuSign, a web-based electronic signature platform. Once the researcher received the signed informed consent, a screening email to confirm eligibility criteria and answer basic demographic questions was sent to each counselor. Counselors who signed the informed consent, responded to the screening email, and met eligibility criteria were invited to schedule an interview with the researcher. Once a date and time were agreed

upon, the researcher emailed the participant a link to the meeting on Zoom, a web-based conferencing platform.

Before beginning each interview via Zoom, the researcher reviewed the previously signed informed consent with the participant. The consent included information about the following: purpose of the study; voluntary nature of participation; freedom to withdraw participation at any time; confidential and anonymous participation; inclusion criteria of the study; data collection, storage of information, and interview recordings procedures; possible risks and benefits of participation; and verification procedures. The researcher then followed the semi-structured interview protocol with each participant.

Instrumentation

Recruitment of participants and data collection for this study began after obtaining written approval from the University of North Carolina at Charlotte Institutional Review Board.

Screening Email

All participants completed a screening email that included confirmation of the eligibility criteria and demographic questions. The demographic questions included the following areas: age, gender identity, race/ethnicity, sexual orientation, highest degree completed, and degree discipline. The time to complete the screening email was approximately five minutes.

Semi-Structured Interview

A semi-structured interview protocol was used to address the main research question of this study: What are the lived experiences of counselors who report

posttraumatic growth linked to harmful clinical supervision? Semi-structured interviews allow the researcher to guide the participant to specific areas while allowing them to freely share their experiences (Smith & Nizza, 2022). In doing so, the researcher can assist the participant in describing their experiences with the phenomenon of interest (Moustakas, 1994), such as posttraumatic growth linked to harmful clinical supervision. The average time in minutes to complete the interview was 55.5 minutes (*SD* = 18.3). Participant interviews were downloaded from Zoom onto the UNCC Dropbox. As suggested by Smith and Nizza (2022), the researcher personally transcribed each interview verbatim to become deeply familiar with the data. Once transcribed, each interview was saved using a participant chosen pseudonym on Dropbox. Each participant was emailed a de-identified interview transcript to review for accuracy. If any corrections or additions were made, the participant was asked to email the transcript back to the researcher within one week. Only one participant made corrections to their transcript. Once all the transcripts were finalized, interview recordings were deleted from Dropbox.

Data Analysis

Moustakas (1994) defines specific methods for analyzing phenomenological inquiry. First, the researcher must fully describe their personal experiences with the phenomenon to acknowledge and set aside those experiences. The researcher journaled throughout the research process to ensure the focus of the study was on the participants and not the researcher. Next, the researcher personally transcribed each interview verbatim and read them multiple times to become fully immersed in the data (Smith & Nizza, 2022). This process also allowed the researcher to become better acquainted with the content before moving on to coding the data. The researcher used a reflexive journal

to note thoughts and feelings that surfaced while reading the transcripts. This process of journaling continued throughout the data analysis. While reading the transcripts, the researcher developed codes associated with important words, subjects, or ideas. These codes were reviewed and revised as needed. The researcher also engaged in horizonalization, which involved noting every expression or statement relevant to the experience and giving them equal value (Moustakas, 1994; Sheperis et al., 2017). The researcher reviewed the statements to determine the invariant constituents or "horizons" that described the "core themes of the experience" (Moustakas, 1994, p. 121). Relevant invariant constituents, with verbatim examples from the interviews, were used to construct individual textual descriptions of the experience. These individual textural descriptions were used to create individual structural descriptions of how the experience occurred (Moustakas, 1994). Finally, the researcher combined the textural and structural descriptions to illustrate the perceived meaning and essence of the experiences.

Verification Procedures

To maximize the accuracy and trustworthiness of a study, qualitative research uses validation and verification strategies. Guba (1981) suggests using multiple, overlapping means to highlight the researcher's integrity, the participants, and the participant data. The researcher included multiple validation and verification methods in this study. First, the researcher bracketed personal experiences of harmful clinical supervision and posttraumatic growth in a subjectivity statement. This statement assists readers in understanding the researcher's point of view, biases, and assumptions that may have impacted data collection and analysis. Second, the researcher engaged in bridling by keeping a reflexive journal throughout the study. This journal included reactions to each

interview, thoughts about the data being collected, and any other ideas that surfaced during the process. Third, the researcher invited all participants to engage in member checking, which is essential in qualitative studies to increase accuracy and credibility (Brinkmann & Kvale, 2015; Moustakas, 1994). Member checking involved the researcher emailing each participant a de-identified word document of their interview. Participants were encouraged to review the document for accuracy, provide feedback to the researcher, and clarify if their experiences were captured correctly. Only one participant emailed the transcript back to the researcher with corrections. The transcripts were finalized, and data analysis could begin. Fourth, the researcher used triangulation to verify the data. The researcher's reflexive journal entries were compared with the interview transcripts. This process allowed the researcher to thoroughly reflect on the data, examining it against the interview transcripts, engaging in objective analysis of participant experiences, and promoting the validity of the findings. Fifth, the researcher enlisted the help of two fellow doctoral students as peer coders of the interview transcripts. Each peer coder individually read and coded each transcript. The researcher then met with both peer coders via Zoom to compare and discuss individual codes and reach a consensus on the final codes. Lastly, the researcher met with a peer reviewer each week to discuss the study and provide an external check of the data analysis. Not only did this help keep the researcher accountable, but it also encouraged open and honest discussion about the methods, meanings, and interpretations of the data.

Subjectivity Statement

To become a licensed professional counselor, I completed a period of supervised practice. As a new graduate hired as a substance abuse counselor, I was thrilled to be

assigned a well-respected clinical supervisor with decades of professional experience. Initially intimidated by my supervisor, I was pleasantly surprised when we settled into an easy working relationship. My supervisor listened to my client tapes, gave detailed feedback, and appeared invested in my professional growth. As time progressed, she suggested conducting our sessions outside of the office. We began to meet at Starbucks or a local diner, with my supervisor offering it as her "treat." These supervision sessions made me feel special but also disarmed me. I admired her professionally and felt indebted to my supervisor for her generous mentorship offer. Her attention blinded me to the changing dynamics of our relationship. My supervisor began critiquing my personal life: how I wore my hair, where I lived, and even whom I dated. To please my supervisor, I agreed to run her errands, house sit when she went on vacation, and clean her office. These boundary violations escalated over a year and a half, becoming more destructive and eventually ending our supervisory relationship.

My experiences of harmful clinical supervision were emotionally challenging and traumatic. I was wary of my next clinical supervisor and disillusioned by the supervisory process in general. Over time, these feelings subsided but not without a great deal of introspection and guidance by more experienced counselors. Eventually, I came to the place I am today. My past experiences were essential to my growth and development as a counselor and supervisor. Rather than causing me to break, these experiences have strengthened my resolve. Growing through my experiences has helped me understand the importance of the supervisory relationship and the ethical considerations vital to its success.

Risks, Benefits, and Ethical Considerations

Due to the topic of this study, harmful clinical supervision, there were risks, benefits, and ethical considerations to be described to ensure participant safety. Participants were advised that interview questions focused on past negative experiences, and some participants might find these questions stressful. Although this stress was not likely to be more than what is experienced in an average day, participants could choose not to answer a question. Participants could also stop their involvement in the study at any time. Options for additional support or counseling were made available to all participants at the beginning and end of the interview. While there were no known benefits of participating in the study, individuals may have benefitted from sharing their experiences and being part of ongoing research on the topic.

Summary

This chapter outlines the methodology used for this phenomenological study. This research study sought to fill the gap and contribute to the current literature by providing insights from counselors who have experienced posttraumatic growth linked to harmful clinical supervision. Participants were counselors licensed by the NCBLCMHC, had at least five years of post-licensure counseling experience, and self-reported experiencing harmful clinical supervision. The NCBLCMHC email directory was used to recruit participants. Counselors who responded to the request by signing an informed consent form also completed a screening email to confirm eligibility criteria and answer demographic questions. In addition, participants participated in a recorded interview via Zoom that followed a semi-structured interview protocol. During data analysis, common phenomenologically based methods were employed, including bracketing and bridling of

the researcher's experiences, developing significant statements, horizonalization, developing themes, summarizing textural and structural descriptions, and synthesizing the data. To increase accuracy and trustworthiness, several validation and verification procedures were employed. Due to the topic of this research study, risks, benefits, and ethical considerations were discussed.

CHAPTER 4: FINDINGS

This study sought to describe the lived experiences of counselors who report posttraumatic growth linked to harmful clinical supervision. Semi-structured interviews were used to collect data to answer this study's primary question: What are the lived experiences of counselors who report posttraumatic growth linked to harmful clinical supervision? Two additional questions were: (a) in what context does posttraumatic growth occur? and (b) what is the process of counselor posttraumatic growth? This chapter presents the findings from the data analysis of 12 participant interviews. Each participant holds licensure by the NCBLCMHC as either an LCMHC or LCMHCS, has at least five years of post-licensure experience, and self-reports experiencing harmful clinical supervision. This chapter begins with a brief description of each participant, followed by a discussion of the themes and subthemes found through data analysis, and the part the theme plays in answering the research questions. Next is a section that examines the types of harmful clinical supervision and categories of posttraumatic growth the participants reported. Finally, a conclusion prepares for the discussion of the findings in the next chapter.

Participants

Participant chosen pseudonyms were used when possible unless further modification by the researcher was needed to protect anonymity. Participants provided description data during the screening process and subsequent interviews. Specific details were changed or omitted when needed to increase confidentiality. Participants are listed in the order they were interviewed.

Kadie

Kadie is a 54-year-old, White, lesbian female with over 24 years of counseling experience. She currently works as a counselor educator and provides guidance and clinical supervision to her students and other professionals in the community. Kadie holds the LCMHCS credential along with other state and national certifications.

Felicity

Felicity is a 41-year-old female who preferred not to disclose her race/ethnicity or sexual orientation. She is a military veteran who has spent eight years as a counselor working with other veterans and their families. Felicity holds licensure as an LCMHCS but works for a national agency outside North Carolina.

Jenny

Jenny is a 48-year-old, White, straight female who owns her private counseling and clinical supervision practice. Jenny began her counseling career 14 years ago in community mental health but now primarily works with individual adults. She holds licensure as an LCMHCS.

Eleanor

Eleanor is a 41-year-old, White, straight female who owns a private counseling practice and a performing arts studio. She works with adolescents and young adults incorporating counseling with expressive arts. Eleanor has been a counselor for over 13 years, holds the LCMHCS credential, and specializes in eating disorders.

Janice

Janice is a 64-year-old, White, straight female who holds a doctorate in Counselor Education and Supervision and teaches graduate-level classes online. She began her

professional career as a school counselor and has held the LCMHCS credential for 12 years. Janice lives outside of North Carolina.

Kate

Kate is a 54-year-old, White, straight female who holds the LCMHC credential along with the Licensed Clinical Addictions Specialist (LCAS) and Certified Clinical Supervisor (CCS) credentials from the North Carolina Addictions Specialist Professional Practice Board (NCASPPB). She has worked with substance-using populations in multiple settings for over 21 years and specializes in group therapy.

Hendrick

Hendrick is a 56-year-old, White, straight male who decided to become a professional counselor after working several years as a church pastor. He has been a licensed counselor for seven years and holds the LCMHC credential. Hendrick works in private practice and enjoys supervising masters-level interns during their clinical experiences.

Peter

Peter is a 51-year-old, White, straight male who started as a counselor eight years ago, providing intensive in-home services. After earning his LCMHC credential, he decided to focus on his LCAS to become dually licensed in mental health and substance use. Peter currently works in an outpatient setting and sees a broad range of clients for individual and family sessions.

Isabela

Isabela is a 54-year-old, Latina, lesbian female who started working as a substance abuse counselor in the Dominican Republic. After immigrating to the United

States in 1999, she earned her counseling degree and specialized in Addictions. Isabela holds both the LCMHC credential and LCAS and hopes to earn her LCMHCS once she moves into an official supervisor position.

Barbara

Barbara is a 32-year-old, White, straight female who has held counseling positions in community and school settings over the last five years. She works part-time in private practice and holds both the LCMHC and LCAS credentials. Because of her early work with substance use clients, Barbara has a passion for prevention work.

Lori

Lori is a 49-year-old, straight, White female who has worked as a counselor for 19 years. She has experience working in multiple clinical settings with diverse populations but is now employed at a private practice and limits her clients to individual adults and couples. Lori has held the LCMHCS credential since 2010.

Katherine

Katherine is a 41-year-old, White, straight female whose counseling career has spanned almost 15 years. From a very young age, she knew she would be a counselor and currently owns a private practice. Katherine holds the LCMHCS credential and specializes in treating clients diagnosed with Attention-Deficit Hyperactivity Disorder (ADHD).

Themes

Data resulting from the primary research question and two sub-questions led to the following five themes: (a) Confusion, (b) Support and Encouragement, (c) Safety and Protection, (d) Financial Security, and (e) Professional Duty. Six subthemes also

emerged, including three under Support and Encouragement: Walk with Me, Hard Work, and Professional Development; and three under Safety and Protection: Physical, Emotional, and Administrative. Each theme section includes some information about the theme's role in answering the research questions, but this will be discussed further in the next chapter.

Theme One: Confusion

The first theme, Confusion, emerged when participants described their personal experiences of harmful clinical supervision. As each participant explained the context surrounding their experiences, feelings of confusion were prevalent for all. Initially, as reported by Hendrick, the interactions with his supervisor "threw me for a loop." Despite having clinical supervision throughout his educational program, Hendrick had never encountered supervision like this before and commented,

> It became so…she was an extreme, I'm talking an *extreme* micromanager. There was no room for me to explore and be creative with what I was doing. It was, 'These are the expectations, and this is the way you have to do it.' And that didn't make sense to me. Aren't there a lot of ways to do things?

For recent counseling graduates, coming from a place of learning and exploration to a job with hard-set rules can be a difficult transition. As new professionals, supervisees often feel unable to question or contradict their supervisors, given the supervisor's years of counseling experience and the inherent power differential within the supervisory relationship. This deference to the supervisor's expertise was reported in past literature (Gray et al., 2001; Nelson & Friedlander, 2001) and found in this study. Katherine described her experience, saying,

> He was fully licensed man who wrote my paychecks. I'm not going to come at you and tell you that you don't know what you're doing. You must be the expert. I mean, you've been in this field for 40 years or whatever, right?

As the participants spent more time in their positions, the feelings of confusion would often compound. After two years, Eleanor explained that her confusion turned inward, "It was all really frustrating and really overwhelming and I didn't know what to do with it. And then I was left questioning myself. Like, hmmm…am I crazy?" Other participants reported their confusion turned outward, specifically about their supervisor as a professional counselor. Because counselors learn to offer unconditional positive regard and support to their clients, supervisees often expect supervisors to do the same. As Lori shared,

> I think there's just the assumption that all supervision is good. I mean, we're counselors, right? Why would we hurt each other? I just never would have thought…I mean never, in a million years, that I would be treated so horribly by someone who was a trained counselor.

Felicity echoed this statement by saying, "It never occurred to me that [supervision] would be like this. I mean, we're on the same team, right?" Similar to the findings in Ladany (2014), a supervisor's profession does not diminish their capacity to do harm.

Having the same background as a counselor made it possible for a few participants (n = 3) to address their confusion directly with their supervisor. While some planned these interactions, for Jenny, there came the point where her confusion finally boiled over,

> There was one session where she was critiquing, criticizing, whatever, and I blurted out, 'Did I do anything right?' And she said, 'What's the point of pointing out what you did right? We need to work on the areas where you need to do better.' So, I said to her, 'Of all the supervision training that I have had, I have never been taught to do it this way. This is not a model I have ever seen. So, I'm just having a really hard time understanding how this works.' She said, 'I don't need a model to know how to supervise. I don't need to follow a model to supervise.' You don't need a model? All I could think was, 'Flag on the play!'

The revelation that Jenny's supervisor did not think it was necessary to know about or follow a specific supervision model was troubling but also enlightening. After considerable time and reflection, Jenny's confusion became an aha moment,

> What I figured out was she's not a supervisor. She's just been practicing for 25 years. That hadn't occurred to me until then. Oh, she's not even… she's not a supervisor. She's just an experienced counselor.

Similar to the rationale described in the literature (Borders et al., 2014; Falender & Shafranske, 2021), Jenny's experience illustrates why clinical supervision is considered a distinct specialty that requires specific education and training to be effective.

For a few participants (n = 3), experiences of harmful clinical supervision occurred while attending counselor education programs. Two participants shared that while working on their master's degree, it was clinical supervision provided by doctoral students that was harmful. Barbara described the supervision from the doctoral student teaching her internship class as, "terrible [because] I didn't feel like she had enough time for me." With some hesitancy, Barbara described the situation further, saying

> You said that it was going to be confidential, and I could tell you what I wanted so I'm going to be honest. I was paired with a doctoral student who did not care if I was struggling. Or did not care if I didn't understand. Like her supervision model was…she described it to me as I was her young bird that was flying out of the nest, and I needed to 'figure it out.'

Unfortunately, because Barbara was in the process of learning how to be a counselor, figuring it out on her own was difficult. In a similar situation, Jenny shared that the feedback from her doctoral student supervisor made her question her ability to be a counselor, saying

> [She said], 'You're not doing it right.' And I was like, 'I feel like there could be multiple ways of doing it,' but that's not where my mind went. In those moments when we were having supervision it was like, I'm never going to get this. I'm never going to get it right. There's just no way.

This section provided specific examples of how Confusion emerged as a theme in all participant interviews. Initially, participants expressed confusion about what was happening in supervision. This confusion was partly because new clinical supervision experiences did not match past experiences. Additionally, participants expressed deference to their supervisors because of their years of experience and assumed expertise. As time passed, participants began to question if they were the problem or if their expectations about their clinical supervisors were correct. While some participants could talk to their supervisors about their confusion, most were not.

The theme of confusion represents the first step in the counselor's journey toward posttraumatic growth. Each participant described how these new experiences did not

match their previous experiences or expectations about clinical supervision. Fundamental beliefs about clinical supervision were challenged, and the participants were left struggling to make sense of what was happening. Mirroring the description by Tedeschi et al. (2018), these harmful experiences were "seismic," and rocked the participants to their cores. It is only through events of this magnitude that posttraumatic growth can occur.

Theme Two: Support and Encouragement

Support and Encouragement emerged as a theme when participants discussed positive examples of supervision or what was lacking in their experiences of harmful clinical supervision. For some participants, it was only through outside support and encouragement that they were able to leave their harmful supervisor. The following section explores the subthemes that appeared in the participant interviews. These subthemes are Walk with Me, Hard Work, and Professional Development.

Walk with Me

As a profession, counseling is taught by example. Counselor educators model appropriate techniques and encourage development through ongoing clinical supervision. This educational process acclimates counselors to being observed and receiving constructive feedback. Counselors are typically eager to learn and are trained to process these learning experiences with a supervisor. Kadie described her first supervisor by saying,

> She was fantastic and had been doing this for years. Was very in tune with our clients. Was very smart, very knowledgeable. Walked me through stuff. This is

> the how, this is the why, this is what's going on, this is…you know? I could ask her anything and no question was stupid.

Felicity had a similar experience with her first supervisor, saying, "[She] was very hands on, very come and watch, come and do, come and be observed, lots of good feedback, very professional. She was down in the trenches with me." These supervisors were intimately involved in the learning experiences by sharing in the supervisee's work. Consequently, the learning was more impactful. Peter explained this, saying his supervisor was,

> This perfect person [that came] at the right time, at my most fragile time. [She] came into my life and I began my process of becoming a counselor. That's the real key. I don't know that we would be talking had I not landed on good supervision early. Someone who really walked the path with me.

When faced with unexpected or dangerous circumstances, asking for and receiving timely supervisory support is critical for counselor growth and development. In her job as a substance use counselor, Barbara was taken aback the first time a client turned in drug paraphernalia. She managed the situation as best she could, but then Barbara needed to process the experience, saying,

> When I called my supervisor—she wasn't actually there, she was [off-site] because, of course, with limited resources you don't have supervisors on-site, you have to spread yourself thin—without hesitation, she drove to [me]. She had somebody else lead my group because I was up next and she let me sit there and cry. She drove over and let me have my time. Actually, looked at the things with me. She was willing to walk with me and I wasn't alone.

In all these examples, the supervisor took time to be with the supervisee and share in their physical space. The supervisor was accessible and related to the supervisee in a personal, hands-on way. Consequently, the supervisee was able to grow through their experiences and build professional confidence. This connection and exploration as a team is similar to what Calhoun and Tedeschi (2013) describe as expert companionship. The supervisor acts as a guide, helping the supervisee observe and learn, as they travel through the experience together.

On the other hand, when supervisors are absent, either physically or through avoidance, supervisees often struggle. Counselors receive general training in school, but after graduation, specific training is essential to learn the expectations and responsibilities of a new job. For Katherine, the physical absence of her supervisor left her without help when she needed it, saying,

> I could not find him. Like, *I could not find him*. He had an office right down the hall from me and he had a very large caseload. He would be working and then he would be gone. So, I kind of had to learn [everything] just by trial and error. Which meant I made a lot of mistakes.

Some supervisors, despite being physically present, actively avoid their supervisees. In Kadie's experience, she "felt dismissed" on multiple occasions by "supervisors [who] shooed me away from their door." Because these supervisors avoided her, Kadie was without her primary information resource. Negative interactions like these typically have a lasting impact, as described by Kadie, "And here's what I'm thinking, 'I can't count on you.' So, the next time the building is on fire, this won't be the first place I go."

Hard Work

Counseling is more complicated than it looks. What appears to be a simple conversation between two people is a professional, therapeutic relationship. The counselor works to assist and guide the client in coping with their problems (APA, 2022a), but as Eleanor described, this is not easy work,

> I am one hundred percent fully present for the entirety of the time that I am with you. And not only am I entirely present I am also interpreting while I am listening. I am reflecting while I am listening. I am doing all of these things. I am working through treatment plan options. My brain is doing 50 bajillion things at one time. Counseling is not like busy work where I'm just punching numbers.

Lori felt similarly and described being a counselor as "labor intensive…because I can't just turn it on and off like a light switch."

Across the interviews, participants agreed that having supervisors who recognized their hard work made their jobs more manageable and contributed to their satisfaction in the supervisory relationship. Without this recognition, morale among counselors often suffered, as described by Kate,

> She was one of those people that didn't…she didn't acknowledge the affect that counseling sessions or interactions with clients had on me or any of the counselors. Even if I tried to explain it to her, she wouldn't have understood. She didn't want to see. She didn't want to understand. Do you know what it's like when you know, deep down, that your supervisor doesn't care about you or the hard work you do?

This decline in morale is often attributed to a breakdown in the supervisory alliance (Ghazali et al., 2016; Son & Ellis, 2013). A disconnect, along with additional harm, often emerges when supervisors fail to acknowledge what their supervisees experience. For Jenny, the lack of recognition resulted in her feeling detached from her profession, as she stated,

> There was never a mention of how hard the work is or how hard we're working or what the times are. No mention of any of that. Not one word. And we're all busting our tails off day after day after day. You can only do that so long before you burn out. I didn't want to be a counselor anymore.

Professional Development

Clinical supervision provides an opportunity for new counselors to develop professionally. Not only do counselors grow in their professional identity, but they also gain the knowledge and skills necessary to move up the career ladder. When asked to provide a personal definition of harmful clinical supervision, Isabela said, "I think it is when the clinician doesn't get what they need to grow as a professional. They don't get what they need to develop as a clinician." Consequently, if a supervisor does not provide this instruction, it leaves the supervisee lost. As Katherine explained,

> I didn't feel like I really knew what I was doing until I had been fully licensed for five years. And I think part of that was because I lacked good supervision and guidance. It really slowed down my professional development.

Along with not encouraging professional development, several participants reported that their supervisors went further by actively discouraging their development. In one blatant example, Isabela said her supervisor, "Told me I couldn't apply for my CCS [Certified

Clinical Supervisor credential] because she didn't have it." In this instance, the supervisor focused on herself rather than the supervisee's professional growth. When sharing about a more subtle form of discouragement, Kate said,

> You know, it's that, 'Don't go anywhere, don't move anywhere, don't do anything new' vibe. Making you feel guilty for trying to move on. He never encouraged me to apply for [new] positions. I don't want to say that he intentionally held me back but he sure didn't encourage me to move forward or move up and out of this job. He wanted me to stay put so he didn't have to hire somebody new.

In contrast, when Kate was able to move to a new position with a different clinical supervisor, she felt empowered. Kate described her supervisor, saying, "She encouraged my professional development and talked to me about it…she really wanted me to do more, and that made me want it too."

This section detailed some examples associated with the theme of Support and Encouragement. Three subthemes were discussed: Walk with Me, Hard Work, and Professional Development. In Walk with Me, participants highlighted the importance of having an engaged supervisor within the same physical space as the supervisee. The willingness to teach and the physical proximity of the supervisor enhanced the quality of learning experiences. The subtheme of Hard Work illustrated the ways counseling is a demanding profession. Participants expressed frustration with supervisors who either did not or would not recognize the challenging aspects of their work. Lastly, the subtheme of Professional Development described how participants experienced encouragement or active discouragement of their growth as counseling professionals.

The theme of Support and Encouragement continues the counselor's journey toward posttraumatic growth. While experiencing the confusion associated with harmful clinical supervision, counselors face ongoing circumstances that lack the supervisory support necessary to promote their learning and growth as a counselor. These situations result in counselor frustration, uncertainty, and stagnation.

Theme Three: Safety and Protection

The third theme of Safety and Protection arose when participants described specific supervisor actions or inactions that resulted in supervisee harm. This theme also emerged when participants discussed what they need to do their jobs effectively. Because some participants described working with troubled clients in less-than-ideal settings, feeling safe and protected was crucial to ensure job performance. The theme is divided into subthemes of Physical, Emotional, and Administrative:

1. Physical includes incidents where the supervisee was threatened by clients with physical harm or experienced a bodily injury.
2. Emotional details participant examples of emotional harm or discomfort.
3. Administrative involves situations where those individuals beyond the clinical supervisor, often in managerial or administrative positions, contribute to the experience of harmful clinical supervision.

Physical

Maintaining physical safety while providing counseling services to aggressive or violent clients requires honest communication and trust within the supervisory relationship. When counselors do not feel safe with their clients, the therapeutic relationship between counselors and clients is often ineffective or non-existent.

Counselors are responsible for informing their supervisors when concerns arise regarding their ability to work effectively with clients. Supervisors are tasked with assisting the counselor work through this issue, taking the client on their caseload, or assigning the client to another counselor. The result can be dangerous if a supervisor fails to listen to a counselor or follow up on their concerns. This outcome was the case for Eleanor as she described what happened at her first counseling job, stating,

> This kid I was working with was probably six feet and two hundred and fifteen [pounds]. He was a big kid, very violent, threw things. I'm pretty petite, five feet, really small. Then the threats began. They were grotesque, as far as him describing what he would do to me. In almost serial killer, serial rapist fashion. I told my supervisor, 'I do not want to meet with this client. Period.' When [she] did not respond, I went down to the courthouse, and filed a protective order. Brought that back and [she said], 'He is your client, you have to meet with him. You have to at least have a termination session.' Again, I said, 'I do not want to meet with him.' She said, 'You will lose your job.' I didn't really have anything to fall back on at the time and financially I was in a difficult place. So, I said 'Fine. I will have one termination session. I would like to be in the room that has the two-way window where I can be observed.' This supervisor told me, 'I will be there myself and there will also be a male.' Nobody was there. I ended up getting choked and passing out. By chance a co-worker [heard] what was happening and came and was able to pull this client off of me.

Despite efforts to protect herself from harm, Eleanor reported feeling pressure from her clinical supervisor to see her client again. As a result, Eleanor sustained significant injuries to her throat and was hospitalized for two days.

For several participants (n = 4), being threatened by a client happened on more than one occasion and is consistent with findings in other research (Maagerø-Bangstad et al., 2019; Odes et al., 2021). While most threats did not lead to physical harm, the supervisor's response did nothing to calm or reassure the supervisee. Kate, who worked in a residential treatment facility, described her experience, saying,

> There was a client who was very obsessed with knives. He would sit in group and look very intently and talk about his interest with these knives…and what he could do with them…and where he had them…and how easy it would be to get them…and it just freaked out all the clients. And I tried to talk to my clinical supervisor…and that was another time that it was just, 'Well, do you think he has some knives?' And (my supervisor) would talk…but it wasn't…it didn't feel like he was taking me seriously.

After raising her concerns again, Kate recalled her supervisor's response,

> He said, 'You can talk to him. You can bring him into your office.' Wait…are you telling me this person that I think is dangerous, you want me to call him into my office? Be by myself with him? Does that make sense to you, sir?

In cases where the supervisor and supervisee do not agree on the safety or severity of a situation, it is the supervisor's responsibility to acknowledge the supervisee's perspective and take precautions to protect the supervisee from danger. After her experience of

physical violence, Eleanor described it bluntly, saying, “Safety is pertinent. You have to ensure safety in every environment.”

Emotional

Counselors are taught to identify clients’ feelings during formal education. To ensure accuracy, counselors often reflect those feelings to the client and process the client’s response. While the supervisory relationship differs from a therapeutic relationship between counselor and client, it shares certain baseline aspects (Martin & Turner, 2020). Identifying and processing emotions is possible in relationships with open communication and conveying supervisor genuineness. These characteristics were commonly mentioned in participant interviews when describing positive supervisory experiences. Kate, while sharing about a supportive clinical supervisor, said,

> She talked to me about it. If I was excited about what was going on with the client. Or if something was worrying me. Or something was wrong or going on with me. She would talk to me about those things. She cared about what was going on with me emotionally.

In this supervisory relationship, Kate indicated that she could discuss her feelings and emotions without fear of judgment or reprisal. Kate summed up the reason for this, saying, “I think that comes down to safety. Feeling cared for and protected.”

Conversely, when participants did not feel safe with a supervisor, they did not share their emotions. As Isabela recalled, “I did not express how I really felt. That it really affected me. I never did. It wasn’t safe with her.” Additionally, Isabela described the futility of her situation, saying, “I didn’t tell her what you did made me feel this way because she probably didn’t agree with me. So, there’s no point.”

Administrative

Multiple layers of supervisors and administrators are common within agency or community counseling settings. Administrators typically work at the program management level, while counselors and clinical supervisors conduct direct client care. Positive interactions between counselors and administrators occur, but participants in this study shared experiences that left them feeling uneasy or unsafe. As Jenny described,

> The straw that kind of broke the camel's back was that we had a clinician commit suicide. And [the administrator] was the last one to see her. She was the last one to talk to her and…I had questions. I just had questions about it. The last conversation they had…I felt like…she knew.

In this situation, Jenny did not trust that an administrator did the right thing to protect the clinician. Instead, when attempting to discuss this with her clinical supervisor, Jenny was shut down, "She told me I didn't know what I was talking about."

Trusting individuals in administrative positions to act in the best interest of the staff they manage promotes a sense of safety and protection. In the few instances participants reported their experiences with harmful clinical supervision to administrative personnel (n = 3), the response was unexpected. For example, Janice was surprised by what she learned, saying,

> I also went to the program director who was [my] supervisor's boss…and I don't do that…I usually just sit back and, you know…because most people aren't all that abusive. But I did report him, and [the program director] said, 'I know, I know.' You *know*?

For Janice, the realization that her harmful clinical experiences were not unknown, isolated incidents was disturbing. The fact that administrative staff knew but did not correct the situation or prevent it from happening again left Janice feeling hurt and disappointed. Similarly, when Barbara reported her clinical supervisor to the administration, she also left feeling upset, saying,

> And then I felt like her supervisor didn't give a damn either. Like she was just checking a box of 'Oh, somebody filed a complaint and I need to look into this.' But [she] never really had my back because nothing happened.

Rather than keep the lack of response to herself, Barbara shared her experiences with her co-workers. This revelation provided Barbara with comfort from her peers, but it likely caused a silencing effect on those around her. As described by Kiewitz et al. (2016), silence is often used as avoidance-based behavior to prevent further harm in supervisory relationships. Kate, who found herself in a similar type of situation, said,

> I don't think I went above her head because I know that when [my co-worker] tried that, to go and talk to [the administrator], [the administrator] told her supervisor everything that had been said and what was going on. So, that didn't feel safe.

An additional administrative resource concerning counselor conduct is the state licensing board. All participants of this study hold credentials issued by the NCBLCMHC and some are also credentialed by the NCASPPB. Both boards provide a means for individuals to file complaints against the counselors they license. Of the participants in this study, only the males (n = 2) contacted a licensing board. Hendrick, who called the NCBLCMHC, described this, saying,

> I think the sad part to all this…and I'm not sure if I really wanted to say this but, I called the Board. I called on two different occasions. Found out who I was supposed to call. And they have *never* returned my phone calls. They have *never* called me back.

Peter, who contacted the NCASPPAB, described his efforts, saying,

> I did send a letter to the Board…and I told…about the bullying. What I got back, and I have to be careful here, but this is the truth, I got a response…that was inappropriate and wrong. It was way too personal. I don't need to know about [what's going on with your family]. My heart goes out to [you]…but I'm afraid [your personal life] has nothing to do with what happened to me. And so I realized that I didn't have any recourse for what happened.

In this section, the theme of Safety and Protection was explained as a necessary condition for counselors to work and interact effectively. The three subthemes of Physical, Emotional, and Administrative grouped participant experiences to clarify the multiple dimensions of the overarching theme. The Physical subtheme included participant examples of being threatened or experiencing a bodily injury. The Emotional subtheme detailed participant examples of emotional harm or discomfort. Lastly, Administrative provided participant experiences with managerial staff or licensing boards whose actions or inaction contributed to experiences of harmful clinical supervision.

The theme of Safety and Protection is prevalent throughout the counselor's transition from a place of harmful clinical supervision to posttraumatic growth. As the counselor continues to experience confusion regarding their interactions, it becomes apparent that feeling safe and protected within the supervisory relationship is missing.

Participants were often disappointed when they reached out to others beyond the clinical supervisor for help. Rather than alleviate negative participant feelings, administrative responses tended to exacerbate the situation.

Theme Four: Financial Security

The fourth theme of Financial Security consists of participant experiences involving money. Examples include money paid for clinical supervision, wages withheld by employers, threats of being fired, lack of employment options, and being the family's sole breadwinner. In addition, participants reported that these financial concerns caused significant distress and often described feeling trapped in their situations.

Financial concerns appeared early in participant interviews due to the connection between clinical supervision and an associate counselor's path to full licensure. During a period of supervised practice, associate counselors must receive clinical supervision from a licensed counselor with a supervisor credential. Employers that offer clinical supervision through appropriately credentialed staff or a contracted provider claim this as part of their benefits package, as Lori described,

> I was lucky that I didn't have to pay for supervision because [my employer] made sure that all the supervisors were licensed and certified to give you supervision. It was kind of a perk of working there. Supervision is *really* expensive, like over $100, $150 an hour. You're required to have one hour of supervision every week for *two years*…I mean, I was a newbie counselor making less than $35,000 a year. I couldn't afford supervision if I had to pay for it myself.

If an employer does not provide clinical supervision, associate counselors must independently contract with a clinical supervisor and pay out-of-pocket for the service.

Additionally, if the supervisory relationship ends without the supervisor completing the verification paperwork required by the licensing board, the associate counselor can be left with nothing. As Peter described,

> I've got thousands upon thousands of dollars invested. I've got incredible amounts of time invested in supervision. I've paid money for all this stuff and now I'm dependent on [my clinical supervisor]. I think I met with him 18 times. And that's weekly. And at the end, he drops me and doesn't sign off on hours. I lost a full year, maybe more, I don't know. And I get no credit for that. And in my mind, that's disgusting. That's where the real trauma came in for me. That's where theft, I mean straight up theft happened. Robbing me of money. I call it 'bottom-feeding.'

Similarly, Eleanor lost money and hours of supervised practice when her clinical supervisor, a licensed social worker, failed to complete the NCBLCMHC requirements to become an approved counselor supervisor. Eleanor said, "I lost…600 hours of direct client contact…and 20 individual supervision hours. And I paid for every single one of those."

For those participants wanting to leave the harmful situation, changing jobs would incur additional costs and did not appear financially feasible. Participants reported feeling trapped, as Hendrick explained, saying,

> I was also the primary breadwinner of my family. So, I was…and just to leave there and to go somewhere else would have been yet another transition that I thought I could not do at that moment. We were financially dependent on my income. So, there I was. Stuck.

Fear of leaving current employment was compounded by uncertainty during the COVID-19 pandemic. Jenny described her situation, saying, "I think at this point, I already knew this [job] was not kosher. But this was during the pandemic. I mean, I'm not going to get another…where am I going to work?"

Despite having reservations, participants reported significant financial events that finally pushed them to leave their jobs. Hendrick, who worked over two years for a private agency, described his experience by saying,

> This was the straw that broke the camel's back…this guy [I was seeing], he left with a balance. In other words, he still owed money to the agency. And they took the money that he owed out of my paycheck. So, the agency got theirs. And then left me in a position where even if I contacted him and got payment, that payment would still have to go through the agency. So that right there, that was the end for me.

Additionally, after quitting his job, Hendrick learned he was not the only counselor that had this type of experience, saying,

> I later found out that there was another girl that had been under supervision there and when she left, they billed her $3000 for outstanding client fees…and she paid it. *She paid it*. Because I guess, like me, she didn't know any better.

This example aligns with the definition of harmful supervision described by Ellis et al. (2014a) where “a supervisor’s behavior is known to cause harm even though the supervisee may not identify the action as harmful” (p. 440).

Within this section, participant experiences centered on financial concerns. Participants described staying in harmful situations for up to five years out of fear they

would not be given credit for the clinical supervision they paid for or how they would support their families. For half of the participants (n = 6), harmful experiences related to financial security were the tipping point to finally leaving their job.

In terms of counselor posttraumatic growth, the Financial Security theme is a crucial factor in pushing the counselor to action. After a period of confusion regarding harmful experiences in the supervisory relationship, participants focus on what they need or lack to make the situations bearable. Over time, participants experience a tolerable amount of financial insecurity or stress. This tolerance ends when participants experience a significant, money-related event. It is this financial event that propels the counselor to action and change.

Theme Five: Professional Duty

The last theme identified in the data analysis, Professional Duty, emerged when participants were asked to look back on their experiences of harmful clinical supervision and share any personal or professional changes they went through as a result. Every participant (n = 12) described changes connected to their professional identity as a counselor. Additionally, these changes were characterized by a sense of duty or obligation to the counseling profession. Katherine explained this, saying,

> I think it made me now, as a supervisor, I am very particular about the requirements that I have…and listening to recordings and documenting everything. All of those things which my supervisees appreciate. It's almost like this overcompensation. I'm going to be a great supervisor because mine was not.

Comparably, other participants reflected on how their past experiences informed the counseling professionals they are today. For Kate, the connection is simple: "I think I'm a

better clinical supervisor now because I had crappy clinical supervision or no clinical supervision." In Lori's experience, harmful clinical supervision gave her a template of what not to do, saying, "I'm a better counselor because I know what a bad counselor is. I'm a better supervisor because I know what a bad supervisor is."

Providing supervisees with positive clinical supervision experiences was a goal for most participants (n = 9). Specifically, increasing supervisee confidence was mentioned across the interviews, as Jenny described, saying,

> I want you to feel good and feel confident and love the profession. I want you to build your identity. That's really what I want. I remember when I finally felt like I identified with my license. I remember settling into that and being I know who I am, and I know why I'm not an LCSW and I know why I'm not an LMFT. I know who I am. That only comes, I think, with being around other experienced clinicians. That didn't come with supervision, but I wish it had. I wish it had come with supervision with another experienced clinician really saying, 'Look, look at what you're providing. Only you can provide this from *your* experience, from *your* education, from *your* education, from *your* drive.' And that's why I do it with my supervisees. When you leave a session, I believe this, you should feel like you are *rocking* it. Every time. You should be like, 'I am killing it!' when you leave a supervision session.

Jenny continued, saying,

> When I met with my supervisees, I am so positive. You know, 'You're doing great!' I tell them how much I appreciate them. How brave they are. Developing their confidence. Because they will come in and be like, 'I'm screwing everything

> up.' And I'm like, 'I highly doubt it. Tell me what's going on.' And then I can give them examples of things that I've been through and where I have stumbled and fallen and stuff with clients. I feel really good about that too. Bringing myself into the space like, 'Oh my goodness, that has only happened to me *all the time*.'

Normalizing the supervisee's experiences by revealing personal examples was indicated by several other participants. This method helped 'level the playing field' between supervisor and supervisee by decreasing the perceived power differential and reinforcing the shared background as counselors.

Most participants (n = 8) currently hold licensure as a counselor supervisor (LCMHCS) with NCBLCMHC. Those participants without the credential (n = 4) are actively working toward licensure in their current job or plan to once they secure a clinical supervisor position. Isabela shared about her future plans as a supervisor, saying, "If I ever get a position as a clinical supervisor, I definitely will give good communication and have support there all the time. Because I know if it's not there, you don't grow."

The theme Professional Duty highlights how participants described using their past experiences of harmful clinical supervision in positive and productive ways. In addition to influencing the participant's professional identity development, the experiences had an impact on the way participants chose to interact with other counselors going forward. While participants were not asked directly about posttraumatic growth, the changes participants reported in relation to their past experiences of harmful clinical fit the definition of posttraumatic growth described by Tedeschi and Calhoun (1996).

Types of Harmful Clinical Supervision

One of the main criteria for inclusion in this study was participants who self-report harmful clinical supervision. While each experience is unique, a classification method was needed to demonstrate the similarities between the participants experiences in an organized fashion. The nine general descriptions of harmful clinical supervision offered by Ellis et al. (2014a) provide a range of categories for this task including: (a) sexual intimacy or improprieties; (b) physically, emotionally, or psychologically aggressive or abusive behaviors; (c) supervisee boundary violations; (d) using power for personal gain or at the expense of the supervisee; (e) macro- and microaggressions; (f) public humiliation or deriding; (g) demeaning, critical, or vindictive attitude toward supervisee; (h) exploitative multiple relationships; and (i) failing to take action that results in supervisee or client harm.

During the interview process, each participant described at least one supervisor who engaged in harmful clinical supervision while four participants described two or more harmful supervisor experiences. The experiences of each participant were compared to the nine general descriptions and tallied according to best fit. In analyzing the participant interviews, two of the harmful clinical supervision categories were not represented in the data analysis while the frequency of other categories ranged from one to 11 times. The most common harmful clinical supervision category represented in the data was demeaning, critical, or vindictive attitude toward supervisee (n = 11), followed by failing to take action that results in supervisee or client harm (n = 6). Ellis et al. (2014a) Table 1 shows the frequency each category of harmful clinical supervision appeared in the interviews.

Table 1

Harmful Clinical Supervision Categories Represented in the Data

Category	Frequency
Sexual intimacy or improprieties	0
Physically, emotionally, or psychologically aggressive or abusive behaviors	3
Supervisee boundary violations	2
Using power for personal gain or at the expense of the supervisee	1
Macro- and microaggressions	3
Public humiliation or deriding	4
Demeaning, critical, or vindictive attitude toward supervisee	11
Exploitative multiple relationships	0
Failing to take action that results in supervisee or client harm	6

Note. Harmful clinical supervision categories from Ellis et al. (2014a)

Categories of Posttraumatic Growth

The purpose of this study was to examine posttraumatic growth linked to harmful clinical supervision. Given the charged nature of the topic of interest, care was taken to reduce response bias. Specifically, the term *posttraumatic growth* was not included in the recruitment email, consent to participate, screening email, or semi-structured interview protocol. The term *trauma* was only used in the definition of harmful clinical supervision, as described by Ellis et al. (2014a), to confirm participant eligibility. This definition

appeared on the recruitment email, screening email, and introduction of the semi-structured interview protocol. Because of these measures, how participants reported experiencing posttraumatic growth was determined by analyzing the data and not through direct questioning.

Using the categories outlined in the Posttraumatic Growth Inventory (PTGI) (Tedeschi & Calhoun, 1996), the researcher placed participant experiences in one or more of the following types of growth: (a) relating to others, (b) new possibilities, (c) personal strength, (d) spiritual change, and (e) appreciation for life. The growth category relating to others encompasses positive change in relationships, including personal attitudes or behaviors in the relationship. New possibilities describe how individuals can recognize new possibilities in their lives, take a different life path, or develop new interests or habits. The category of personal strength refers to experiences of "increased self-reliance…sense of strength and confidence, and a perception of self as survivor or victor rather than 'victim'" (Tedeschi et al., 2018, p. 27). The growth category of spiritual change targets the experiences of religious, agnostic, or atheist people and those from other cultures who endorse broader spiritual or existential changes (Calhoun et al., 2010; Tedeschi et al., 2017). Finally, appreciation for life includes experiences of increased awareness and appreciation for all that life has to offer. The participant experiences described in the interviews covered all but one growth category, with personal strength experienced by all participants. Table 2 shows the complete list of growth categories and the frequency found in the data.

Table 2

Growth Categories Represented in the Data

Growth Category	Frequency
Relating to others	1
New possibilities	3
Personal strength	12
Spiritual change	0
Appreciation for life	4

Note. Growth categories from Tedeschi & Calhoun (1996).

An additional growth category not described by the PTGI was noted by the researcher. This category, *professional duty*, includes experiences where the individual feels an obligation to their profession to 'right the wrongs' that were done to them. This type of growth was observed in each of the 12 participants. Some examples of this include earning a supervisor credential, providing supervision free of charge, advocating for counseling students, and becoming a counselor educator.

Summary

This chapter presents the findings from the data analysis of 12 counselor interviews. These interviews were focused on the primary research question: What are the lived experiences of counselors who report posttraumatic growth linked to harmful clinical supervision? Two additional questions were: (a) in what context does posttraumatic growth occur? and (b) what is the process of counselor posttraumatic growth? The discussion began with a brief description of each participant. This was

followed by a presentation of the themes and subthemes found though data analysis. Next, using the nine types of harmful clinical supervision outlined by Ellis et al. (2014a), participant experiences were categorized and tallied. Due to some participants reporting multiple experiences, the total number is greater than the total sample size (n = 12). Finally, using the five growth categories outlined by Tedeschi and Calhoun (1996) in the PTGI, participant experiences were sorted into all but one of the categories. The researcher also presented an additional growth category, professional duty, that was identified in all participant interviews.

CHAPTER 5: DISCUSSION

This qualitative study aimed to explore counselor experiences of posttraumatic growth linked to harmful clinical supervision. Semi-structured interviews were conducted with 12 participants to facilitate in-depth descriptions of their experiences. All participants were credentialed counselors through the NCBLCMHC, had at least five years of post-licensure experience, and self-reported experiencing harmful clinical supervision. From the data analysis, five main themes emerged: (a) Confusion, (b) Support and Encouragement, (c) Safety and Protection, (d) Financial Security, and (e) Professional Duty. Six subthemes were also identified. Under Support and Encouragement, the three subthemes of Walk with Me, Hard Work, and Professional Development emerged. The theme of Safety and Protection included the three subthemes of Physical, Emotional, and Administrative. These themes and subthemes answer the primary research question: What are the lived experiences of counselors who report posttraumatic growth linked to harmful clinical supervision? and two additional questions: (a) in what context does posttraumatic growth occur? and (b) what is the process of counselor posttraumatic growth? In this final chapter, a discussion of the findings related to relevant literature leads to a description of the context and process of counselor posttraumatic growth observed in the study findings. Sections on contributions and implications of the findings, limitations of the study, and suggestions for further research will conclude the chapter.

Connecting Themes to Relevant Literature

In this study, 12 counselors shared their experiences of harmful clinical supervision. While not explicitly stated in the recruitment materials or directly asked in

the semi-structured interviews, this study sought to explore counselor posttraumatic growth linked to harmful clinical supervision. Through the interviews, themes emerged highlighting how counselors experience posttraumatic growth like other people but also in unique ways connected to their professional identity as counselors. The five main themes, Confusion, Support and Encouragement, Safety and Protection, Financial Security, and Professional Duty, provide a map of the journey these counselors went through to move past their harmful experiences to a place of posttraumatic growth and change.

Confusion

The theme of Confusion arose when participants began to share specific incidents of harmful clinical supervision. Participants reported disorientation and uncertainty when supervisors engaged in multiple incidents of demeaning, critical, or vindictive behavior. As described in the literature, this category of behavior is one of the nine general descriptions of harmful clinical supervision offered by Ellis et al. (2014a) and was reported by all but one participant (n = 11). Because this negative interaction with a supervisor had never happened before, participants reported not knowing how to respond. Some participants assumed they were to blame for this treatment and remained quiet, while others confronted their supervisor. Unfortunately, both types of counselor responses did not stop the supervisor's behaviors.

The examples of confusion shared by the participants in this study mirror the first three principles of posttraumatic growth theory that center around schema change (Tedeschi & Calhoun, 1995). Schema is how an individual organizes knowledge about concepts to guide cognitive processes and future behavior (APA, 2022c). An individual's

schema is a blueprint of how the world works. For the counselors in this study, their schema related to clinical supervision was challenged, causing them significant confusion and distress. Consequently, the confusion response to harmful clinical supervision is the beginning of the process of posttraumatic growth.

Support and Encouragement

The second theme of Support and Encouragement became apparent when participants discussed positive examples of clinical supervision or described what was lacking in their experiences of harmful clinical supervision. For some participants, it was only through outside support and encouragement that they could finally leave their harmful supervisor. This theme includes the Walk with Me, Hard Work, and Professional Development subthemes.

First, the subtheme Walk with Me, illustrates how counselors are educated and trained. Through direct example and modeling, supervisors actively participate in the hands-on teaching of their supervisees. The supervisor is a guide to help and support the supervisee as they travel through the experience together. This idea is similar to Calhoun and Tedeschi's (2013) concept of expert companionship, where the supervisor is a participatory member of the team, walking beside the supervisee rather than remaining on the sideline. Likewise, participants in this study reported positive experiences with clinical supervisors who were physically present with the supervisee.

Second, the subtheme of Hard Work describes the counselor's need for supervisors to recognize the specialized and taxing nature of being a counselor. When clinical supervision lacked this recognition and support, morale among participants and their co-workers often suffered. This decline in morale is seen in the literature and

represents a breakdown in the supervisory alliance (Ghazali et al., 2016; Son & Ellis, 2013). Just as Ellis et al. (2014a) found increased rates of stress and burnout in counselors who lack a solid supervisory relationship, participants in this study reported similar experiences.

Lastly, the subtheme of Professional Development includes how clinical supervision enhances professional identity development and career advancement. Clinical supervisors are often the supervisee's model of what it is to be a professional counselor. Not only do supervisors teach by example, but they can also make or break a supervisee's advancement in the field. Ellis et al. (2000) included professional functional impairments and loss of self-confidence among the effects of harmful clinical supervision. These two effects were mentioned multiple times by the participants in this study.

Safety and Protection

The theme of Safety and Protection includes specific actions or inactions by the clinical supervisor or their superiors that result or contribute to supervisee harm. When working with troubled clients or in environments that contribute to the probability of harm, counselors need to feel safe and protected to work effectively. This theme has three subthemes. First, two subthemes, Physical and Emotional, indicate the type of harm that occurred, while the subtheme of Administrative refers to others above the clinical supervisor who contributed to harmful experiences.

Physical, the first subtheme, includes instances where the supervisee is threatened by a client with physical harm or experiences bodily injury due to an altercation. Recent research by Maagerø-Bangstad et al. (2019) and Odes et al. (2021) suggested how mental health practitioners can address staff-directed violence in the workplace and commented

on the frequency of incidents. This research parallels the current study as several participants (n = 4) reported being threatened by clients, one of whom sustained severe injuries despite reporting these threats to her clinical supervisor. Additionally, the findings of this study endorse previous research (Howard et al., 2006) that stresses how counselors are unlikely to provide effective, clinical services if they do not feel physically safe.

The second subtheme, Emotional, consists of participant expression or concealment of feelings and emotions within the supervisory relationship. Although supervisory relationships share characteristics (e.g., genuineness, unconditional positive regard) of the therapeutic relationships between counselor and client (Martin & Turner, 2020), incidents of harmful clinical supervision often silence the counselor's willingness to be open and vulnerable. Similar to the findings Kiewitz et al. (2016) reported, participants in this study concealed their feelings to prevent further harm, judgment, or reprisal.

The last subtheme, Administrative, includes interactions related to those above and beyond the clinical supervisor but contributes to harmful experiences. When counselors do not feel safe or protected in supervisory relationships, reporting their concerns to those in administrative positions seems logical. Unfortunately, the small number of participants (n = 3) who went to administrative personnel aligns with the low reporting found in previous research (Pope & Vetter, 1992; Van Horne, 2004) and national statistics (CNA/HPSO, 2019). For the two participants who sought help from their state licensing board, the response was either non-existent or did not address the participant’s concern. Additionally, those participants were the only two males

participating in this study, thus raising questions about gender differences in reporting harmful clinical supervision.

Financial Security

Financial Security, the fourth theme in this study, consists of participant experiences involving money. From the interviews, participants described events in two general categories: (a) costs associated with clinical supervision and (b) counselor compensation. Regarding the cost of clinical supervision, a few participants (n = 3) received free supervision because their employer provided it. Similar to the conclusions of Magnuson et al. (2002), the participants in this study realized that free supervision does not always equate to good supervision. As a result, one participant reported contracting with a supervisor outside her agency for $125 a session. Over a year, this weekly clinical supervision would cost $6,500. This amount is sizable for associate counselors earning significantly less than the $48,520 median annual wage of mental health counselors in the United States (BLS, 2022). Of the participants who paid out-of-pocket for clinical supervision, some (n = 4) reported losing that money when the clinical supervisor would not provide documentation to the state licensing board verifying their hours of supervision and supervised practice. Participants reported feeling they had no recourse in these situations, which is similar to findings in literature associated with other human service professions (Slanzi & Sellers, 2022). Often, participants reported accepting what happened and starting over with a new supervisor.

The second general category, counselor compensation, involved incidents where participants were not paid for their work or had money deducted from their paychecks without their knowledge or prior consent. Most participants (n = 9) reported working at

least once as contract employees for a private counseling practice or agency. These situations required participants to sign employment contracts, usually with no prior knowledge or experience with these documents. In addition, participants often reported that the business owner was their clinical supervisor. These dual relationships and unclear boundaries made participants unwilling to complain about lost compensation for fear of losing their job and supervisor simultaneously.

Professional Duty

The final theme, Professional Duty, refers to the sense of responsibility and obligation to other counselors described by each participant. Past harmful clinical supervision significantly influenced who participants were today in terms of their professional identity. Participants reported ways they wanted to give back to the profession, including earning the supervisor credential, offering free clinical supervision, becoming a counselor educator, and taking the lead in training associate counselors and interns at their agency. These examples describe positive and permanent changes linked to significant, traumatic experiences. As such, the examples also fit the definition of posttraumatic growth originally described by Tedeschi and Calhoun (1996).

Context and Process of Counselor Posttraumatic Growth

The themes identified during the data analysis of this study work together to answer the research questions. The primary question focused on exploring the lived experiences of counselors who report posttraumatic growth linked to harmful clinical supervision. Two additional questions concerned the context and process of counselor posttraumatic growth.

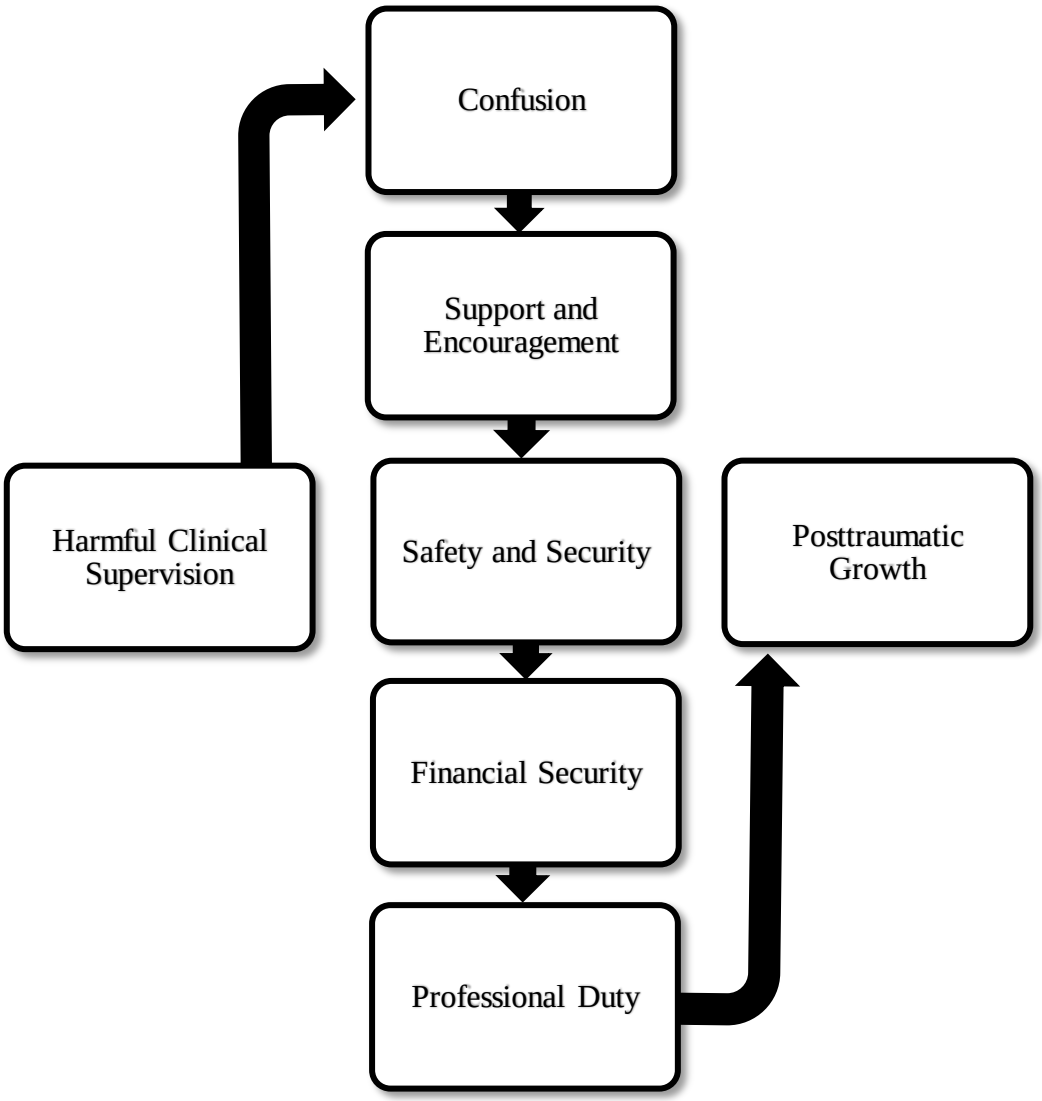
Despite coming from diverse backgrounds and experiencing multiple types of harmful clinical supervision, the participants in this study shared a similar context and process toward posttraumatic growth. Regarding context, each counselor identified as the supervisee and subordinate within the supervisory relationship. As defined by the themes and subthemes of this study, the process begins with a period of Confusion. Each participant described feeling puzzled and uncertain when confronted with instances of harmful clinical supervision. These situations were disorienting because they lacked the Support and Encouragement found in past supervisory relationships. Supervisors who contributed to each counselor's positive learning and development were often those willing to Walk with (Me) the counselor, as an expert companion. These supervisors recognized the supervisee's Hard Work and consistently promoted their Professional Development and growth.

As participants began to ruminate about their situation, they identified a lack of Safety and Protection in the supervisory relationship. Specifically, participants noted Physical and Emotional types of harm. When some participants sought help from those in Administrative positions, they were disappointed by the lack of response and help. As time passed, additional instances of harmful clinical supervision began to compound the participants' feelings of isolation and despair. Eventually, a significant event, most commonly tied to Financial Security, pushed the participants to end their supervisory relationships. Over time, participants began to realize the transformative nature of their harmful experiences. Finally, participants reported seeking training opportunities to become clinical supervisors and counselor educators. Becoming an excellent clinical

supervisor was their Professional Duty and was described as a way to “right the wrongs” of what they experienced. This path is illustrated in Figure 1.

Figure 1

Path From Harmful Clinical Supervision to Posttraumatic Growth



Contributions

This study is the first to examine counselor posttraumatic growth linked to harmful clinical supervision. The findings contribute to the existing literature on clinical supervision by shifting the focus from commonly reported adverse outcomes to positive benefits linked to harmful experiences. Additionally, this study affirms the impact and importance of supervisory relationships on the growth and development of professional counselors. Finally, the findings highlight a significant deficit in counselor education programs as each participant (n = 12) denied learning about harmful clinical supervision while in school.

Implications

Several implications for the counseling profession emerged from this study. The first implication involves updating the counselor education curriculum to include information on harmful clinical supervision. By beginning the discussion early in the education process, new counselors would be able to recognize and address harmful clinical supervision when they experience it. This knowledge would also empower counselors to speak out about inappropriate or unethical practices rather than keep silent. By reporting supervisors who fail to provide minimally adequate supervision or engage in harmful clinical supervision, a more accurate assessment regarding the scope of the problem and remediation would be possible.

In addition to information about harmful clinical supervision, counselor education programs could assist new counselors by adding instruction that focuses on the legal aspects of being a private contractor. Participants in this study reported being uninformed about the numerous legal aspects of working as a contract employee. New counselors

often take for granted that their clinical supervisor has their best interest in mind during this process and fail to ask pertinent questions designed to protect themselves. Because participants in this study lacked the knowledge of what an employment contract should and should not include, they signed the contract without realizing the impact on their paycheck.

Another implication concerns the ability of supervisees to evaluate their supervisors. Similar to supervisors completing evaluations of counselor competence and suitability to the profession, supervisees should also have the opportunity to evaluate and provide feedback regarding the supervisor's performance. Given the implications associated with these evaluations, it is unlikely that state licensing boards would be willing to take on the responsibility. As such, it is foreseeable that a dedicated hotline or website may be necessary to provide counselors with basic information or consultation on their specific situations. This type of service could assist counselors in processing what has happened, evaluating the extent of the situation, determining the following steps, and facilitating any needed referrals.

The findings of this study also call attention to the need for ongoing clinical supervision of licensed counselors. Like other state licensing boards, the NCBLCMHC does not require counselors or supervisors to receive clinical supervision after being granted full, unrestricted licensure. While often viewed as a benefit of being fully licensed, the harmful experiences described in this study demonstrate why ongoing clinical supervision is vital to ethical counselor practices and competency. Additionally, because all supervisors are capable of harm (Ammirati & Kaslow, 2017; Borders, 2017), precautions are needed to reduce the likelihood of it happening.

Finally, the last implication of this study is the introduction of a pathway from harmful clinical supervision to posttraumatic growth. Figure 1 provided a conceptualization of how counselors in this study moved through the identified themes and on to growth and development. This diagram highlights aspects of the supervisory relationship that are critical to counselor development, self-efficacy, and satisfaction as a professional.

Limitations

There were four limitations identified in this study. The first limitation is the lack of diversity among the participants. Most of the participants were White (n = 9), straight (n = 9), and female (n = 10). While the Bureau of Labor Statistics (2022) continues to describe counseling as a profession of predominately White females, there was an effort to recruit a more diverse sample using the entire NCBLCMHC email directory. The second limitation involved the distribution of participant licensure type. More participants in the sample held the LCMHCS (n = 8) than the LCMHC (n = 4). This distribution was unexpected, most notably because only 14% of NCBLCMHC counselors hold the LCMHCS credential. On the other hand, counselor supervisors may be better informed about harmful clinical supervision due to the training required to earn the LCMHCS. This training could be perceived as bias in what the participants reported but it may also be a strength because they were able to recognize their experiences as harmful and prompted their participation in the study. The third limitation is the use of Zoom to interview participants rather than conducting interviews in person. Zoom allowed individuals to participate in the study by removing the distance barrier. Despite this, drawbacks to conducting interviews online include a lack of connection between

researcher and participant, missing non-verbal communication, connectivity problems, technology error, and an increased chance of distractions or interruptions to the interview. Lastly, this study is limited by focusing only on counselors licensed by the NCBLCMHC and cannot be generalized to counselors licensed in other states.

Future Research

The process of conducting this study underscored the desire of counselors to share their stories of harmful clinical supervision in future research. An eligibility criterion for this study was that participants must have at least five years of post-licensure counseling experience. This requirement was linked to the study's focus on posttraumatic growth theory, as time must have elapsed for individuals to process and understand the impact of their harmful experiences. Several counselors responded positively to the recruitment email but lacked the required amount of counseling experience. Additionally, multiple associate counselors, or those holding the Licensed Clinical Mental Health Counselor Associate (LCMHCA) credential, heard about the study and contacted the researcher. These individuals wanted to participate and suggested that counselors who were closer in time to their harmful experiences were better able to remember and describe the events. Harmful clinical supervision is a prevalent issue within the counseling profession. As such, research including all NCBLCMHC licensure types (LCMHCA, LCMHC, LCMHCS) will contribute to learning the depth and breadth of the problem. An email survey or other quantitative methods would give a voice to those unable to participate in this study, encourage additional counselors to participate, require a smaller time commitment, and provide more direction for subsequent research.

Another suggestion for future research involves counselor education programs. Every participant in this study (n = 12) denied receiving education or training specific to harmful clinical supervision during their counselor education program. While most participants (n = 9) attended educational programs in North Carolina, three participants attended online programs based in other states. This lack of specific education across multiple different institutions suggests a wider deficit in training programs. Given that clinical supervision is the primary means to educate and train counselors, providing students with information about the possibility of harmful supervision is essential. In addition, research examining how counselor education programs address the topic of harmful clinical supervision could assist in program improvement or future curriculum development.

Additional future research is needed to address the gender and age differences in reporting harmful clinical supervision. Reasons for this suggestion include the following:

1. Only the two male participants in this study reported their concerns to state licensing boards, while the ten female participants did not.
2. All three participants who reported their concerns to administrators were female.
3. The youngest participant, aged 36 years, was the only one to go to Human Resources with her concerns, and on multiple occasions.

A final suggestion for future research would examine the gender and race differences within counseling supervisory relationships. Because gender and race influence how individuals interact, it would make sense that they also affect the supervisory relationship and play some role in harmful clinical supervision. While

information about participant gender and race was collected in this study, specific questions regarding supervisor demographics were not part of the interview protocol. During data analysis, some information about supervisor gender and race was collected but not enough to provide any meaningful conclusions.

Conclusion

This chapter discussed the study findings regarding counselor experiences of posttraumatic growth linked to harmful clinical supervision. Specifically, the five main themes of Confusion, Support and Encouragement, Safety and Protection, Financial Security, and Professional Duty were detailed and connected to the literature on posttraumatic growth and clinical supervision. This section on themes was followed by a description of the context and process of counselor posttraumatic growth. Finally, sections involving the contributions and implications of the findings, limitations of the study, and suggestions for further research completed this chapter.

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APPENDIX A: INSTITUTIONAL REVIEW BOARD APPROVAL

CHARLOTTE
RESEARCH AND ECONOMIC DEVELOPMENT

To:	Tristin White University of North Carolina at Charlotte
From:	Office of Research Protections and Integrity
RE:	Notice of Exemption with Limited Review Approval
Approval Date:	03-Jul-2022
Exemption Category:	2
Study #:	IRB-22-1060
Study Title:	Counselor Experiences of Harmful Clinical Supervision

This submission has been reviewed by the Office of Research Protections and Integrity (ORPI) and was determined to meet the Exempt category cited above under 45 CFR 46.104(d). In addition, this Exemption has received Limited Review by the IRB under 45 CFR 46.111(a)(7). This determination has no expiration or end date and is not subject to an annual continuing review. However, you are required to obtain IRB approval for all changes to any aspect of this study before they can be implemented and to comply with the Investigator Responsibilities detailed below.

Important Information:

1. Face masks are optional on UNC Charlotte's campus. This includes classrooms and other academic spaces. Researchers conducting HSR activities in other locations must continue to adhere to local and state requirements in the setting where the research is conducted.
2. Face masks are still required in healthcare settings. Researchers conducting HSR activities in these settings must continue to adhere to face coving requirements.
3. Organizations, institutions, agencies, businesses, etc. may have further site-specific requirements such as continuing to have a mask requirement, limiting access, and/or physical distancing. Researchers must adhere to all requirements mandated by the study site.

Your approved study documents are available online at Submission Page.

Investigator's Responsibilities:

1. Amendments must be submitted for review and the amendment must be approved before implementing the amendment. This includes changes to study procedures, study materials, personnel, etc.
2. Data security procedures must follow procedures as approved in the protocol and in accordance with

OneIT Guidelines for Data Handling.

3. Promptly notify the IRB (uncc-irb@uncc.edu) of any adverse events or unanticipated risks to participants or others.
4. Five years (5) following this approval, ORPI will request a study status update.
5. Be aware that this study is now included in the Office of Research Protections and Integrity (ORPI) Post-Approval Monitoring program and may be selected for post-review monitoring at some point in the future.
6. Reply to ORPI post-review monitoring and administrative check-ins that will be conducted periodically to update ORPI as to the status of the study
7. Complete the Closure eform via IRBIS once the study is complete

Please be aware that additional approvals may still be required from other relevant authorities or "gatekeepers" (e.g., school principals, facility directors, custodians of records).

This study was reviewed in accordance with federal regulations governing human subjects research, including those found at 45 CFR 46 (Common Rule), where applicable.

APPENDIX B: RECRUITMENT EMAIL

Hello!

My name is Tristin White, and I am a doctoral candidate in the Counselor Education and Supervision program at the University of North Carolina at Charlotte (UNCC). I am conducting a research study to explore **counselor experiences of harmful clinical supervision**. *Harmful clinical supervision* is defined as any inappropriate action or inaction by the supervisor causing psychological, emotional, and/or physical harm or trauma to the supervisee.

I am seeking participants who:

- Are credentialed as a Licensed Clinical Mental Health Counselor (LCMHC) or Licensed Clinical Mental Health Counselor Supervisor (LCMHCS) by the North Carolina Board of Licensed Clinical Mental Health Counselors (NCBLCMHC)
- Have at least five (5) years of post-licensure counseling experience
- Self-report experiencing harmful clinical supervision

This is a UNCC IRB approved study: IRB-22-1060. Participation in the study will include signing an informed consent form; responding to a screening email with basic demographic questions; taking part in an individual, online interview; and reviewing follow-up material. The total time commitment is less than 105 minutes. Participation is completely voluntary. Your privacy will be protected, and confidentiality will be maintained to the extent possible. There is no compensation for your participation in this study. Study details and consent information is available via the DocuSign link at the top of this email.

If you meet the eligibility criteria above and would like to participate in this research study, please follow the DocuSign link above to review and sign the informed consent form.

Thank you for your consideration! If you have any questions, please contact the study team below.

Tristin L. White, MA, LCMHCS, NCC, LCAS, MAC, CCS
Doctoral Candidate | Department of Counseling
University of North Carolina at Charlotte
Primary Investigator
tlorrain@uncc.edu

John R. Culbreth, PhD, LCMHCS, LCAS, CCS
Professor | Department of Counseling
University of North Carolina at Charlotte
Faculty Advisor, Dissertation Chair
jculbret@uncc.edu

APPENDIX C: INFORMED CONSENT

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Consent to be Part of a Research Study

Title of the Project: Counselor Experiences of Harmful Clinical Supervision
Principal Investigator: Tristin L. White, MA, LCMHCS, NCC, LCAS, MAC, CCS, Doctoral Candidate, Department of Counseling
Faculty Advisor: John R. Culbreth, PhD, LCMHCS, LCAS, CCS, Professor, Department of Counseling

You are invited to participate in a research study. Participation in this research study is voluntary. The information provided is to help you decide whether or not to participate. If you have any questions, please ask.

Important Information You Need to Know

- The purpose of this study is to examine counselor experiences of harmful clinical supervision.
- You will be asked to participate in an individual, online interview through Zoom, a web-based conferencing platform.
- If you choose to participate, it will require 105 minutes or less of your time.
- Risks or discomforts from this research might include mild emotional distress.
- You will not receive incentives or benefit personally by participating in this study.

Please read this form and ask any questions you may have before you decide whether to participate in this study.

Why are we doing this study?

The purpose of this study is to explore counselor experiences of harmful clinical supervision. We also hope to learn about the different types of outcomes from these experiences, how they occur, and the process involved.

Why are you being asked to be in this research study.

You are being asked to be in this study because you are credentialed as a Licensed Clinical Mental Health Counselor (LCMHC) or Licensed Clinical Mental Health Counselor Supervisor (LCMHCS) by the North Carolina Board of Licensed Clinical Mental Health Counselors (NCBLCMHC), have at least five (5) years of post-licensure counseling experience, and self-report experiencing harmful clinical supervision.

What will happen if I take part in this study?

If you choose to participate in this study, you will be asked to sign an informed consent form, respond to a screening email to confirm eligibility, and answer basic demographic questions. You will then take part in an individual, online interview through Zoom, a web-based conferencing platform. This interview will be scheduled on a mutually agreeable day and time by the principal investigator. Once scheduled, you will be emailed a Zoom link to the interview. The interview will be audio recorded. After the interview is transcribed, you will be emailed a

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de-identified copy of the transcript for your review. You will be asked to email the transcript back to the principal investigator with any corrections, clarifications, notes, or additional information within one week. If the transcript is not returned after one week, it will be considered correct and finalized.

You time commitment will be about 105 minutes or less and consist of the following activities: 10 minutes for the informed consent and screening email, 5 minutes for the demographic questionnaire, 60 minutes for the interview, and 30 minutes for a follow-up review of material.

What are the benefits of this study?

You will not benefit directly from being in this study. However, others might benefit by what we learn about counselor experiences of harmful clinical supervision.

What risks might I experience?

You may experience some emotional distress as the interview questions focus on past experiences of harmful clinical supervision. To minimize this risk, you may choose not to answer a question or stop your participation at any time.

How will my information be protected?

Your privacy will be protected and confidentiality will be maintained to the extent possible. Your interview will be treated as confidential and will not be linked to your identity or email address. Your interview and email address will be stored separately with access to this information controlled and limited only to people who have approval to have access. Your interview will be transcribed, de-identified, and saved using a pseudonym of your choosing. Once transcribed, the interview recording will be deleted.

How will my information be used after the study is over?

After this study is complete, study data may be shared with other researchers for use in other studies without asking for your consent again or as may be needed as part of publishing our results. The data we share will NOT include information that could identify you.

What are my rights if I take part in this study?

It is up to you to decide to be in this research study. Participating in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and stop at any time. You do not have to answer any questions you do not want to answer.

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Who can answer my questions about this study and my rights as a participant?

For questions about this research, you may contact the principal investigator, Tristin L. White, tlorrain@uncc.edu, (980) 259-2061 or faculty advisor, John R. Culbreth, jculbret@uncc.edu, (704) 737-8580.

If you have questions about your rights as a research participant, or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please contact the Office of Research Protections and Integrity at uncc-irb@uncc.edu.

Consent to Participate

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will receive a copy of this document for your records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I understand what the study is about and my questions so far have been answered. I agree to take part in this study.

_____
Name (PRINT)

_____
Signature Date

_____
Email Address

_____
Name and Signature of person obtaining consent Date

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APPENDIX D: SCREENING EMAIL

[Participant Name],

Thank you for responding to the email about my study!

In order to confirm eligibility for this study, please respond to this email with answers to the following questions:

1. What license do you hold with NCBLCMHC?
2. How many years have you been licensed?
3. *Harmful clinical supervision* is defined as any inappropriate action or inaction by the supervisor causing psychological, emotional, and/or physical harm or trauma to the supervisee.

   Have you experienced harmful clinical supervision?

Additionally, your answers to the following demographic questions will assist me in learning about the counselors who responded to my recruitment email:

4. What is your age?
5. How do you identify in terms of gender?
6. How do you describe yourself in terms of ethnicity/ race?
7. How do you describe your sexual orientation?
8. What is the highest degree you completed?
9. What is your degree discipline?

Thank you for your time and consideration in participating in my study – I look forward to receiving your email!

Tristin L. White, MA, LCMHCS, NCC, LCAS, MAC, CCS
Doctoral Candidate | Department of Counseling
University of North Carolina at Charlotte
Primary Investigator
tlorrain@uncc.edu

APPENDIX E: SEMI-STRUCTURED INTERVIEW PROTOCOL

Introductory Protocol

To assist my notetaking, I would like to record our conversation today. After this recording is transcribed, it will be destroyed. For your information, please know that: (1) all information you share will be held confidential, (2) your participation is voluntary, and you may decline to answer any question or stop at any time, and (3) there is no intention by the researcher to inflict harm or discomfort. Thank you for your time and willingness to participate.

I have planned this interview to last approximately one hour. I have several open-ended questions I would like us to cover during this time.

Introduction

My name is Tristin White, and I am a doctoral candidate in the Counselor Education and Supervision program at the University of North Carolina at Charlotte. I am also a licensed counselor who has experienced harmful clinical supervision.

You meet the criteria for this study because: (a) you have been licensed as an LCMHC or LCMHCS for at least five years and (b) you have experienced clinical supervision that you consider to be harmful. *Harmful clinical supervision* is defined as any inappropriate action or inaction by the supervisor causing psychological, emotional, and/or physical harm or trauma to the supervisee. **The research project focuses on the experiences of counselors who report past harmful clinical supervision.** My study does not aim to evaluate your experiences. Instead, I am trying to learn more about how counselors are affected by these experiences. Hopefully, I will be able to draw some conclusions about the process counselors go through.

I. Interviewee Background

Tell me about your path to becoming a counselor.

Probe: What made you decide to become a counselor?
What counseling program did you attend?
What was important to you in choosing a counseling program?

II. Experiences as a Counselor

Tell me about your experiences working as a counselor.

Probe: What was your first job as a counselor after completing your degree?
Have your experiences working as a counselor been what you imagined they would be?
What type of counseling work do you do now?
How have your early counselor positions influenced your career path?

III. Experiences of Clinical Supervision

Tell me about your experiences with clinical supervision.

Probe: What was your experience of clinical supervision during your counseling program?
How did clinical supervision change in your first job as a counselor after graduation?
What ways did clinical supervision change once you received full licensure?

Tell me about your experiences with harmful clinical supervision.
Probe: How would you describe harmful clinical supervision?
How have you personally experienced harmful clinical supervision?
What was the context surrounding your experience? (clinical setting, format of supervision, stage of training, supervisor chosen or assigned, cultural differences, etc.)
How did you become aware that the clinical supervision was harmful?
To what extent did you attempt to address your concerns with your supervisor or others beyond the supervisor?
How did you cope with your experiences with harmful clinical supervision?

IV. Experiences of Posttraumatic Growth

Tell me about your experiences of posttraumatic growth.
Probe: How have your experiences of harmful clinical supervision impacted you personally? Professionally?
Have your thoughts about your harmful experiences changed over time?
In what ways have you changed personally from the harmful experiences? Professionally?
What have you learned from your harmful experiences?

V. Looking Back

Knowing what you know now, would you change anything about your experiences?
Is there any advice you would offer new counselors about harmful clinical supervision?

VI. Conclusion

Is there anything else you would like to share that I have not asked you about?

Thank you so much for your time and the valuable insights you shared with me.

APPENDIX F: PARTICIPANT DEMOGRAPHICS

Table 3

Participant Demographics

Name	Age	Gender	Ethnicity/ Race	Sexual Orientation	Highest Degree	Degree Discipline	License Held	Years Licensed
Kadie	54	Female	White	Lesbian	Masters	Counseling	LCMHCS	24
Felicity	41	Female	PNA*	PNA*	Masters	Counseling	LCMHCS	8
Jenny	48	Female	White	Straight	Masters	Counseling	LCMHCS	12
Eleanor	41	Female	White	Straight	Masters	Counseling	LCMHCS	13
Janice	64	Female	Other	Straight	Doctoral	Counselor Education & Supervision	LCMHCS	12
Kate	61	Female	White	Straight	Masters	Counseling	LCMHC	6
Hendrick	56	Male	White	Straight	Masters	Counseling	LCMHC	7
Peter	51	Male	White	Straight	Masters	Counseling	LCMHCS	8
Isabela	54	Female	Latina	Lesbian	Masters	Counseling	LCMHC	5
Barbara	32	Female	White	Straight	Masters	Counseling	LCMHC	5
Lori	49	Female	White	Straight	Masters	Counseling	LCMHCS	19
Katherine	41	Female	White	Straight	Masters	Counseling	LCMHCS	14

*Prefer Not Answer