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Stories of Licensed Counseling Supervisors Who Identify as Wounded Healers

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Walden University
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Abstract

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MS Counseling, Southern Methodist University, 2015

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Dissertation Submitted in Partial Fulfillment

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Doctor of Philosophy

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Abstract

Although a large percentage of counselors who are wounded healers eventually become clinical counseling supervisors, little is known about the effects on clinical supervision. Counseling supervisors have the responsibility of gatekeeping, managing client care, and modeling counseling for counselors-in-training; the process is likely affected by woundedness as is the counseling process. The purpose of the current qualitative narrative study was to identify the stories of wounded healers as clinical counseling supervisors to recognize how supervision is affected and influenced by being a wounded healer. The data were analyzed using the theoretical lens of existentialism and the conceptual framework of the wounded healer. Four participants were recruited from social media and licensed professional counseling supervisor list servs. The participants were interviewed via Zoom and audio recorded using a hand-held recorder. A HIPPA-compliant professional transcription service transcribed the audio portion of the recordings. Narrative analysis was used to reveal themes and codes from the participants' stories. Six themes emerged from the codes: (a) encountering an initial wounding, (b) seeking help and being unsuccessful at healing, (c) receiving healing at a later age, (d) transmitting healing, and (e) offering effective bias-free supervision. Their stories indicated an influence from healing versus unhealed on the supervisory process and relationship. All the supervisors indicated a biased and impaired approach to supervision when healing was not achieved. The research can affect social change by offering a model to provide effective supervision for individuals who are clinical counseling supervisors and identify as wounded healers.

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Dedication

This dissertation is dedicated to my family, who spent many hours without me because of my studies and many hours with me helping me push through challenging times. Specifically, my mother, who answered numerous calls while I learned the methods and sent me articles to help guide me. She taught me critical thinking and raised me to believe that I could do anything I wanted. To my children, who inspire me daily to be a better person and they influenced me to get an education so that I could model for them that they can do anything with enough tenacity and belief in themselves. A special dedication to my daughter Caytlin, who spent long hours without me because of my schoolwork and always encouraged me to see the positive things about myself that I was unable to see. Lastly, I dedicate this work to my higher power, who provided me with the gifts and talents to persevere.

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you for loving me when I could not love myself. Thank you to the most supportive and wonderful family I could ask for; all the good things in my life are because of you and include you!

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Chapter 1: Introduction to the Study

Background

Counselors often enter the counseling field due to past personal, familial, mental, and physical challenges (Kern, 2014). Approximately 75% or more of counselors are drawn to the field of counseling due to previous wounds (Kern, 2014). A counselor's past experiences can lead to a passion for helping others heal and a higher likelihood of pathologizing other individuals. Professional identity, an essential aspect of counseling and an ethical requirement, can also be a strain on individuals who suffer or suffered from the residual of past issues (American Counseling Association [ACA], 2014; Kern, 2014). Pathologizing other individuals violates ethical counseling guidelines (ACA, 2014). Effective clinical supervisors are mitigators for assisting counselors in overcoming barriers related to their past and being effective counselors (Bernard & Goodyear, 2014).

Because adequate clinical supervision is one of the most critical aspects of navigating past issues with counseling relationships, clinical supervisors are charged with ensuring that they are emotionally healthy enough to recognize counselors-in-training issues. But harmful clinical supervision often goes unnoticed or acknowledged due to power dynamics in the supervision relationship (Ellis et al., 2017). Because of the hierarchal and evaluative component of clinical counseling supervision, unwell supervisors can misuse their power and neglect the gatekeeping role of clinical counseling supervision. Harmful clinical counseling supervision is a significant issue for the developing counselor, and research indicates that it occurs between 25 to 35% of clinical counseling supervision experiences in the United States (Ellis et al., 20142015).

Clinical counseling supervisors can be impaired for some of the same reasons that counselors are impaired, such as burnout, substance abuse, emotional and mental disorders, and past personal or familial issues (Muratori, 2001).

The current study focuses on the clinical counseling supervisor's past mental, physical, and familial challenges that influence them as clinical counseling supervisors. There is an abundance of articles related to previous wounding's negative and positive effects on a counselor (Cvetovac & Adame, 2017; Groesbeck, 1975; Jackson, 2001; Jung, 1954). There is also literature on the negative aspects of previous wounding and how that wounding shapes the clinical counseling supervisor (Ellis et al., 2014, 2105; Kern, 2014; Muratori, 2001). However, existing research focuses on the negative aspects of wounding and the impaired clinical counselor supervisor. Revealing varied experiences, both positive and negative, can lead to a wealth of information that will help understand and assist the many clinical counseling supervisors who have previous wounds.

Problem Statement

Individuals who are or have been wounded are drawn to the field of counseling. Being wounded can present positive and negative effects on the individual and the counseling relationship (Kern, 2014). Due to counselors' transition into clinical counseling supervision, many counselors with previous wounds are likely transitioning into clinical supervisors. Because wounding has different effects on the counselor, such as helping or hurting their effectiveness, wounding likely has similar positive and negative effects on a clinical supervisor (Groesbeck, 1975; Jung, 1954). However, the literature focuses on the negative aspects of previous wounding on the clinical counseling

supervisor (Ellis et al., 2014; Ellis et al., 2015; Kern, 2014; Muratori, 2001). It is vital to examine clinical supervisors' experiences with previous wounding to understand better how the clinical counseling supervisor moderates and experiences wounding within the clinical counseling supervision relationship. Understanding the varied experiences of clinical counseling supervisors may reveal information that can improve client care due to the influence of clinical counseling supervision on client care.

Purpose of the Study

The purpose of the qualitative narrative study was to understand better the stories of clinical counseling supervisors who identify as wounded healers. Conflicting information exists, suggesting that being a wounded healer can help or hinder helping relationships such as counseling (Groesbeck, 1975). There is limited information regarding the helping relationship between clinical counseling supervision and wounded healing (Cvetovac & Adame, 2017; Jackson, 2001; Jung, 1954). The limited information regarding how wounded healers experience being a counseling supervisor leaves questions about how wounded healing influences their helping ability. By uncovering the stories of clinical counseling supervisors who identify as wounded healers, I shed light on the best practices for counseling supervisors who are wounded healers. As discussed, many individuals with previous wounds are drawn to the counseling field, and some eventually become clinical counseling supervisors. The current research results may allow individuals to increase the effectiveness of clinical supervision, which leads to more effective counselors by describing how the clinical counseling supervisor manages being a wounded healer while supervising counselors-in-training.

Research Question

What are the stories of clinical counseling supervisors who identify as wounded healers?

Conceptual Framework

The conceptual framework for the current study is the wounded healer. As described in detail in the next chapter, the wounded healer concept has historical roots. A wounded healer is an individual with previous wounding who has gone through the healing process and seeks to assist others in their healing (Jung, 1957). Many counselors are wounded and enter the field of counseling to seek meaning and purpose for their wounds. The wounding itself does not constitute being defined as a wounded healer; the wounded healer develops from the process of healing and then sharing healing with others (Jung, 1951, 1957).

Groesbeck (1975) and Jung (1957) suggested that individuals must be aware of their woundedness to be effective healers. Without acknowledgment of wounds, there are numerous negative implications, such as higher rates of substance abuse relapse, issues with transference and countertransference, projection, over-identification, and serious client harm (Conchar & Repper, 2014; Cvetovac & Adame, 2017; Jung, 1951, 1957; Zerubavel & O'Doughtery-Wright, 2012). Jung (1951) argued that the therapist's vulnerabilities and wounds need healing so that his wholeness rather than "clean hands" perfection creates the power to heal. Being wounded is insufficient for healing others; the healing potential comes from the healer's recovery process. As I viewed the stories of

and interacted with the participants in the current study, I viewed the stories through the framework of wounded healer.

Theoretical Framework

The theoretical framework for the current study was existential theory. Existential theory is about human existence, which leads individuals to explore relationships with others who exist (Reker & Chamberlain, 2000). Exploring themselves and other individuals leads them to situations in which they must make decisions that lead to different possibilities. Eventually, individuals seek meaning for these decisions and seek meaning and purpose for the consequences of decisions. Existential theorists posit that individuals frequently seek meaning, defined by Martin Heidegger's phrase Dasein ("there being"), because they are defined by their existence (Petzet & Heidegger, 1993). As individuals search for meaning in situations, their response to that meaning affects the outcome of their wounding and their abilities to transmit healing to others (Frankl, 1967). Thus, individuals may seek to heal others as they make meaning of their wounding. I viewed the stories of participants by identifying theoretical meaning-making and interactions with others (existentialism), specifically the concepts proposed by Frankl (1967). I also viewed the stories through the conceptual framework of the wounded healer. These two concepts complement each other, the narrative framework, and the purpose of the study.

Nature of the Study

I used a qualitative narrative design to understand clinical counseling supervisors' stories who identified as wounded healers. Narrative design allows for understanding a

certain population's experiences within a phenomenon (Clandinin, 2016). Narrative design is consistent with distinctive aspects of individual stories, unlike quantitative studies that focus on testing scientific theories (Clandinin, 2016). Because there are no operative definitions or theories to test regarding the topic, a narrative, qualitative study was the best exploration option. I collected data via audio interviews with clinical counseling supervisors who identify as wounded healers.

Definition of Terms

In the following section, I identify key terms and provided definitions for each. The terms defined are clinical counseling supervisors, counselors-in-training, healers, healing, wounds, healers, and wounded healers. When defining the terms, I also include a rationale for the choice of definition.

Clinical counseling supervisors: Supervisors who are licensed in their state as supervisors and supervise counselors-in-training who have already graduated and are working under a provisional license (Bernard & Goodyear, 2014). The clinical aspect of the term means that the supervisor is not administratively supervising the counselor-in-training; the supervisor is only supervising the counselor-in-training from a clinical, client-focused manner. Likewise, a counselor-in-training is a counselor who is provisionally licensed and is practicing counseling outside of a practicum or internship experience.

Healer: An individual who assists others in a healing capacity (Conchar & Repper. 2014). For the current research, the healer is an individual who assists individuals with mental health problems stemming from a variety of mental, physical,

and emotional disturbances. The healer, a counselor, uses healing as a form of meaning-making from their past wound. Healing is defined as a process an individual engages in recovering from a past or current challenge (Cvetovak & Adame, 2017). Healing may involve medical care, therapy such as counseling, somatic interventions, and the like.

Wound: A serious mental, physical, or emotional challenge previously experienced directly or indirectly by an individual (Jung, 1957; Zerubavel & O'Doughtery Wright, 2017). A direct wound happens (or the individual contracted, such as an illness or disability) directly to the individual. An example of a direct wound is childhood sexual abuse. An indirect wound is something that affects an individual that happened to someone else or that the individual witnessed. An example of an indirect wound is witnessing another individual's suicide or murder.

Wounded healer: An individual who experienced previous wounding and who engages in personal healing and assists others with wounding (Jung, 1951, 1957). The wounded healer becomes a wounded healer only after completing their healing process. In some cases of an ongoing wound, the individual has mastered coping with and identifying when the woundedness affects themselves or others. Conchar and Repper (2014) suggested clear differences between the walking wounded and the wounded healer; the difference is that the wounded healer has been healed and uses that process to heal others.

Assumptions

In this study, I assumed that there are differences in experiences for wounded healers who are clinical counseling supervisors than clinical counseling supervisors who

are not wounded healers. The assumptions are based on the literature, which suggests that wounded healers have different experiences within helping relationships. I also assumed that clinical counseling supervisors transition from being clinical counselors. Some clinical counseling supervisors serve in the advocacy arena and do not serve clients from a typical counseling perspective, such as having helping sessions and assisting them directly with their issues. Lastly, I assumed participants were honest in identifying as wounded healers.

Delimitations

I deliberately limited the participant pool to licensed clinical counseling supervisors. There may be individuals acting as clinical supervisors who are unlicensed. However, licensed clinical counseling supervisors have traditionally started as counselors and have training and expertise for being a supervisor and supervising counselors-in-training (Bernard & Goodyear, 2014). I limited the participant pool to clinical supervisors versus administrative supervisors because I am interested in how their woundedness is experienced when assisting counselors in improving their client's care. Administrative supervisors often focus on administrative aspects of the counselor-in-training, agency rules, and agency requirements.

Limitations

The primary limitation of the current study is the small number of participants and likely homogenous participant pool. Although narrative designs primarily have a few participants, the small number of participants may affect the results. There were no other study limitations.

Significance of the Study

The research filled a gap in understanding by exploring the experiences of counseling supervisors who are wounded healers. The current project is unique because it addresses an area unaddressed by available research. The current study results provide insights into best practices for counseling supervisors who identify as wounded healers. There are many wounded healers in the counseling field, and there are varied client outcomes associated with wounded healers (Cvetovac & Adame, 2017; Groesbeck, 1975; Jackson, 2001; Jung, 1954). With increased knowledge of supervisors as wounded healers, there is an opportunity to improve client care through improving clinical supervision.

Furthermore, there are implications regarding supervisors and the enormous effects on counselors-in-training development, which also translates to client outcomes (Bernard & Goodyear, 2014). Because of the power differential between supervisors and counselors-in-training, it is difficult for counselors-in-training to know when there is an issue with a counseling supervisor (Brown-Rice & Furr, 2015). With the current research, social change will occur by understanding counseling supervisors as wounded healers while translating that information into improved supervision of counselors and improved counselor training, which may lead to improved client care.

Summary

Researchers and philosophers have studied the concept of wounding and wounded healers across time and in-depth (Conchar & Repper, 2014; Cvetovac & Adame, 2017; Jung, 1951, 1957; Zerubavel & O'Doughtery-Wright, 2012). Wounded healers can

represent a greater opportunity to heal, but a wounded individual trying to heal others may harm the individual they are helping (Groesbeck, 1975; Jung, 1951; Jung, 1957). Clinical counseling supervisors transitioning from being wounded healers as counselors enter into a new helping relationship by helping counselors-in-training. Little is known about the experiences of these wounded healers as clinical counselor supervisors. Their impact on the developing counselor is critical to developing clinically effective counselors and furthering the helping profession of counseling.

Chapter 2: Literature Review

The concept of the wounded healer exists in many areas of healing. Many scholars have identified the positive and negative aspects of being a wounded healer (Groesbeck, 1975; Jung, 1951, 1957, Meier, 1959). The problem addressed in this study is the impact on the counseling field regarding the clinical counseling supervisor and wounded healing. Clinical supervision is a crucial aspect of counselor growth and client care. The information gained from the current study can lead to improvements in clinical supervision and client care. In Chapter 2, I give an overview of the literature related to wounded healers, clinical counseling supervision, and the connection between counselors as wounded healers and clinical supervisors as wounded healers.

Literature Search Strategy

I conducted a literature search using databases at Walden University, Southern Methodist University, and Texas Women's University library systems. The databases I searched within the universities' library systems included Academic Search Complete, MEDLine with Full Text, CINAHL Plus with Full Text, PsychARTICLES, PsycINFO, and others. When researching outside of the academic library resources, I utilized Google Scholar. All research was peer-reviewed journals or academic books. The search terms that I used consisted of combinations of multiple terms, including *clinical counseling supervision*, *wounded healers counseling*, *wounded healers clinical counseling supervision*, *impaired clinical supervisors*, the *purpose of clinical counseling supervision*, *counseling supervisors*, *counseling supervision*, *requirements of counseling supervisors*, *stories of counseling supervisors*, and *stories of wounded healers counseling*. Besides the

resources mentioned, I used academic textbooks about clinical supervision, narrative theory, and wounded healers to identify in-depth information about the research and applicable theories.

Theoretical and Conceptual Framework

The theoretical framework for the study is existential theory, and the conceptual framework was based on Jung's wounded healer. The main aspect of existential theory applicable to the current study is seeking meaning. Individuals seek meaning for their wounding (Reker & Chamberlain, 2000). Sometimes, seeking meaning for wounding leads them to seek counseling positions to assist others with similar ailments. Seeking meaning through others makes the individual a healer. However, the current study's conceptual framework focused on the wounded healer concept. The wounded healer is an individual with wounding who heals themselves through various methods and transmits that healing to others (Jung, 1957). The combination of these two concepts, seeking meaning and sharing healing, is the lens through which I viewed participants' stories.

Literature Review

Defining Wounded Healer

The term *wounded healer* has roots in many cultures, mythology, and Jungian philosophy (Jung, 1951; Meier, 1959). Psychological healing generally comes from allopathic or homeopathic means (Groesbeck, 1975). Allopathic healing is also known as psychopharmacology. Homeopathic healers heal by making meaning of the mental illness and resulting symptoms. Whether from a Jungian or mythological perspective, the wounded healer is viewed as a homeopathic healer. In the following sections, I will

review the wounded healer from multiple perspectives and make connections between the wounded healer to the field of counseling.

Depending on the culture or era, the definition of a wounded healer has taken the form of a construct. The construct of a wounded healer is used to illustrate the ability of "woundedness" to allow individuals to heal others, often when also trying to heal themselves (Jamieson & Sherman, 2014). The wounded healer is an individual who experienced previous wounding, whether physical, emotional, or psychological, and then uses their healing experiences to assist others in their healing. The "wounded" becomes the healer, and the woundedness becomes an intricate part of the healing process. Thus the wounded and healer make up the wounded healer; as a paradigm, the wounded healer represents duality instead of a dichotomy (Zerubavel & Dougherty-Wright, 2012). An individual's woundedness exists on a continuum and that the paradigm of the wounded healer should focus on the ability to use the wounding to assist others instead of focusing on the wound (Zerubavel & Dougherty-Wright, 2012). An individual's suffering becomes an experience to draw from to assist others in their suffering.

Development of a Wounded Healer

The wounding, often like the help-seeker's wounds, is a path for improved empathy and understanding. Traditionally, uncontrollable circumstances cause wounding in an individual's life, which catalyzes the healer to enter the healing and helping professions. It has been suggested that the wounded healer develops through a mixture of heterogenous inborn traits and exposure to the environment that begins in childhood, affects the individual's development, and creates the paradigm within the individual

(Henry, 1966). The interactions between the individual and their extended family and the reactions to these interactions sculpt the individual. Many individuals who become wounded healers are likely predisposed to contemplation and self-examination (Henry, 1966). Wounded healers try to navigate family issues by using their insight to "heal" the family, starting the process of accepting responsibility for others' healing and leadng to future desires to be a healer.

The healer, through their suffering, decides to transfer the pain into purpose and assist others (Stone, 2008). The healer's search for answers for their healing guides the healer to the information on the healing process and transforms the wounded into the wounded healer. The individual's compassion toward healing also helps form the wounded into a healer. The acceptance of the wound and the future use of the wound for healing also contribute to the wounded healer's formation. Lastly, the type of the individual's wound often dictates the healing in which the wounded healer engages (drug abuse treatment, trauma, etc.)

History and Cultural Representations of Wounded Healers

Many cultures have figures like the Greek representation of the wounded healer (see Meserve, 1991). A wounded healer prototype can be found in Hebrew lore, Babylonian myths, Indian, and Norse Tales. The images of wounded healers are also prominent as mythological images throughout history.

Shamanism

Specifically, the wounded healer concept is a staple of shamanism. In Shamanism, the wounded healer is a healing tradition (Jamieson & Scherman, 2014). Shamanism, a

spiritual practice, focuses on practical and sensible solutions to everyday problems, such as personal and family illness, professional issues, family conflict, and ancestral issues. An individual seeks out a shaman, who are representatives of the spiritual world who alter their state of consciousness to heal and help others. Shamans also use an individual's healing to manifest healing in the community. The shaman emphasizes their afflictions in their ability of the power to heal. An individual can only enter shamanism after recognizing their affliction and a period of illness and isolation. The period of illness and the withdrawal causes a psychological crisis that serves as the basis for the shaman's transformation; the transformation allows the shaman to re-emerge into society as a healer with the knowledge of the nature of individuals, illnesses, and cures.

The shaman's encounters with disease, pain, and healing, specifically the healing and overcoming of wounds give the shaman a connection to the spiritual world, which is the origin of the Shaman's healing abilities (Jamieson & Scherman, 2014). The shaman's challenges with pain, illness, and wounds play a pivotal role in becoming a shaman, indicating that the wounding and subsequent healing is the only path to becoming a healer. Unlike some cultures in which wounding is seen as a negative attribute, the shaman must first "establish their credentials as a person who knows first-hand about suffering, who have suffered and emerged from that experience stronger and wiser, and now have the capacity to serve others as healers of the souls" (Jackson, 2001, p. 6).

Islamic Culture

Abu Bakr Muhammed Ibn Zakariya Al- Razi is the Islamic culture's figure representing the wounded healer (Meyerhof, 1948). Al-Razi was a musician who later

studied alchemy. During his studies of alchemy, he developed a serious eye disease, which philosophers claim led Al-Razi to begin his studies in medicine. As Al-Razi's eye disease progressed, he refused treatment and eventually became blind. Al-Razi valued the wounding as giving him the position of a superior healer. Al-Razi's acceptance of his wound, the blindness, allowed him to gain insight into healing and suffering. He was known for his insight and holistic treatment, knowing ahead of his time that the individual must heal physical, mental, and psychological wounds.

Mythology

Asclepius was a legendary Greek physician who represented divine healing (Edelstein & Edelstein, 1945). In ancient healing practices, sickness was a divine action that could only be healed through divine intervention (Meier, 1959). The healer was the divine, as he was both the sickness and the healer. The healing and infliction processes were identical; the healer became inflicted by the patient and found the manner of healing through becoming inflicted themselves.

Accounted by Epidaurus, the origin of Asclepius as a wounded healer is that Apollo united with Coronis, and Coronis gave birth to a child (Hart, 1965). There are differing views, suggesting that Asclepius was always a god or later became deified a hero-physician-healer (Meier, 1959; Graves, 1955). Nevertheless, Epidaurus claimed that Coronis exposed Asclepius to a mountain known for plants with medicinal virtues (Meier, 1959). On the mountain of Titthion, Asclepius is fed by goats through the suckling of goat's milk. As Asclepius becomes the leader of the goats, a voice proclaims that Asclepius is the healer and the origin of all sickness cures.

The second view of Asclepius' origin as a wounded healer is that Asclepius was born from Apollo and Coronis through a cesarean section (Hart, 1965). After Apollo learns that Coronis had an affair, he murders Coronis and sends Asclepius to live with Chiron. Chiron, already known as a wounded divine physician, is the only Greek god who suffered a mortal, incurable wound. Chiron's wound was believed to be the source of Chiron seeking a cure for the incurable. Chiron resembled both an incurable wound and the source of cure for others. Asclepius became the combination of Apollo, his father, and the rational side of medicine, and Chiron, the wounded healer and the dark side of medicine.

Jung (1951) presented a unique view of the Greek myth of Chiron. Chiron, considered the representation of a wounded healer, was a centaur, which is a tribe of men who are half-horse. Chiron, a Greek word meaning "hand" or "skilled with hands," is like the Greek word for surgeon (chirourgos). According to Jung (1951), Chiron was accidentally wounded by Zeus through a poisonous arrow; however, because Chiron was immortal, he had to continue to stay on earth in great pain while healing others. Agonized, he became the ultimate representative of the wounded healer, the paradox of a great healer who could never be healed. Eventually, Chiron gave his mortality to Prometheus so that Chiron could die. Many of the central themes in Chiron's stories represent the main aspects of the wounded healer archetype (Benziman et al., 2012).

The Jungian Perspective of Wounded Healing

Jung (1951) considered the wounded healer an archetype and dynamic between the analyst and the analyzed. Jung proposed that the fundamental growth of a

psychotherapist occurred through disease, also known as wounding. Jung considered the therapeutic relationship a dialectical process in which both the wounded and the healer participate equally in the healing process. Jung proposed that "only a wounded physician could treat effectively" (p. 116). The knowledge of the wound makes the healer a companion to the wounded, no longer seen as a superior force but as an understanding source of knowledge. The wounded healer must be aware of their wounds; possession of the wound is insufficient for healing the wounded (Jung, 1951).

Guggenbuhl-Craig (1971) expanded on Jung's work by proposing that the wounded healer archetype creates a transformative healer with better healing powers than a non-wounded healer. The relationship between the wounded healer and the wounded becomes transformative for both parties (client and counselor). Jung suggested this transformative process was part of the collective unconscious because Jung considered the relationship between the wounded healer and the wounded's healing to exist within the unconscious realm primarily. The unconscious relationship, according to Jung, determines the outcome of the healing. The flowing process of the unconscious creates a third being, the transference relationship. The healer's insight, gained from their wounding and healing, allows for the formation of transference. The transference process allows the healer and "patient" to increase their consciousness toward the issues. Jung considered bringing the unconscious into the conscious as the medium for increased healing powers.

How Healing Occurs

Curing illness through Asclepius and Chiron often occurred by touching the hand of the ill and inflicted (Meier, 1959). Meier (1959) also suggested that inflicted individuals entered the temple to await a dream in which a God would come to the inflicted and affect the cure by touching the individual's inflicted part. Often, individuals would remove bandages after being healed to hang from a tree to "transfer" the illness to the tree. Meier (1959) believed that transference originated from the idea of diseases being transferred from the bandages to the tree.

The paradox of the healing story is that Chiron, who repeatedly cures, remains eternally ill and incurable (Groesbeck, 1975). The underlying mystery of healing is that the knowledge of the healer's wound may be how the healer deeply partakes in the healing process. In other words, the healer's knowledge of their wounds creates a healer within known as an "inner healer" (Guggenbuhl-Craig,1971, p. 89). The healer repeatedly cures yet remains inflicted by their wounds, which becomes the vessel for healing. Groesbeck (1975) suggested that the healer must be aware of their wounds before healing can occur. The myth of Asclepius is modern-day transference.

Guggenbuhl-Craig (1971) proposed that the wounded healer archetype exists within each healer-wounded relationship. The wounded seeks a healer, and the healer's wounds are activated by the wounded. As the inner healer is activated within the healer, the wounded's wounds are transferred to the healer, and the healing factor is activated, therefore healing the inflicted wounds. The wounded healer also activates the wounded's

inner healer, allowing the wounded to participate in the healing process. External factors, such as techniques and medicinal interventions, are also a part of the healing.

However, without the inner healer's activation within the wounded healer, full healing cannot occur (Jung, 1946). From a psychological perspective, this means that the wounded healer (counselor) must be aware of their wounds and activate their inner healer to heal the psychologically inflicted. Healers and wounded get in touch with their inner healers by connecting through the wounded and the healer's unconscious connections. Jung (1946) suggested that the healing process occurs primarily in the unconscious. The unconscious relationship between the wounded and the healer determines the outcome of the healing process (Jung, 1946).

Ten Steps of Wounded Healing Transaction

Miller and Baldwin (2000), the helping relationship consists of interactions and processes and that there are ten steps to a healing transaction for wounded healers. The first step is the wounding; the individual receives a wound. The individual cannot heal independently, so they consciously seek help to relieve the pain. The second step is when the clinician attempts to identify the wounds and work with the wounds objectively. The therapist's attempts at objectifying the wounds create an emotional and physical imbalance that triggers polarization. The desire to heal and be cured and the client's inability to focus on the pain make the client unable to activate their inner healer. The polarity of the client's inner healer is transferred to the counselor. The counselor accepts the client's projection, and the counselor's wounded healing is activated; this accentuates the counselor's vulnerability. The counselor's woundedness is placed or projected onto

the client, and the therapist and client identify with each other. The outer-healer of the counselor activates the inner-healer of the client. Even when the inner wounds are identified on the outer layer, the healer is still activated. The counselor's outer-healer makes a direct effort to support the outer-healer of the client, and this process facilitates the integration of the inner and outer healer. The client is then able to become their inner healer, and the experience of healing reactivates the healing process of the wounded healer.

Counselors as Wounded Healers

Considerable research exists regarding the wounded healer phenomenon and mental health professionals (Adams, 2014; Cvetotac & Adame, 2017; Kern, 2014). The expectation that counselors can help because they are healthy, knowledgeable individuals exists in most branches of mental health professions. There are mixed reviews regarding how the woundedness within counselors affects their abilities to help others. The questions surrounding what helps or hinders the wounded healer in the helping profession and therapeutic relationship have been answered with various tones and outcomes. In the following sections, I discuss counselors' aspects as wounded healers as applicable to the current article.

Reasons Counselors Enter the Field

Many counselors enter the field of counseling due to past personal challenges (Kern, 2014). Furthermore, the counselor's type of wound often determines the clientele they treat and their choice of treatment modality (Adams, 2014). Clinicians are often expected to represent strength and invulnerability. However, many counselors have a

mental illness, childhood abuse, trauma, physical illness, and life issues related to wounding that affect their ability to treat clients and maintain wellness. It is well-documented that therapists enter the profession of helping after their journey of pain and subsequent healing (Barnett, 2007; Sussman, 2007). A primary motivation for entering the profession of therapy is woundedness during childhood.

Need for Acknowledgment for Transmission of Healing

Jung (1966) believed that all individuals experience trauma and determine and define their trauma. However, because most individuals experience trauma on some level throughout their lifetime, those entering the mental health profession will bring their experiences of trauma into the helping session, and the individuals seeking help will bring their trauma into the helping session. However, that experience of trauma alone does not make an individual a wounded healer. The counselor's wounds should be examined and acknowledged for their wounds to assist rather than hinder the healing process (Jung, 1951). According to Jung, the central concept of the wounded healer is the transformation process of overcoming the trauma that allows the individual to be enlightened and become a wounded healer. Some individuals reach this process through personal counseling, while others reach transformation through the workplace environment, supervision, individual self-reflection, and counseling groups.

Conchar & Repper (2014), critics of Jung's definition of wounded healers, argue that Jung overlooked the intricate identities and experiences individuals experience. The experience of wounding is often viewed as a deficit, disempowering the individual instead of empowering the individual into transformation. The process of wounding itself

does not generate the ability to heal others. Yet, the process of healing and the experiences associated with healing create an individual capable of helping others.

Gelso & Hayes (2007) proposed that "Therapists who deny their conflicts and vulnerabilities are at risk for projecting onto patients the persona of 'the wounded one' and seeing themselves as 'the one who is healed' (p.107). When the previously wounded counselor enters the counseling relationship with the dichotomous belief that they are healed versus healing, they cannot access the wounds. Without access to the wounding, vulnerability, and accessing suffering, an increased offering of empathy decreases or disappears. Furthermore, without recognizing the healer's wounds, the healer is unlikely to acknowledge or encourage the client's healing process; thereby disempowering the client, reducing the client's healing powers, and fostering dependency on the counselor.

Jackson (2001) suggested it is important to clarify the differences between a true wounded healer and a healer who is an "impaired professional." When counselors do not heal their wounds, their distress negatively affects their clinical practices. Some counselors have done enough work towards healing to be sufficiently healed and know enough of the healing process to prevent the wounds from adversely impacting therapy and the therapeutic relationship. Often, wounded clinicians are concerned about reaching out for help due to the stigma of disclosing wounds.

The Stigma Attached to Disclosure

The stigma attached to mental illness or previous wounds exists for all individuals but is more damaging to those attempting to treat others who are psychologically wounded (Adame, 2011). Despite the connection between wounded healers and the field

of counseling, many counselors fear revealing their wounds to supervisors and colleagues (Adame, 2011; Sawyer, 2011). Depending on the nature of the wound, there are different reactions from other professionals, colleagues, and potential clients regarding the individual's competency in practice. When counselors fear judgment, they often live in secrecy regarding their wounds, which leads to shame, self-blame, and self-stigma. Adame (2011) proposed that the stigma attached to being a wounded healer can be distressing on a personal level. However, the most critical aspect of the stigma attached to disclosure is that the stigma may keep counselors from seeking necessary support services (Cvetovac & Adame, 2017).

Kern (2014) suggested that counselors often do not seek psychotherapy because of their fear of professional consequences and fear that their personal life would be exposed to others. Counselors also fear that wounding stigma may lead to the loss of credibility from their clients and colleagues. In some mental health care treatment areas, such as substance use treatment, it is commonplace and preferred that a provider is in recovery from substance use disorders. However, if the wound is a serious mental health disorder, the clinician may be seen as incompetent, and other clinicians may scrutinize their professional competency. Because there are inconsistent responses to the disclosure of wounds, counselors often withhold disclosure and fear seeking assistance.

If a previous wound is reopened, the wounded counselor can bring great risks to the client in the therapeutic relationship. The wounded healer is at risk of having their wounds reopened (Groesbeck, 1975). Sometimes, the wounded healer cannot connect to the client's attempts at getting help, and the wounded healer may withdraw from the

healing relationship. The wounded healer's ability to assist others depends on the understanding and acceptance of the wounded healer's wounds and the acknowledgment, processing, and healing of any reopened wounds.

Wounded Healers and Clinical Supervision

Although there is no known research on wounded healers as counseling supervisors, several articles approach the healing relationship from the theoretical perspective of the wounded healer archetype. Varied outcomes of therapeutic effectiveness exist with counselors who are wounded healers. Because counseling supervisors begin as counselors, the transmission of information from counseling supervisors to counselors may also be affected by a wounded healer. In the following sections, I will discuss the wounded healer as a counseling supervisor and the various topics surrounding the wounded healer as a clinical supervisor.

Connection of Wounded Healers to Clinical Supervision

There is ample research regarding the wounded healer and clinical practice. Wheeler (2007) suggested that the clinical supervisor plays an important role in the wounded counseling intern's care and wound disclosure. Because of the important role the supervisor plays, Wheeler (2007) proposed that "Everything that has been said about therapists as wounded healers applies to supervisors too" (p. 255). However, no known studies assist in knowing wounded healers' experiences as clinical supervisors.

Bernard and Goodyear (2014) proposed that clinical counseling supervision differs from clinical counseling due to the evaluative nature of supervision. The counseling supervisor's wellness affects multiple supervisory processes, such as

disclosure, development of the supervisory relationship, modeling, parallel process, countertransference, and transference. Counseling supervisors often need higher levels of maintenance (self-care) than counselors due to the impact of the clinical counseling supervisor's responsibilities. Little is known regarding the additional impact of being a wounded healer on the clinical counseling supervisor's wellness.

Similarities and Differences in Counseling and Clinical Counseling Supervision

The primary difference between counseling and clinical counseling supervision is clinical supervision's evaluative component (Ladany et al., 2013). While counseling focuses on the client's growth, clinical supervision focuses on the supervisee's growth, the supervisory relationship, and the client. Counseling and clinical supervision have a teaching and learning component; psychoeducation occurs in both the counseling and clinical supervision settings. The content of clinical supervision is based on agency or supervisee needs, while the focus of counseling reflects client needs. Clinical supervision is based on supervisee needs, while client goals and needs drive the time frame of counseling; both can be long-term or issue-driven. Both counselors and supervisors need empathy, listening skills, to follow ethical guidelines, and to engage in professional development. Being an effective counselor does not equate to being a proficient supervisor, and it is unlikely that a clinical supervisor would lack experience as a counselor.

Clinical Counseling Supervision

As previously discussed, clinical supervision is an important aspect of growth and effectiveness for counselors-in-training. Clinical supervisors are required to maintain

contact with supervisees and monitor client care. The clinical supervisor has varied tasks, responsibilities, processes, and a guiding model that allows the supervisor to provide effective supervision. I discuss the responsibilities, processes, supervisory relationships, supervision issues, and supervision-specific models in the following section.

Responsibilities of Clinical Counseling Supervisors

Clinical counseling supervisors have varied responsibilities. The culmination of these responsibilities ends in ensuring counselor growth and client welfare. The main responsibilities of the counseling supervisor are gatekeeping and monitoring client care.

Gatekeeping. Homrich and Henderson (2018) proposed that gatekeeping is a primary role of clinical supervisors across all mental health professions. Gatekeeping is the evaluation of mental health professionals by their supervisors to keep impaired or unprofessional individuals out of the mental health field. Gatekeeping also includes the remediation of impaired professionals through various remediation efforts. Sometimes, a supervisor may deny a supervisee their professional license and create efforts towards the supervisee's sanctions. The mental health status of the supervisor is an important factor for gatekeeping. An impaired supervisor is unlikely to recognize an impaired supervisee, and the supervisee is often unaware that their supervisor is impaired.

"Students and supervisees monitor themselves for signs of impairment from their physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others. They notify their faculty and supervisors and seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their

professional responsibilities until it is determined that they may safely resume their work" American Counseling Association [ACA] (2014)(p.12).

Monitoring Client Care. ACA (2014) proposed that one of the clinical supervisor's main functions is to monitor the care of clients. Part of monitoring client care is the supervisor's assessment of the supervisee's professional development and assisting supervisees in developing skills to work with a range of clients. Clinical supervisors are also responsible for ensuring supervisees maintain ethical practices with clients and follow their applicable code of ethics. The supervisor monitors client care through regular meetings with the supervisee and evaluates their work with clients, their consent forms, and their awareness and adherence to legal, ethical, and licensing codes.

Supervisory Relationship

The supervisory relationship is essential to transferring information from supervisor to supervisee (Ellis, 2010). Ellis stated, "Good supervision is about the relationship" (p. 106). Multiple aspects of the supervisory relationship affect the quality of supervision, which eventually transfers to the quality of the supervisee's therapeutic relationships and their clients. In the following sections, I address some key components and aspects of the supervisory relationship.

Supervisory Relationship as a Triadic System. Fiscalini (1997) is the first to consider the supervisory relationship as a triadic relationship. The relationship, consisting of the therapist, supervisor, and client, is made in a pyramid fashion. Fiscalini believed the "supervisory relationship is a relationship about a relationship about other relationships" (p.30). The supervisee is seen as the triadic system's pivoting point and the

intermediary of information from the supervisee and the client for the supervisor. The manifested relationships are the client-supervisee and the supervisee-supervisor, and the supervisee is the information transmitter. Although the triadic relationship concept seems simple, the complexity occurs when the relationships affect each other in ways undetected by one or more parties in the triad. The phenomena that result from this triad are examined in the remaining sections covering the supervisory relationship.

Disclosure in the Supervisory Relationship. Because counselors often enter the field and choose a specialty based on previous wounds, it is critical to examine the counselor's previous wounds and for the counselor to be able to disclose those wounds to their colleagues and supervisors (Wheeler, 2007). Wheeler (2007) suggested that a lack of disclosure increases the likelihood that the wounded healer can transmit their wounds without knowledge. Furthermore, the counseling supervisor cannot assist the counselor with growth without adequate disclosure.

Mehr, Ladany, & Caskie (2015) suggested that the quality of the supervisory relationship, one of the key factors in outcomes of clinical supervision, highly depends on the supervisee's ability to disclose in clinical supervision. The supervisor cannot respond to clinician issues if the supervisee does not disclose those issues. When the supervisor cannot identify supervisee and client issues, the supervisor is also at risk of being held responsible for the supervisee's behavior. Disclosure in clinical supervision typically focuses on client issues, clinical issues, supervisory issues, ethical concerns, and personal issues.

Parallel Process. The parallel process is one of the most known phenomena in clinical supervision. The parallel process is the process in which supervisees present as their clients to their clinical supervisors (Morrissey & Tribe, 2001). The supervisee unconsciously replicates the therapeutic relationship and the client's behaviors during supervision. This process, a key for supervisory intervention and learning, is also a powerful intervention when the supervisor is aware of it happening. Supervisors also reverse this process and adopt the supervisee's (and client's) attitudes and behaviors, changing how the supervisor interprets the issues with the case being discussed.

Wheeler and Richards (2007) studied interactions between supervisors and supervisees. Because the parallel process causes the supervisee to elicit reactions from the supervisor that the supervisee felt in counseling, the therapeutic relationship problems can transfer to problems in the supervisory relationship. When the client, supervisee, and supervisor are from different cultures, parallel process becomes bidirectional and more directly and negatively affects the client, supervisee, and supervisor.

Early initial accounts of parallel process considered the process a bottom-up phenomenon in which the supervisee displayed the client's characteristics during supervision (Searles, 1955). However, Doehrman (1976) completed a dissertation revealing that the parallel process was bidirectional. Doehrman (1976) criticized previous views, suggesting that previous views described the process as a "domino" effect in which the supervisor was unaffected. Doehrman studied dyad pairs of client-counselor and counselor-supervisor over time and concluded that the unconscious replication of behavior duplicates throughout each individual in the client, counselor, and supervisory

relationships. The process is always present in supervisory relationships. The harm occurs when the process is unknown or ignored.

Isomorphism. Isomorphism is the reverse of parallel process; the counselor and supervisor's relationship transfer onto a therapeutic relationship (Weir, 2009). A phenomenon within the supervisory relationship and triad, isomorphism is a process in which differing content takes on the same form in each relationship structure. For example, the influence that therapy and supervision have on each other and the resulting behaviors of the triad (supervisor, supervisee, and clients). Because supervision is an isomorph of therapy, all the rules that apply to the supervisory relationship apply to the therapeutic relationship. The supervisory relationship is primarily affected by isomorphism by replicating the things necessary for developing the therapeutic relationship.

The supervisee often replicates the therapeutic relationship by asking the supervisor for help as the client asks the counselor for help (Koltz et al., 2012). Corresponding processes such as goal setting, challenging realities, and acknowledging sensitivities reflected in the counseling relationship isomorphs into the supervisory relationship. The key for the supervisor is the awareness that the same dynamics occurring in the supervisory relationship are reflected in the counseling relationship. Supervision is seen as an isomorph of therapy; these processes replicate and enhance the supervisory relationship and the growth of the counselor and client.

Transference. At the core, transference is a phenomenon that occurs in the therapeutic and supervisory relationship in which one of the individuals in the

relationship transfers an aspect of a past relationship to a current relationship (Watkins, 2011). The aspects of clients who transfer their past relationships onto their therapists are well-known. However, supervisees also have transference-based responses to their supervisors. Although transference can affect the supervisory relationship in many ways, some may negatively affect the supervisory relationship. The supervisee sometimes perceives the supervisor as more or less critical, and the supervisor perceives the supervisee as more or less cooperative, and similar related interactions occur during transference.

Transference can also take a positive form. Supervisees can idolize their supervisor, which leads the supervisee to lean on their supervisor during the early stages of development (Lewis, 2001). Lewis also suggested that the contrast between the transference in the counseling relationship and the supervisory relationship is that the transference in the therapeutic relationship seems relatively anonymous. The transference in the supervisory relationship allows the supervisor to assist the supervisee in acknowledging and understanding transference. When the supervisor advises the supervisee of the transference occurring within the supervisory relationship, the supervisee can recognize transference in the counseling relationship.

Countertransference. Balint (1948) was the first to acknowledge countertransference in the supervisory relationship. Countertransference is the response that the supervisor has to the treatment of the supervisee (Ladany et al., 2001). Ladany et al. (2001) was the only known researcher who identified countertransference's inner workings as applied to the supervisory relationship. The main themes of

countertransference are the supervisor's stress about the workload, the overidentification of the process occurring during the counselor's early career, and the negative feelings associated with the supervisee's inability to take the supervisory relationship as a serious and necessary relationship.

Countertransference typically occurs within the first few months of the supervisory relationship and has primarily negative consequences (Ladany et al., 2000). Ladany et al. (2000) suggested that the negativity results from the lack of awareness in the supervisee and the resulting break in the supervisory relationship. Multiple issues trigger countertransference in the supervisory relationship. The interpersonal aspects of the supervisee trigger some of those issues, and the personal issues of the supervisor trigger some issues. Left unresolved, countertransference can impede the supervisory relationship and supervisee growth.

Working Alliance. Bordin (1983) was the initial researcher and coined the term working alliance. The working alliance is composed of many factors, and those factors can predict the level of the bond between the supervisor and supervisee. The working alliance is a "collaboration to change" (p.73) composed of the agreement on goals, the tasks to complete those goals, and the emotional bond that would promote those goals. In the supervisory relationship, the working alliance is the alliance formed between the supervisor and supervisee that promotes the supervisee's growth.

The supervisory working alliance is a strength for the supervisee's growth when the working alliance is strong (Nelson et al., 2001). The supervisor and supervisee must acknowledge and appreciate the variables in the working alliance. There are multiple

predictors and indicators of the working alliance. Supervisory factors, such as style, self-disclosure, emotional intelligence, and ethical behaviors, predict the supervisory relationship's quality. The supervisee's emotional intelligence, level of stress, and the supervisee's negative perceptions of supervision affect the supervisory working alliance. Lastly, some supervision processes affect the working alliance, such as evaluation methods, role ambiguity, open discussions during supervision, and how the supervisor-supervisee complements each other.

Issues with Clinical Supervision

Clinical supervision is an important part of counselor growth. When the supervision process is effective, the supervisee shows growth, and client welfare remains intact. However, certain issues can cause problems within the supervisory relationship and the supervision process. When issues exist in the supervisory relationship and process, supervisee growth is hindered, and client care is negatively affected.

Implications for a Power Imbalance

A power imbalance exists between supervisees and supervisors (De Stefano et al., 2017). The supervisory relationship and supervision process permits a power imbalance that creates vulnerability for the supervisee and clients. As with many hierarchal relationships, there are inherent risks in the supervisory relationship. Supervisees often cannot express the desire to discontinue supervision due to the power imbalance and possible consequences of discontinuing the supervisory relationship. Because the supervisory relationship includes an evaluative component, the supervisor is responsible for evaluating clinical competencies. The power imbalance is not inherently problematic;

when the supervisor is professionally incompetent or impaired, the supervisee involved in the power imbalance is subjected to a lack of effective supervision. A lack of effective supervision leads to a lack of supervisee growth and inevitable client harm.

Supervisor Impairment. Supervisor impairment manifests in many ways, and there is a lack of literature regarding supervisory impairment (Muratori, 2001). Supervisor impairment, the inability to perform supervisory tasks because of something in the supervisor's internal or external environment, leads to ineffective supervision and improper client care. Because of the power differential, supervisees who acknowledge or experience supervisor impairment are often limited in their outreach regarding the issue. Some of the most profound experiences of supervisor impairment involve sexual misconduct. However, supervisor impairment issues involve burnout, substance abuse, and emotional and mental issues). Although many different types of impairment exist, the severity of the impairment dictates the supervisee's level and the client's harm.

Supervisees receiving poor supervision often get inadequate training, which causes client harm (Magnuson et al., 2000). Magnuson et al. (2000) proposed that "lousy supervision" falls into six different categories. The categories of poor supervision are unbalanced supervision, supervision that is not developmentally appropriate, tolerating and honoring differences, poor modeling of skills within the supervisory relationship, and apathy. Furthermore, the supervisor typically exhibits impairment in the supervisory relationship's three main aspects: organizational, technical, or relational.

Negative Supervisory Relationship. Nelson et al. (2008) discussed the impact of the mishandled supervisory relationship; loss of trust in the counseling process, loss of

self-efficacy, and chronic stress all occur in problematic supervisory relationships. Poor supervisory relationships can impair learning and significantly negatively affect the supervisee's development. Because the disclosure rates are low regarding a negative supervisory relationship, supervisees often resist participating in studies regarding negative supervisory relationships. Furthermore, clinical supervisors often act to protect colleagues from complaints regarding issues within the supervisory relationship.

Main Models of Clinical Supervision

There are three main models of supervision (Bernard & Goodyear, 2014). Supervisors need a model to guide them through the various supervision processes and further develop the supervisee. In the following sections, I briefly discuss the main models of clinical supervision.

Discrimination Model. Bernard (1979) suggested that clinical supervision aims to produce competent counselors. To produce competent counselors, a supervisor would focus on three skill areas: processing, conceptualization, and personalization. The discrimination model is a guide for supervisors that focuses on the three skill areas.

The supervisor focuses on the counselor's overt behaviors, referred to as processes under the discrimination model (Bernard, 1979). Process behaviors include competence in basic counseling skills, assisting clients with expression, using verbal and nonverbal behaviors, implementing intervention strategies, and closure of the session. The supervision session content also focuses on the conceptualization, which is the ability to understand the client, the supervisee's ability to identify appropriate goals, and the appropriate strategy to meet the goal and recognize improvement in the client. Lastly,

the supervisor focuses on personalization. Personalization is the counselor's personal aspects: the ability to assert themselves in the therapeutic relationship, listen to client challenges, the skill of being comfortable with the counselor's emotions and values, and the counselor's ability to respect the client.

Bernard (1979) suggested that the supervisor's supervision roles should be the deliberate choices of the supervisor. The supervisor chooses from three roles: counselor, teacher, and consultant. As the supervisee progresses, the supervisor focuses highly on the consultant role. The supervisor in the counseling role of supervision focuses on the personal needs of the supervisee. The supervisor in the teacher role of supervision focuses on translating knowledge and expertise to the supervisee. The supervisor in the consultant role of supervision focuses on exploring the supervisee's expressed needs and case consultation.

Developmental Model. The developmental model is one of the most common models of clinical supervision (Stoltenberg et al., 1998). Supervisors using the developmental model focus on defining the supervisee's development stages, ranging from novice to expert. Supervisees at the novice level are typically beginning counselors and have limited skills and low confidence. Supervisees in the middle stages of development have developed skills but are still balancing confidence with growing independence from and dependence on the supervisor. The supervisee at the expert level is at the highest developmental level, uses exceptional solving skills, and offers insight and reflection about the counseling and supervision process.

Littrell et al. (1979) suggested that the supervisor accurately identifies the supervisee's developmental level. When the supervisor accurately identifies the supervisee's developmental level, the supervisor can provide the necessary feedback and support that aligns with the supervisee's developmental level. Supervisors using the developmental level also facilitate the supervisee's progression to the next developmental level. Supervisors using the developmental model also apply scaffolding to assist the growing supervisee by encouraging the supervisee to apply previously learned skills to newly learned skills.

Systems Approach Supervision. Holloway (1995) suggested that the core of supervision is the supervisory relationship. Power is distributed to both members of the supervisory relationship, and the supervision sessions focus on seven dimensions. The seven dimensions the supervisor uses in the systems approach are supervisory functions, supervisory tasks, the client and trainee, the supervisor, and supervision. Although covert influences affect clinical supervision, supervision processes are seen as a system in which each interaction reflects combinations of the seven dimensions of the systems approach to supervision.

Narrative Research Approach

Narrative research, the method I used for the current study, is rooted in early storytellers and how storytelling is used for learning and teaching (Clandinin & Connelly, 2000). Strongly influenced by John Dewey, narrative researchers focus on personal and social experiences. Individuals tell their stories and explain their personal and social experiences through the language they use in their stories. The social construction of

language is a concept that relates to how individuals create meaning in their language and the language they choose to create the meaning. Social constructivists suggest that individuals look for explanations for their world experiences and direct meaning to objects and things.

Narrative inquirers believe that the social construction of language is influenced by social factors, such as culture and external influences (Clandinin, 2013). Individuals are born into meaning derived from the cultures they live and grow in. The interpretation of this language is the basis for narrative inquiry; the language creates meaning, and the researcher seeks to identify the meaning and origin of the meaning. Because the researcher also constructs meaning based on their personal cultural experiences, the narrative inquirer becomes a part of the research, and their experiences influence the researcher's interpretation. Meaning is always a social concept arising from interactions with other individuals and social groups.

The narrative research approach and narrative therapy have similar tenets. Narrative researchers and counselors using narrative therapy employ the stories that individuals tell to identify the meaning of individual experiences (Clandinin, 2013; Combs & Freedman, 2012). The primary difference between the narrative research approach and narrative therapy is the purpose. Narrative research aims to identify themes from stories related to a specific phenomenon (Clandinin, 2013). Narrative therapy aims to assist individuals with issues by identifying the meaning they've assigned to experiences and re-story that meaning in an adaptive manner.

Summary

In the preceding chapter, I reviewed the concepts related to wounded healers and clinical supervision. Beginning with an overview of the historical roots of wounded healers, I included the process of becoming a wounded healer and the differences between being a wounded healer and a helper who is wounded. I also discussed several concepts key to understanding clinical supervision and the importance of clinical supervision and the supervisory relationship. Lastly, I gave a brief overview of some of the main models used by clinical supervisors.

The primary themes in the literature are that there are enormous rates of wounded individuals in the field of counseling. The wounded individuals often seek meaning for their wounds by attempting to assist others. Some of the wounded individuals become clinical supervisors. Although many articles exist on the effects of wounding on the therapeutic relationship, there is a gap in the research regarding clinical counseling supervisors as wounded healers. Due to the importance of clinical supervision, it is crucial to better understand clinical supervisors as wounded healers.

Chapter 3: Research Method

This qualitative, narrative research was conducted to understand the stories of wounded healers who are also clinical counseling supervisors. Many individuals in the field are wounded healers, and some of those individuals will become clinical supervisors. Because of the impact on the field of counseling regarding how a wounded healer experiences being a clinical supervisor, the current research may help identify themes in navigating being a wounded healer. In the following chapter, I will discuss the research design, the researcher's role, methodology, participant recruitment, and procedures.

Research Design and Rationale

The chosen research design for the current study is qualitative. Qualitative researchers can develop rich content and a depth of knowledge from topics difficult to study qualitatively (Clandinin, 2016). Qualitative research also applies to subjective concepts related to meaningful life experiences, such as the wounded healer's concept. Qualitative researchers seek to put meaning to difficult experiences to measure or define (Clandinin, 2016). In the current study, I sought to gain insight into the phenomenon and explore the depth and complexity inherent in the phenomenon of wounded healing. Qualitative research design is applicable for identifying subjective information from unique concepts (Clandinin, 2016). This helped answer the research question: What are the stories of counseling supervisors who identify as wounded healers?

Narrative research design is a design that allows the human experiences of subjective experiences to be revealed in the stories of participants. By collecting research

through storytelling, the researcher can uncover stories and themes that lead to deep insight and information sources (Clandinin (1990). Narrative research allows the story to develop while asking minimum questions, allowing the researcher to understand the participants' stories (Clandinin, 2016). Narrative research design is also used when a researcher tries to identify themes in narratives of individuals experiencing a particular phenomenon. In the current study, the phenomenon is wounded healing and clinical supervision. The narrative research design aligns with the purpose of the study by allowing me to understand the experiences of wounded healers as counseling supervisors.

Role of the Researcher

My role in the study was an observant participant, as I was the primary researcher. The primary researcher's role is to hold the interviews and interpret and report the resulting data (Glesne & Peshkin, 1992). When choosing participants, I interviewed each participant to determine if they met the investigation criteria and discussed the time commitment and interview process with the participants through informed consent. I also advised participants of the recording of the interview and the narrative nature of the study by notifying them and getting informed consent. I remained neutral in the interviews and was aware of any bias the participants may have toward the material or the population (Glesne & Peshkin, 1992).

Further, I did not recruit participants with whom I have personal or professional relationships. The study was not conducted in my work environment, and no known conflicts of interest existed. There is a known power differential as I am a doctoral student and researcher, but I mitigated this power differential by offering the participant a

comfortable environment and the ability to withdraw from the study at any time. I also have experience with the topics. However, I was cognizant of any biases and monitored my interpretation of the stories to reduce bias in the interpretations. I am a wounded healer and have been a clinical (non-licensed) supervisor. I have encountered supervisors struggling to navigate their roles due to their previous wounds. On the other hand, I have also experienced many supervisors who excel at their role as supervisors, seemingly using their previous wounds to model appropriate clinical care to supervisees. The goal was to assist others in storytelling by becoming the neutral conduit for retelling participant narratives (Clandinin & Connelly, 2000). As such, I recognized my bias, conducted interviews, and translated data in a neutral format. During the research process, I kept a journal to record all events and aspects of the research, including researcher bias.

Methodology

Participant Selection and Population of Interest

The population of interest was clinical counseling supervisors. The clinical counseling supervisor is a supervisor who focuses on the supervisee's clinical and professional development. I recruited clinical supervisors who were licensed counseling supervisors within their state of practice. The participants self-identified as wounded healers, which was an additional criterion for participation in the study. The participants completed a brief interview to ensure they met the requirements for this study and an informed consent in which they electronically consented. I also verified the participant's

licensure by verifying with the appropriate state licensing board website or asking for a copy of their current supervisory license if their state did not offer license verification.

Procedures for Participant Recruitment

I emailed all licensed counseling supervisors listed on the Texas licensing website. I also made posts on social media sites consisting of licensed counseling supervisors. I posted on CESNET and other messaging boards consisting of licensed clinical counseling supervisors. My posts included an overview of the study and the notation that participation is voluntary and participants could withdraw from the study at any time. I emailed all participants an informed consent after the participant expressed interest and when they were identified as meeting the participant criteria. The participants had the option to withdraw from the study at any time. The informed consent included the purpose of the study and confirmed the eligibility criteria for participants with a request for the participant to reply to the email with the words “I consent” to confirm participation in the study.

Sampling Strategy

Purposive sampling methods are considered expert samples and are non-probability samples (Denzin & Lincoln, 2008). A type of purposive sampling, snowball sampling, is sampling in which identified participants suggest other potential participants for the study (Denzin & Lincoln, 2008). Snowball sampling can also be done virtually, as I did in the current study, such as through social media posts or message boards (see Denzin & Lincoln, 2008). I recruited participants through Facebook groups, CESNET message boards, supervisory online message boards, and social media pages. When

someone identified a possible participant, I forwarded the research participation request to whoever fit the criteria. Lastly, I asked participants to provide information to me of potential participants who also fit the criteria, and I notified them of the opportunity to participate.

Sample Size

Clandinin (2016) suggested that narrative studies should focus on a few detailed stories instead of many surface-level stories. Denzin and Lincoln (2008) reviewed narrative studies and suggested that narrative studies typically have one to two participants. Clandinin and Connelly (2000) proposed that narrative research is a "collaboration between researcher and participants, over time, in a place or series of places, and in social interaction with milieus" (p.20). To ensure adherence to the nature of narrative studies and the ensure depth of information, the current study will have two to four participants.

Qualitative research saturation occurs when the researcher does not elicit new information from participants (Denzin & Lincoln, 2008). Saturation is a term derived from grounded theory research that applies to most qualitative methods. Researchers thinking from a narrative perspective shift the focus from saturation to exploring the dimensions of a few richly detailed stories (Clandinin, 2016).

Data Collection

Narrative researchers can employ various data collection methods, such as interviews, journals, biographies, memory boxes, pictures, field notes, letters, conversations, and individually written stories (Clandinin & Connelly, 2000). Data,

called field texts in narrative designs, are composed by the researcher interpreting the representation of stories collected in the study's data collection phase. When creating narrative field texts, the narrative inquirer keeps the relationship with the participant central to gaining the story (Clandinin, 2016). Clandinin (2016) also proposed that "the way an interviewer acts, questions, and responds in an interview shapes the relationship and therefore the ways participants respond and give accounts of their experience (p.110).

I used video calls through Zoom for interviews and recorded the audio on a small audio recorder to acquire field texts. This method aimed to focus on my relationship with the participant and non-verbal cues so that I could audio record and transcribe the sessions. Although the semi-structured interviews were conducted through video calls on Zoom, only the audio portion was recorded. I considered field observation and field notes as a method for acquiring field texts. However, Clandinin and Connelly (2000) proposed that a researcher using a transcribed recorded interview as field text often has more accurate interpretations of stories than other types of field texts.

Details of Collection, Storage, and Exit of Study

I did an initial semi-structured interview of 90 minutes to collect the field texts. Data audio was recorded using a tape recorder while I did video interviews through Zoom. Participants had a private, password-protected, and secure link to the interview. The interviews were stored in a password-protected cloud-based service. I used Rev transcription services to transcribe the interviews (who signed an agreement for privacy) and the transcriptions were also stored in a password-protected cloud-based service. Participants exited the study with a debriefing to ensure closure and allow for referrals for

any distress that occurred due to the study. There were no follow-up interviews or contact after the study regarding the study.

Data Analysis Plan

The field text (data) collected was audio recordings of participants and transcriptions of the interviews. I listened to the recordings and recorded my observations in memo form. Narrative coding is most appropriate for stories and narratives (Saldana, 2015). Narrative coding involved several types of coding, such as thematic, structural, dialogic, and performative. For this study, I used a narrative and thematic analysis. Narrative thematic analysis involves coding the data to find themes, categorizing the themes, and interpreting the themes (Saldana, 2015). I identified categories of the themes so that I could interpret the data. Interpreting themes involves making meaning from the data (Clandinin, 2016). I studied the categories, themes, and corresponding codes to find overarching themes, as Clandinin and Connelly (2000) suggested. I identified and interpreted the codes by determining predominant themes and relating them to the narratives.

Issues of Trustworthiness

For qualitative studies, trustworthiness translates to accurate data (Creswell, 2007). Trustworthiness is the alternative to reliability and validity, which are quantitative concepts that do not fit the qualitative research structure. In qualitative research, trustworthiness includes credibility, transferability, dependability, and confirmability (Shenton, 2004). I discuss credibility, transferability, dependability, and confirmability in the following sections.

Credibility

Credibility is the belief that the results of qualitative research are believable (Patton, 2005). Patton (2005) proposed that credibility relates to the richness of the data collected and that the reader judges credibility. Credibility can be established using rigorous analysis methods like emotion coding and thematic analysis. I recorded the sessions and used established data analysis methods to establish credibility. I also established credibility by using triangulation.

Transferability

Transferability is the degree to which a research study transfers to other settings (Golafshani, 2003). In the current study, transferability is the degree to which the information on wounded healers as clinical supervisors could transfer to other mental health fields. The current study appears to have transferability and could likely transfer to other fields, such as psychology or social work. Furthermore, the current study could transfer to other clinical supervision types, such as other helping occupations. Including specifics of a study also increases transferability (Golafshani, 2003). I included specifics of the study in the article to increase transferability.

Dependability

Dependability is the ability to depend on the research results for repeatability (Patton, 2005). Like transferability, researchers measure and ensure dependability by reporting how the researcher conducted the study and the procedure of the study (Patton, 2005). To ensure dependability, I provided detailed information regarding the process used in the study so that subsequent researchers could repeat the method.

Confirmability

Patton (2005) proposed that confirmability is the relationship of the results to the data collected; bias easily occurs in qualitative research due to integrating qualitative researchers' perspectives. To increase confirmability, the researcher asked a neutral source for an internal audit of the data and the results. I asked a neutral source to audit the data and results internally. Furthermore, I provided details of the reflexive processes used to explain my conclusions.

Ethical Procedures

ACA (2014) provides guidelines for producing ethical research. ACA proposed that informed consent is necessary to conduct ethical research. Informed consent should include providing participants with a proposed study's nature, purpose, and procedures. Researchers must also provide information regarding data recording, transcription, and storage. Informed consent must include any risks of participating in the study, confidentiality, voluntariness of participation, and the information that the participant can withdraw from the study at any time. I provided all participants with informed consent that meets the ACA requirements to ensure an ethical study. Walden has an institutional review board (IRB) that reviewed the current study and ensured that it meets all ethical guidelines to proceed with the study. I adhered to all suggestions by the IRB and interview protocol.

I stored all data in a cloud-based, password-protected service. I kept a password on my computer and kept my computer behind a locked door. I scanned and uploaded all hand-written notes onto a password-protected cloud-based service and shredded the

document after scanning. I coded all participants by a first initial and kept their names and contact information in a single encrypted and password-protected document. To ensure confidentiality, I removed identifying information from the transcriptions before submitting them to the transcription and coding service. The study does not involve participants from my work environment, a conflict of interest, or power differentials. There are no incentives offered in the study.

Summary

In the preceding chapter, I discussed the design of the study and my role as the researcher. I also discussed the methodology, including sample size, data collection, participant selection, data collection, and data analysis. Lastly, I discussed the ethical aspects of the current study. In chapter 4, I discussed the setting, demographics, data collection and analysis, and results.

Chapter 4: Results

The purpose of this qualitative, narrative study was to identify the stories of clinical counseling supervisors who identify as wounded healers. As the researcher, I sought to identify the experiences of clinical counseling supervisors who identified as wounded healers to uncover common themes of how being a wounded healer affected clinical counseling supervisors and clinical supervision of provisionally licensed counselors. The research question was "What are the stories of counseling supervisors who identify as wounded healers?" In the following chapter, I discuss the setting of the study, participant demographics, data collection, and analysis, trustworthiness, and results.

Setting

No known personal or organizational conditions influenced the participants or their experience at the time of the study and interview. There were no known conditions that may influence the interpretations of the study results. The interviews were conducted via Zoom from my home office.

Demographics

Participant A is from the southwest United States. Participant A is in her mid-to-late 40s and identifies as a heterosexual Caucasian. Participant A has been a clinician for 17 years and has been a clinical supervisor for 4 years. Participant A self-identified as a wounded healer.

Participant B is from the Midwest and Texas area. Participant B identifies as a queer, White/Native American. Participant B also identifies as an assigned female at birth

and is in their early 40s. Participant B has been a clinical counseling supervisor for 5 years and has been a clinician for 13 years. Participant B self-identified as a wounded healer.

Participant C is from the south and central Texas area. Participant C identifies as a bisexual Hispanic female. Participant C is in their mid-30s. Participant C has been a clinician for 8 years and a clinical counseling supervisor for two years. Participant C self-identified as a wounded healer.

Participant D is from the Midwest and Texas area. Participant D identified as a cisgender, heterosexual female. Participant D identifies as non-Latino and white. Participant D is in their mid-50s. Participant D has been a clinical supervisor for 5 years and a clinician for 22 years. Participant D self-identified as a wounded healer.

Data Collection

Semi structured interviews were used to collect data from four participants. The location of the interviews was my home office via Zoom. The interviews were recorded using an audio recorder. There was one interview for each participant. The duration of the interviews varied, although the interviews were planned for up to 90 minutes. Some participants spent time speaking of their wounding, and other participants were reserved in speaking of their healing, which caused a variation in the time of the interviews. Participant A's interview was 72 minutes, Participant B's interview was 74 minutes, Participant C's interview was 59 minutes, and Participant D's interview was 47 minutes. Participant D's interview was significantly shorter because they did not share as much about their wounding, and I wanted to remain true to narrative interviewing by refraining

from prompting for more information. During Participant D's interview, there was a brief lapse in the ability to view the video. But the issue was immediately corrected, and no unusual circumstances were encountered during data collection.

Data Analysis

As discussed in Chapter 3, narrative thematic analysis was used. Narrative thematic analysis involved using a six-step process developed specifically for behavioral research (Braun & Clarke, 2006). I used an inductive approach as there was little or no previous research on clinical supervisors as wounded healers (see Clandinin, 2016). The steps taken to identify coded units and move to categories and themes are familiarization, coding, generating themes, defining and naming themes, and writing the data analysis (Clarke & Braun, 2013).

Familiarization

The first step in narrative thematic analysis is for the researcher to familiarize themselves with the data (Clarke & Braun, 2013). To familiarize myself with the interviews, I listened to the audio recordings thrice and took notes on the participants' emotions and repetitive statements. I listened to the audio recording twice as I checked the accuracy of the transcriptions. I then printed the transcriptions and read through the transcriptions two times while making further notes on emotions and repetitive statements.

Coding

The second step in the narrative thematic analysis is coding the data (Clarke & Braun, 2013). To code the data, I reviewed each section of the participant's story,

highlighted phrases, and identified codes for those phrases. Each code represented the ideas and feelings expressed in the text of the audio transcript. I reviewed each transcript three times to identify relevant codes. After reviewing the codes, I collated the codes into groups that allowed for finding common meanings that recurred through the data while gaining a condensed overview of the main points of the data.

Generating Themes

The third step in narrative thematic analysis is generating themes (Clarke & Braun, 2013). Generating themes involves reviewing the codes created and identifying themes that emerge from the codes. The process of combining codes into themes is a process in which I took codes and put them into broad themes, combining several codes into a single theme. Some codes were too broad or lacked repetition and were discarded.

Reviewing Themes

The researcher must review themes to ensure that the themes accurately represent the data (Clarke & Braun, 2013). For this step, I reviewed the data and ensured that I was not missing any codes or themes, reassessed if the themes were present and repetitive in the data, and reevaluated if there were items in the interviews I could reassess to ensure the themes represent the data. I combined themes and created new themes to ensure accuracy and usefulness as appropriate.

Defining and Naming Themes

Once a list of themes is developed, the next step is to name and define each theme (Clarke & Braun, 2013). By formulating the meaning of the theme, the researcher can find a manner to help the reader understand the data. When defining and naming the

themes, I named themes succinctly with the data and developed themes that were understandable to the reader.

Write-Up of Data

The last step of thematic analysis is to write and report the data analysis (Clarke & Braun, 2013). The write-up and reporting of the data analysis are included in the next sections of the current chapter and Chapter 5. The write-up of the data includes describing the codes and themes that emerged from the data and a summary and narrative of the results. In Chapter 5, I also discuss the results of the analysis.

Specific Codes and Themes Emerging from Thematic Analysis of Data

The codes that emerged from the thematic analysis of the data are listed here in relation to the subsequent themes (see also Table 1):

1. An initial wounding of the individual (codes were childhood trauma and issues, lack of ability to express self, lack of ability to express emotions, early chaos, poor coping skills, and addiction).
2. The individual attempted healing themselves from wounding (codes were unsuccessful early attempt to heal, lack of childhood support, fears of mental health workers, and failed attempts to get help from family).
3. The individual noticed a need for healing from wounding (codes were meaning-making, adult trauma brings up childhood trauma, individual recognizes and knows that they need to get help).
4. The individual received healing from an outside source (codes were finding a supportive person, finding a safe space, and processing trauma).

5. The individual transmitted healing to their supervisees (codes were providing a safe space for others, providing support, and modeling healing).

6. The individual offered effective, non-biased supervision to supervisees (codes were recognizing person issues in supervision, suggesting that the supervisee heals from their wounding, and providing effective bias-free supervision).

Table 1

Results of Thematic Analysis: Codes Organized by Themes

Themes					
Initial Wounding of Individual	Attempts at Healing Self from Wounding	Individual Noticed a Need for Healing from Wounding	Individual Received Healing from Outside Source	Individual Transmitted Healing to Supervisees	Supervisor Offered Effective, Non-Biased Supervision to Supervisees
Codes					
Childhood trauma and issues	An unsuccessful early attempt to heal	Meaning-making	Supportive person	Provide safe space	Recognizing personal issues in supervision
Lack of ability to express self	Lack of childhood support	Adult Traumas bring up childhood trauma	Finding Safe space	Providing support	Suggestion supervisee heal
Lack of ability to express emotions	Fears of mental health workers	Knowing need help	Processing Trauma	Modeling healing	Providing effective supervision without bias
Early chaos	Failed attempts to get help from family				
Poor coping skills					
Addiction					

Evidence of Trustworthiness

I discuss the evidence of trustworthiness in the following section. I describe the implementation of and adjustments to evidence of trustworthiness. The following section includes credibility, transferability, dependability, and confirmability.

Credibility

Credibility was established by recording the audio portion of the interview sessions and transcribing the interviews. Credibility was also established by using triangulation and established methods of data analysis. Furthermore, credibility was established by using rigorous analysis methods such as thematic analysis. There were no adjustments to credibility strategies.

Transferability

Transferability was established in the current study by including the specifics of the study in reporting the results. The results indicated that the results would likely be transferable to other mental health fields. Due to other mental health fields' use of supervision, such as social workers and psychologists, the current study has transferability. There were no adjustments to transferability.

Dependability

Dependability was established in the current study by conducting the study in a manner that could be repeated. I provided detailed information regarding the process used in the study. Participant D's interview was significantly shorter than the other participant interviews, likely due to their lack of discussion regarding their wounding. There were no adjustments to dependability.

Confirmability

Confirmability was established in the current study by recognizing the relationship between my perspectives when interpreting the data. A neutral source conducted an internal audit of the data and results. The reflexive process was used to explain the conclusions I reached. There were no adjustments to confirmability.

Results

The following section offers excerpts from the participants' interviews that influenced my choice of codes and themes. The headings are the themes and divided by participant, with sections of their interviews. After the main heading I separate each participant's interview transcript by codes and list statements made to influence the choice of codes.

Wounding

Regarding childhood trauma and early chaos Participant D shared,

> As far as the trauma, I'm very limited because there is a sense that my-my trauma could overwhelm people. You know um, sexual, um, and physical abuse mostly by my mother. You know sexual abuse from infancy on with my mother can … tends to be a very-very intelligent, um manipulative harmful person, right?

Regarding childhood trauma, addiction, and early chaos Participant B shared,

> As far as my wounding probably started pretty-pretty quickly … my first memories are chaos … lots of early attachment injuries pretty early on from mom … we moved around a lot … everyone around used a lot of drugs and drank a lot so I had to start babysitting at the age of eight … she just seemed so awesome

> [stepmom] until she wasn't she was horribly abusive to me and my brother, um horribly, of everyone who's ever abused me she was the worst.

Regarding childhood trauma and early chaos Participant C shared,

> Um, personal story, I was molested by my uncle from the ages of five to 15. And there was incest, you know all kinds of that. I've got repeated sexual assault, physical abuse, you name it, in my background

Regarding childhood trauma, addiction, and early chaos Participant A shared,

> In a nutshell, I grew up in a home with addiction rampant through-um-out my whole family. Um, had two parents that drank and gambled pretty heavily … Um, even at the earliest age of six or seven, just this overwhelming fear that I was gonna die … you get in a car with a, a parent who's intoxicated and it can get pretty crazy.

Included in the wounding theme was also poor coping skills. Regarding the initial wounding and poor coping skills, Participant A shared,

> I worked two jobs, played all the sports, like, just kept as busy as I could so I'd never be home … I guess I noticed something was wrong, but I just would, kinda pushed them away and just not really, um, I didn't really wanna look at them, I guess.

Participant A shared about acting out to cope by stating,

> I had flipped the teacher off at probably like nine years old … I got really good at stealing, really good at stealing … I was in sixth grade someone caught wind

> of me and another one of my friends planning a runaway … When I was 16 I got in a fist fight with him.

Participant C shared about negative coping with addiction and coping with suicide attempt by sharing,

> And a history of trying to cope with substances and everything else, you name it, kinda in my background … It was through a suicide attempt on my end … I went through self-medicating, heavy drug use, promiscuity.

Attempts and Issues with Healing

The codes included in the theme of attempts and issues with healing included unsuccessful early attempts to heal, lack of childhood support, fears of mental health workers, and failed attempts for getting help from family. All participants shared some aspect of these codes, which seemed to complicate the wounding. Participant A shared,

> I have been seeing therapist since I was a teenager … but seeing counselors, seeing others within the field of counseling, I noticed that there was, it felt very cold. It felt the ones I was seeing, there was what I call the suit mentality of no self-disclosure, sense of the person on the other side, wanting you to, me to share vulnerably, open up ya know everything and then returning very little. And then a lot of others, you know, forgetting to ask about trauma … lets you know throw a medication … My family, there was no growth, no support, nothing there. Nobody knew about what was happening, to me it was a secret.

Participant B shared,

> I got a lot of intergenerational stuff, um did not get help from my family… the strong silent type … The CPS worker told my dad to never touch me, so no hugs, no nothing. Oh, my first episode of therapy, okay, so again when I was eight … it was fucking horrible. Going back again … my mom made me go to therapy and it was an old white dude … I just remember I felt so violated by him. Somehow I knew I was on my own … um so they brought in a CPS worker, I know you are, you don't be honest with these people. You keep your shit at home. CPS had been knocking on our door since, as far back as I can remember … I wasn't honest … I knew to make up some dumb crap … I hated social workers, anybody in mental health, any, anything I hates them, all of them. And, because none of them had ever been good to me ever. Not once.

Participant D shared,

> My mom was no help … in one sentence she could go back and forth between victim and prosecutor, like three times in one sentence … she's a sociopath, right, there's no empathy. I had some therapy from this person … she overidentified with me … I had to really get over my shame about it, but it became this friendship … but there were so many characteristics about her that were similar to my mother … I don't think she was doing her own healing … it was really damaging and it stalled my progress … I was trying to process the things my mother had done and she would say "Oh you need to enjoy the positive things that she does"… if I didn't like something she did then it was on me and I had issues

> … and that's really damaging when this person was like my parent … it caused me to take a long time to disclose to another therapist.

Noticing a Need for Healing and Finding Healing

The theme of noticing a need for healing included the codes of meaning-making of their wounding, an adult trauma bringing up an early trauma, the individual knowing they need help, finding a supportive person, finding a safe space, and finally processing their trauma. The participants seemed to take their earlier experiences of wounding and attempting to get help into adulthood, where they found a need for healing and sought healing. Participant A shared,

> So, um, even pushing into my 30s where I realized, life wasn't as perfect as I thought it was … I was really forced to take a look at my life when other things happened…I was too young to realize what I needed, but when I got older, I could take a look at it. After her funeral (participant's child) … I can just remember feeling very alone … I just remember sitting on the edge of the bathtub with razors … not wanting to feel the pain. Knowing this is not what I am supposed to be doing. As soon as I was about to go through with it [suicide] my doorbell ring … she knew she needed to check on me. They were there for me, supporting me. So you know, we had lots and lots of support, everyone was there. It didn't occur to me to do therapy. For me, my therapy was, like, you gotta give back. Like, you know, you can be support for them, be hope for them … you can share your story. I became, with sharing my story stronger with sharing my story. It wasn't long before I realized that I wanted to be a therapist … a mental health professional. I

> am always grateful for all of the opportunities I had, um for great mentorship … in the midst of all that, my husband and I decided to get a divorce … for me that brought up a lot of grief … it brought up a lot of old stuff. And so that was that time I knew I needed to get into therapy. I started my healing … had some great therapists who helped me … and so um, started walking through healing. And so it was very hard for me to vulnerable … growing up in a home of addiction, you don't feel, you don't talk, you know, um, you just forget. My therapist really worked with me … just started being able to express what I was feeling in the moment … how I found an EMDR therapist was in my first weekend of training and I realized, wow, I am gonna have to do this. Um, and so, walked through that process, challenged my negative beliefs core beliefs about myself, um came to a point where I feel pretty good. I had, I had processed a lot of targets … I felt very positive. Not just in my own grief journey and where I was, in the healing I had to do, but also in holding space for others.

Participant B shared,

> I started as a mental health technician while I was going to school and working on a bachelors in psychology … still wanted to go the forensics route … one of the social workers came into the break room and she was like 'Why don't you wanna be with us' and I said I was leaning more towards, maybe I do want to do therapy and like research. And she looked at me and said 'You know social workers do that too' and I'm like no, social workers just take kids. And, she looks at me and she's like "I've never taken a kid in my life." During all this time, I know I'm

needing therapy but I'm reading self-help book … trying to learn meditation … trying to ramp down my rage. I started doing yoga, working out … I was really trying to get my shit in check … um again knowing I really should be in therapy and I'm not. Occasionally I would seek someone out and then I'd be like "fuck it, I'm not gonna do this." Um, maybe I should find a support group. Maybe I should go to AA … so again, no therapy … I'm having panic attacks … and um but again, still no actual therapy for me … Uh but and again, I knew I should be in therapy, but the problem was, I didn't know many therapists I thought I could connect with. So, part of why I became a therapist is because I want to be the kind of therapist that I needed. I started supervision for my LCSW … that was probably the closest thing to a therapeutic relationship that I had had. Not actually getting therapy … I was the only person I knew specializing working with people who were polyamorous and kinky. I didn't feel safe going to anybody at the time because the social work board at the time was very, very strict and I was petrified, that if people found out they could report me to the board and I could lose my license. I was really, really depressed. I knew I was depressed. And I really, really, really should have been in therapy … good therapists don't take insurance especially back then … I couldn't afford it. And it also felt like a luxury that I couldn't spend on me. Like, it took me a long time to get to the point where it's like fuck it, I don't care if I have to run up my credit card bill, I'm going to therapy. Another therapist moved into our area from out of state who is an AASECT certified sex therapist with the background … so I started working with

> her … she was not a good fit for me…a lot of my old trauma came up like, yeah, my PTSD was hard core activated. And who, um, so, I found the therapist I have now … so she and I started working on things.

Participant C shared,

> I've always known passion for working with others … not only being in the profession but seeing counselors … I knew I needed help … the ones (counselors) that I was seeing there was a lot of what I call the mentality of no self disclosure, no sense of person on the other side, wanting me to share and be vulnerable, open up … and then returning very little. And then a lot of others, you know forgetting to ask about trauma … throwing diagnosis on me … I knew I needed something … it's been a process. But, early on, I don't know if it was the area, I don't know if it was the people, that, you know my family chose for me to go see but there was no growth, no support, nothing there. It wasn't until I was in my late 20s …. where I realized, okay, the therapist, the people I have gone to see, that is not the norm … When I started to study … go through graduate school and learn what therapy is supposed to be and what modalities are … that's when I started to throw myself into therapy on my end … seeking out those resources and not assist. As far as healing, I have done a lot of EMDR … a lot of intensive trauma work.

Participant D shared,

> As I had babies and we had enough distance from my family, that's when the trauma started coming up … it was actually my husband after my parents left, he

> said “something is not right here”… you know and I wasn’t even aware, and that kinda opened up … I started to see a therapist … I started to talk. I couldn’t eat, I couldn’t drink anything and I was genetically hardwired for an eating disorder … So I ended up in treatment for anorexia … I fell hard and fast, it was about six months. I recovered from anorexia … then the trauma work over time, and I think the thing that got me … I was in recovery and healing.

Transmitting Healing and Providing Effective Supervision

The codes for transmitting healing and providing effective supervision included creating a safe space for supervisees, modeling receiving help, providing support, recognizing how the supervisor’s issues came out in supervision, and suggesting that supervisees do their own work. First, the participants expressed a need for a safe space so that supervisees could share their issues with clients without judgment from their supervisees. Participant A shared,

> We created a safe space for her … holding space for them … started supervising … to provide all of the great knowledge that I got from everyone else to the next generation of counselors … we walked through that process … it brought up a lot of old stuff … so I started my healing journey from a therapeutic perspective … even though I’d done some healing, I hadn’t made a lot of connections … to my supervisees that I provide support … hold the space for ourselves that we hold for others … as a clinical supervisor … without my own journey, I wouldn’t, I don’t feel like I would be as effective in the role as a clinical supervisor … I try to integrate both pieces and to create a safe space for supervisees to talk about

> whatever they need to talk about … recommending, you know they get a therapist … reaching out and finding their own, um, you know therapist to continue that work … we have a duty to ourselves and the people we work with to um work through our own stuff … My healing journey is so that I can hold the space for the clinical supervisees that I work with for them to feel safe.

Participant B shared,

> Where supervisees felt safe coming and talking to me if they needed something … I wanted to create this space while for social workers … I wanted put out quality clinicians … I wanted to make sure her needs were met … I've had several conversations about the supervisees getting their own therapy … her internalized stigma was impeding the therapeutic process … I can't make you go to therapy … I strongly suggest you consider seeking someone out to do it [therapy] … the less effective is when I've been triggered and not managing my shit well [during sessions with supervisees] … there've been many times I've had to go back and like own my own behavior, especially with Shannon who is like me … sometimes my own abandonment bleeds over … I'm sitting here hoping my crazy doesn't show.

Participant C shared,

> Working with supervisees on this is what is appropriate. This is what is not appropriate. This is healthy self-disclosure, this is unhealthy. Pushing them to do their own work to make sure … unresolved issues, if you have your own traumatic things in your past, if there is anything you are struggling with, it's

> going to come up in your work with others … keep them, keep me, keep others in check … creating that dynamic and open space with supervisees … it's going to be a very honest and raw process … developing and modeling self-care … setting up an environment that just is conducive towards safety … doing my own work about it … holding them accountable (supervisees) … talking to them after the fact and saying, look this is what came up in me, on my end … openness to feedback … you don't have to have it all together … maintain a sense of authenticity … there is no expectation of perfection…you need to be working on your own stuff and keeping it together.

Participant D,

> I see it coming up, because my tendency from my trauma is to get smarter, achieve more, and so naturally I end up with supervisees that are you know … when your stuff comes up … I didn't really feel, like I could start supervising until I was able to really know myself as a therapist … when things are trying to be forced or pushed in a supervisee … awareness of my own, all of it ya know … because of my harm avoidance, I tend to get, to take on people that are very boundaried … I think a lot of that (issues in supervision) is just my stuff … would have been crappy supervision on my part to take that on, right, and possibly triggering … they probably have a ways to go in their own healing, and so in supervising that, you know, that can get kind of passed on…a wounded healer supervisor that probably have a ways to go in their own healing, and so in

> supervising that can get passed on … I think it can be a real gift if they continue to do their own work … I think there is trauma there [in supervisees] when they don't.

Summary of Participants' Narratives

The stories of clinical counseling supervisors as clinical counseling supervisors shared commonalities and themes. The participants started the interviews by discussing their initial childhood wounding, such as being subjected to alcohol abuse, drug abuse, and mental illness by their parents or primary caregivers. Some participants also endured physical and sexual abuse by parents, relatives, and primary caregivers. Some of the participants felt trapped and unable to understand or process their physical, emotional, and mental wounds. Several participants were forced into seeking help that caregivers and parents influenced; they found this help to do more harm than healing.

All participants reported feeling lost and often sought roles that fit others' ideals and goals. Also, the participants discussed repeated strained relationships or at times, the lack of relationships; mostly citing the improper modeling of healthy boundaries and the lack of healthy childhood relationships. As the participants began to heal in adulthood, their relationships improved, including the therapeutic and supervisory relationships. The participants reported being able to interpret meaning from their failures and transmit that information to clients and supervisees.

Some of the participants' stories also included discussions of personal struggles with addiction and unhealthy coping skills. Primarily in early childhood, the participants discussed eating disorders, drug and alcohol use disorders, or misdiagnosis of mental

illness. The primary assistance in childhood focused on mandated counseling or medication through a psychiatrist. The participants could advocate for themselves as adults and received evidence-based and self-chosen therapy modalities. As such, their wounding was directly related to their healing and the future healing of clients. The supervisees began to disclose as the participants discussed disclosure and healing ensued.

Summary of Results Related to Research Question

The research question is what are the stories of clinical counseling supervisors who identify as wounded healers? The supervisors, as participants, discussed early wounding in their lives; some physical and some emotional. Another commonality was attempting healing and having issues with healing or the issues with the individual responsible for guiding the healing process. As the participants began working in the field of counseling, they noticed a need for healing and received healing. After becoming supervisors and recognizing the transference of their issues to their supervisees, the wounded healers attempted to assist their supervisees in getting help for their past wounds. Lastly, all the wounded healers, as supervisors in the study, noted that they could transmit healing by offering effective, bias-free supervision and modeling for their supervisees. There were no discrepant cases or non-confirming data.

Summary

In summary, the participants appeared to incur significant childhood wounding that caused mental health issues and the participants struggled to receive the necessary treatment needed to heal. However, after recognizing the need to heal, the healing was received so that they could transmit healing to supervisees. The participants also noted

how their issues and the issues of their supervisees affected to client-supervisee relationship and the supervisory relationship.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative, narrative study was to understand better the stories of clinical counseling supervisors who identify as wounded healers. The study was conducted because there is a likely effect on the quality of clinical counseling supervision due to clinical counseling supervisors being a wounded healer (Cvetovac & Adame, 2017; Jackson, 2001; Jung, 1954). Due to the large number of wounded healers in the counseling field and the high number of individuals transitioning from counselors to counseling supervisors, more information was needed to maximize the benefits of the supervisory relationship. Furthermore, the study was conducted to reveal best practices for counseling supervisors who are wounded healers.

The key finding in the study was that wounded healers as counseling supervisors experienced an initial childhood wound that drew them to the counseling profession. Like many others, the wounded healers, as supervisors, wanted to make meaning out of their wounding and share it with others. As supervisors, the wounded healers were unable to heal as children. In adulthood, the supervisors found that their wounding surfaced and negatively affected them. As such, they received the help needed and transmitted that healing to others, including supervisees. After healing, they were able to offer effective supervision and model the need for help to avoid transmission of wounds to supervisees.

Interpretation of the Findings

Development of Wounded Healer

A wounded healer is an individual who encounters a physical, emotional, or psychological wound and uses that wound to help others through their healing process

(Jamieson & Sherman, 2014). Within the interviews, all the participants discussed early wounding that involved a physical, emotional, or psychological wound. A wounded healer may develop due to a desire to use the wounding to support others (Stone, 2008). Although the participants did not know that they would use their wounding, they later made meaning from their wounds by transmitting healing to others.

How Healing Occurs

All the participants also discussed eventual healing and the "woundedness" becoming part of their healing process. Jamieson and Sherman (2014) suggested that the healing process of the wounded healer is a critical aspect of the sharing of healing with others; without the healing of the wounded healer would likely lead to further wounding of the individual. In the current study, the wounded healer was the clinical supervisor, and the individual would be the supervisee. Individuals can use their difficulties to help others (Zerabavel & Doughtery-Wright, 2012). The participants discussed the need for healing to refrain from transference. There was also a pattern of suggesting supervisees engage in healing to ensure that their wound did not affect the client-counselor and supervisory relationships. Through modeling, the participants reiterated that supervisees could work through their wounding and assist others.

Ten Steps of Wounded Healer Transaction

As Miller and Baldwin (2000) suggested, the wounded healer typically goes through a ten-step process for transitioning from wounded to wounded healer. All the participants had an initial wounding occur and sought healing due to their inability to heal independently. The participants also attempted to heal through a clinician, but early

attempts at healing failed due to various circumstances. Later in life, their wounds were triggered by an inability to focus on the pain and activate their inner healer. The participants then found healthy counselors who accepted their projection of wounds and activated their inner healer. After the participant counselors made a direct effort to support the client's healing, the inner and outer healer were integrated. All the participants also discussed how the wounded healer transaction was repeated through their work with clients and supervisees.

Counselors as Wounded Healers

The Jungian perspective of a wounded healer considers the relationship between the analyst and the analyzed as a dynamic relationship in which both parties participate in the healing relationship (Jung, 1951). Jung (1951) also indicated that the wounded healer must be aware of the wounding to assist others. All the participants discussed gaining knowledge of their wounds and receiving help for their wounds after an adult issue triggered their initial wounding. Furthermore, the awareness of their wounding allowed the clinical supervisors to assist the supervisees in managing their wounding and recognizing the need for knowledge about the supervisee's wounding.

Connection of Wounded Healers to Clinical Supervision

All the participants discussed their previous wounding and how the wounding influenced them to get into the helping profession as counselors. Many counselors enter the counseling field due to their previous wounding (Kern, 2014). As suggested in Chapter 3, counselors often transition into counseling supervisors. Each of the participants made the transition into a supervisor role from starting as a counselor.

Stigma Attached to Disclosure

Often, counselors do not seek help for their wounds due to the negative stigma associated with disclosure (Adame 2011). However, disclosure is necessary for seeking healing. All the participants discussed the need for healing and their fears of disclosure. One participant discussed a deep fear of disclosing an eating disorder due to their focus on work in disordered eating treatment centers. Another participant discussed the desire for healing from a sexual disorder and being leery of disclosure due to working in the poly/kink field of counseling. Eventually, the participants received healing despite their fears of disclosure.

Connection of Wounded Healers to Clinical Supervision

Although clinical supervision plays an important role in the development of the counselor-in-training, there is a lack of information regarding wounded healers as clinical supervisors (Wheeler, 2007). evaluative nature of supervision is the predominantly different factor in counseling supervision (Bernard & Goodyear, 2014). All the participants discussed that as counselors, they often encountered transference and countertransference in sessions. Before becoming clinical counseling supervisors, participants were able to recognize how their mental, physical, and emotional wounds negatively affected the counseling relationship. As counseling supervisors, their ability to heal was transformed into advancing the supervisory relationship and an ability to mentor and model the wounded counselor-in-training. As such, the counseling supervisors discussed their need for healing to provide effective, bias-free supervision.

Clinical Counseling Supervision and Responsibilities of Supervisors

Gatekeeping is a primary responsibility of clinical counseling supervisors (Homrich & Henderson, 2018). Remediation, a part of gatekeeping, can be affected by the impairment of the counseling supervisor. When the supervisor is impaired, the supervisor may lack recognition of an impaired counselor-in-training as a supervisee. Wounding frequently causes impairment of a counselor-in-training and supervisor (Jung, 1957). As mentioned by all the participants, the healing process allowed the participants to recognize and promote the healing of the supervisee. Another important role of supervisors is to monitor client care (ACA, 2014). Regular meetings with supervisees and discussing the case study and ethics are the primary means of monitoring client care. All the participants discussed the effects of previous wounds and healing on the task of monitoring client care, primarily focusing on self-care to mitigate transference and parallel process.

Supervisory Relationship

The supervisory relationship is crucial to allow the transmission of information and skills to the supervisee (Ellis, 2010). The quality of the supervisory relationship also directly affects the likelihood of wound disclosure for the supervisee (Wheeler, 2007). Because disclosure is necessary for healing, the supervisory relationship is directly related to the outcomes of clinical supervision. Without disclosure and healing of the supervisee, the supervisee is prone to impairment. All the participants discussed the effects of their disclosure on the supervisory relationship. Specifically, the supervisor's

disclosure prompted and influenced the supervisee to disclose and allowed the supervisor to model healing.

Narratives as Related to Theoretical Framework

The theoretical framework for the study was existential theory. The existential theory posits that human existence influences the tendency to explore relationships (Reker & Chamberlain, 2000). Because wounding is typically related to an interaction between two individuals, meaning making occurs. Participants discussed that they spent considerable time discussing their wounding and the need to explore their previous relationships related to their wounding. Participants also linked their wounding to their desire to help others and how their wounding, post-healing, affected their helping relationships. The participants used the meaning-making aspects of existential theory to influence their desire to help others with similar afflictions.

The participants also followed the path of engaging in healing with an attitude and intent to choose a positive outlook and attitude on the outcome of their wounding. As Frankl (1967) suggested, the outcome of wounding is based on an individual's perception of their wounding. Additionally, the participants chose to support others in their healing after recognizing the value of their wounding and healing experience. As Frankl proposed, each individual chooses their meaning-making based on hope from suffering or pain from suffering.

Narratives as Related to Conceptual Framework

The conceptual framework for the study was the concept of the wounded healer. Jung (1957) defined a wounded healer as an individual who engaged in the healing

process. As such, the healed help the healing and transmit healing to others who are wounded. The key is that the wounding does not make a wounded healer; the healing and transmission of healing is the catalyst. The healing of the healer provides a healthy environment for transmitting healing.

The participants discussed the negative aspects of unhealed wounding on the therapeutic and supervisory relationship. Post-healing, the participants could model wellness and awareness due to their healing. Jung (1951) discussed the "clean hands" approach, which refers to the interactions between the wounded healer and the individuals they are helping. All the participants referred to their healing as a requirement for providing the knowledge and process needed for effective supervision.

Limitations to the Study

As discussed in Chapter 1, the limitations of the study were the small number of participants in the study. Narrative studies often have two to four participants due to the wealth of information that narrative researchers and their participants provide (Clandinin, 2016). There were no limitations to trustworthiness that arose from the execution of the study. The time variance of the interviews was likely due to the amount of time spent describing and discussing the participants' wounds; some participants spent more time discussing their initial wounds than other participants.

Recommendations

The current study yielded results of the study that no known researchers provided. But further research is needed that includes the supervisee's stories to determine the experience of the supervisees as participants. The current study included the experiences

and stories of clinical counseling supervisors; participants of counseling supervisees would likely have different stories and perspectives. Furthermore, the supervisees could provide information regarding their transition from wounded to a wounded healer.

Another recommendation is a quantitative study using the themes and codes as variables. Future researchers could confirm the qualitative results by offering a quantitative study with a larger, broader pool of participants. The researcher completing the quantitative study using themes and codes as variables could also identify outcomes applicable to all mental health fields.

Implications for Positive Social Change

All the participants indicated the negative outcomes for clinical counselors and clinical counseling supervisory relationships from unhealed wounds. Positive social change occurs when individuals participate in therapeutic and supervisory relationships and can heal and share that healing with others. By recognizing themes in the study, I uncovered how the supervisory relationship was affected. Supervisees primarily excel when the supervisor is knowledgeable, genuine, respectful, and supportive (Fallender & Shafranske, 2004). Due to the impact on the developing counselor and the feedback loop to the healing client, positive social change can occur if supervisors model healing and suggest healing for their supervisees.

Conclusion

In the current study, I sought stories of wounded healers as clinical counseling supervisors to show how the supervisory relationship and development are affected by being a wounded healer. There are many counselors who are wounded and desire to help

others heal. The supervisor must do their healing before being able to model healing and effective client care for their supervisees. There were challenges to receiving healing and the lack of healing led many supervisors to identify a gap in their ability to provide effective supervision and effective client outcomes. It is imperative that a clinical counseling supervisor heal their wounds to avoid transmitting these wounds to their clients and supervisees.

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