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Counselor Supervisors' Perceptions of Tertiary Trauma

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Walden University
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Abstract

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MA, Walden University, 2010

BS, Oklahoma State University, 2006

Dissertation Submitted in Partial Fulfillment

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Abstract

Vicarious trauma impacts counselors in various ways: by diminishing their feelings of importance in the profession, hindering their completion of adequate work with clients, and negatively affecting their personal life choices. Although numerous qualitative and quantitative studies have been conducted on vicarious trauma over the past 20 years, there is a rarity of research investigating the implications of trauma for counseling supervisors. The purpose of this study was to examine the lived experiences and perceptions of tertiary trauma among 11 counselor supervisors from Oklahoma and Missouri who were providing active supervision. This study was approached through a hermeneutic phenomenological methodology. The overarching research question investigated how counseling supervisors defined tertiary trauma. Interviews were transcribed and uploaded into NVivo 10, and constructs were identified via an exploratory and inductive analysis. Codes and sub-themes were categorized then deductively divided into 6 primary themes that demonstrate participant perceptions of tertiary trauma. These themes included: (a) what it means to be a supervisor, (b) the understanding of vicarious trauma, (c) the base knowledge of tertiary trauma, (d) the symptoms of tertiary trauma, (e) the meaning of supervisor wellness, and (c), the and role of the supervisor. Findings from the study offer the counseling profession a working definition of tertiary trauma based in counseling supervisors' perception of the phenomenon. The study outcomes are unique because counseling supervisors are vital to the continued growth of both the profession and new counseling professionals, acting as gate keepers to the counseling profession.

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Chapter 1: Introduction to the Study

Counselor Supervisors' Perceptions of Tertiary Trauma

Tertiary trauma refers to a trauma in which there are a minimum of two buffers between the impact of the trauma and those affected by it. (Grossman & Born, 2000). As health professionals have integrated the use of the term tertiary to identify movement beyond a secondary source, the field of counseling has also demonstrated movement of trauma through the parallel process into a tertiary form with counseling supervisors. While vicarious trauma is a cumulative phenomenon associated with affecting counselors in relation to their work with clients, creating self-doubt in counseling skills, lapse in ethical judgment, and a lack of job satisfaction, tertiary trauma is similar, yet a distinct concept. Vicarious trauma occurs progressively over time and may begin to manifest in counselors as they focus on the treatment of clients without attention to their own personal and professional wellness (Adam & Riggs, 2008). Vicarious trauma often created doubt in counselors concerning their professional abilities, leading to compassion fatigue and even burn out (Adam & Riggs, 2008; Rasmussen, 2005). The definition of vicarious trauma outlined a secondary trauma which was not caused by a direct traumatic experience, but from working with someone who has had a direct experience (Rasmussen, 2005).

Tertiary trauma expanded the boundaries of vicarious trauma to include an additional level of trauma: from client to counselor, and then from counselor to counseling supervisor. In an upward parallel process, the counseling supervisor learns

about and experiences her or his exposure to trauma in relation to hearing about other counselors' client experiences during the supervision process.

This dissertation outlines the manifestations of tertiary trauma among counseling supervisors and their potential perceptions of the phenomenon. Of particular interest were counseling supervisors' perceptions of how tertiary trauma may affect not only themselves, but also the supervisory process. Finally, the research expanded the understanding and definition of tertiary trauma, using a hermeneutical phenomenology research design.

Organization of the Chapter

Chapter one begins with a discussion of parallel process and tertiary trauma. Thereafter, psychoanalytic theory, intersubjective metatheory, and differences among vicarious trauma and tertiary trauma are examined. The literature review includes previous research exploring counselor perceptions of vicarious trauma and emphasizes the importance of understanding counseling supervisors' perceptions of tertiary trauma. The problem statement is discussed in detail, creating a foundation for the conceptual framework of the study. An outline of hermeneutical phenomenology is provided as a justification for the chosen research methodology.

Statement of the Problem

A number of researchers have examined the existence of vicarious trauma and suggested the potential of tertiary trauma (Knight, 2010; Tosone, Nuttman-Shwartz & Stephens, 2010; Way, VanDeusen & Cottrell, 2007). While vicarious trauma and tertiary trauma may be a similar phenomenon, they are distinctly different in that the experience

of tertiary trauma is directly linked to the counseling supervisor. Tertiary trauma also differs from vicarious trauma in the number of levels of removal from the original trauma experienced by the client. The long-term effects of providing supervision to trauma counselors' might result in tertiary trauma (Knight, 2010; Rasmussen, 2005). Study results have suggested existing correlations. The understanding of helping professionals' perceptions of trauma related phenomenon, and the reduction of symptoms appeared comparable. The greater the helping professional's understanding of trauma, a more significant reduction of symptoms could be seen in previous research (Adams & Riggs, 2008; Trippany, White, Kress, & Wilcoxon, 2004). Knight (2010) showed that understanding the perceptions of individuals experiencing vicarious trauma is led to curricular expansion in counselor training programs. These programs now include an emphasis on counselor wellness to reduce the impact of vicarious trauma symptoms. Way, et al., (2007) identified little is known about tertiary trauma in counseling supervisors. Also, unidentified is how the continued process of movement of trauma from client to counselor, and then to supervisor would look.

Knight (2010) and Adams and Riggs (2008) addressed the roles supervisors have in the reduction of vicarious trauma among counselors. It was unclear how providing supervision to trauma counselors may affect counseling supervisors and reduce their ability to provide the needed guidance for counselors and counselor trainees (Knight, 2010; Way, et al., 2007). Without an awareness of tertiary trauma and supervisory wellness, counselor supervisors faced the risk of burnout, compassion fatigue, and the

risk of impacting those they supervise negatively through poor clinical judgment (Knight, 2010).

In my review of previous research, I found no studies that examined the perceptions counseling supervisors' client trauma may have their supervision roles. A working definition of tertiary trauma was needed to establish an understanding of how counseling supervisors define the phenomenon. Due to the goal of developing themes that might define tertiary trauma, based on participants' perceptions of the phenomena, phenomenological research was appropriate. A phenomenological study of tertiary trauma assists the counseling profession in illustrating more fully how counseling supervisors perceive the experience of supervising counselors who were providing counseling to clients with a trauma history. Participants explored tertiary trauma within the supervisory process and the overall professional life of the supervisor.

Developing an Understanding of Tertiary Trauma

Vicarious trauma is a phenomenological process often rooted in humanist perceptions of what counselors experienced when working with clients who have experienced trauma (Adams & Riggs, 2008). McCann and Pearlman (1990) considered vicarious trauma a cumulative process which begins to manifest symptoms in counselors over time, often seeping into the core of the counselor's existence. According to Knight (2010), many counselors find themselves questioning their professional skills and doubting if the counseling process has any impact on clients they serve. Counselors might find themselves dissatisfied with job performance or lack the desire to continue their professional paths as counselors (Jordan, 2010; Tosone, et al., 2012).

The manifestation of vicarious trauma symptoms might affect many areas of the counselors' life. Areas such as a) satisfaction with the counseling profession, b) self-perception and increasing difficulty in making decisions in both the personal and professional life are a few examples of the counselors' life. Cohen and Collens (2013) identified those counselors who rate highly on symptoms of vicarious trauma may be at a higher risk for health related incidents. Migraines, suppressed immune system, and even stress related heart attacks are all potential health risks associated with vicarious trauma. Counselors not addressing the symptoms of vicarious trauma may also be at a higher risk of substance abuse (Cohen and Collens, 2013; Tosone, et al., 2012).

A literature search returned minimal information about tertiary trauma in counseling supervisors. What is known was among sources is that counseling supervisors go through a parallel process to counselors, as supervisors are exposed to the same trauma related experiences of clients and counselors through the supervisory process. Counseling supervisors often find themselves in dual roles, acting as both the counselor and counseling supervisor, maintaining their own client caseload while providing counseling supervision to other counselors (Adams & Riggs, 2008; Knight, 2010). The act of counseling supervision is a multipurpose action; however, it is grounded in the counseling wellness model. Through the act of supervision, counselors often sought help in gaining further techniques or insight into difficult client related situations. To better serve the client and to help prevent their own traumatization and burnout, counselors sought continued guidance through supervision (Jordan, 2010; Knight, 2010; Tosone, et al., 2012). This process involved the upward parallel line of communication wherein the

counselor communicates to the counseling supervisor the issues or concerns they are having, allowing the counseling supervisor to assist and offer guidance. The counseling supervisor is now dealing with the trauma and wellbeing of not only the counselors' client but also the counselor (Knight, 2010). The weight of this experience along with the additional job of performing clinical counseling work could result in, compound, or impact the manifestation of tertiary trauma. Jordan (2010) outlined vicarious trauma as a process that occurred because of the empathic engagement the counselor has in placing them self in the clients' footsteps. The process outlined the counselor wanting to build rapport and understand from whence the client is coming. It was the counseling supervisors' role to have empathic engagement with the counselor under supervision in order to understand what the supervisee needs from the supervision process and how to serve best in the role of supervisor. Counseling supervision is a process that holds similar actions to counseling.

Approaches to Supervision

Psychodynamic Supervision

A particular psychodynamic approach to supervision and one that helped guide the theoretical framework of this dissertation was supervisee-centered supervision. Exploring supervision as an extension of counseling, the supervisee-centered approach, according to Haynes, Corey and Moulton (2003), was similar to a client-centered approach in counseling. The focus was on the supervisee's experience working with the supervisee's client and the counseling supervisor. Supervisee's understanding that a parallel process occurs in supervision was foundational for client-centered supervision

(Haynes, Corey & Moulton, 2003). The parallel process in the supervisee-centered approach demonstrates a flow of information that goes from client to counselor and then from counselor to supervisor in an upward motion. Where a supervisor, during supervision, redirects the parallel process in a downward motion where information provided goes from counseling supervisor to counseling supervisee then to the client. The counseling supervisor ideally understands the supervisee is often in the middle of this process. This understanding leads the supervisor to address inter and intrapersonal experiences of the supervisee including assisting with addressing the struggles in the work of counseling and maintaining self-care.

A variety of supervision models have been available for supervisors in their approach to helping counselors grow into their profession (Falender & Shafrankske, 2004; Luke, Ellis & Bernard, 2011). Supervisors could offer support by addressing counselors' personal experiences as they develop in the profession (Falender & Shafrankske, 2004). The counseling supervisor may provide guidance to the supervisee to explore his or her experiences during each phase. The counseling supervisor has a role of guiding and supporting the supervisee as the supervisee transitions from one developmental stage to the next.

The counseling supervisor might act as mentor, teacher, or support for the supervisee, depending on the supervisees' needs and what stage of development the supervisee is in. The developmental model of supervision emphasizes the need for counseling supervisees to explore areas of strengths, weaknesses, and struggles he or she experience in their professional growth (Luke, Ellis & Bernard, 2011). The counselor

supervisor processes each of the stages and experiences with the counseling supervisee as counselor, consultant, and educator, allowing the counselor supervisor to understand the supervisees' whole developmental experience in becoming a more adept counselor (Falender & Shafrankske, 2004; Luke, Ellis & Bernard, 2011)..

Discrimination Model

The discrimination model states that the counseling supervisor will hold many roles during the supervisory process, including supervisor, teacher, and counselor (Luke, et al., 2011). Acting in this role, the supervisor engages with the supervisee to understand his or her needs from the supervisory process and their overall experience (Luke, et al., 2011). This position is similar to that which the counselor has when working with a client. As Jordan (2010) acknowledged, it is this empathic engagement with others that often creates the opportunity for vicarious trauma to develop. If supervisors share a similar empathic engagement with those being supervised, then a paralleled opportunity for tertiary trauma of the supervisor begins to develop over time similar to the opportunity for vicarious trauma of the counselor who demonstrates empathic engagement.

Over the past fifteen years, the research and literature on the topic of vicarious trauma have gained considerable momentum. Researchers have provided counselors not only the knowledge of what vicarious trauma is, but also the assessment tools needed to monitor the potential manifestation of the phenomenon (Cohen & Collens, 2013; Knight, 2010). As this momentum has progressed, few had acknowledged the effects trauma may have in a tertiary aspect on counseling supervisors who are often called up to reduce the

impact of vicarious trauma in others. While some research had implied that there may be similar effects due to the parallel experiences, none identified had spoken of the real manifestations of the phenomena (Knight, 2010).

Tertiary Trauma Symptoms

With little known about tertiary trauma, I drew similarities between counseling supervisors and counselors who are dealing with vicarious trauma. Many of the symptoms associated with vicarious trauma were similar to those experienced by counseling supervisors who were dealing with tertiary trauma. Identifying symptoms was not for diagnostic purposes, but understanding potential symptomology helped to develop the real nature of tertiary trauma (Jordan, 2010).

Purpose of Proposed Study

The purpose of the proposed qualitative study was to explore counseling supervisors' perceptions of tertiary trauma including the manifestations of symptoms. The study assisted the counseling profession in understanding more fully the phenomenon of tertiary trauma and the needs of counseling supervisors in relation to working with supervisees who are counseling traumatized clients. To build a working definition of tertiary trauma developed the opportunity for future research. Future areas of consideration were the exploration of supervisory wellness techniques, strengthening the understanding of how counselor wellness transfers through the supervision process from counseling supervisor to counseling student. The overall outcome of the proposed qualitative study was to strengthen the understanding of tertiary trauma and to provide an evidence base for counseling supervisor wellness.

Research Questions

A theoretical base exist for vicarious trauma, and some academic models suggest integrating different approaches to prepare new counselors for coping, early in academic careers to reduce the risk of vicarious trauma. As new research was developed, researchers demonstrated a clinical and ethical responsibility to examine how counselors perceive vicarious trauma in relation to their wellness. A handful of studies demonstrated that counseling supervisors experience a parallel process to counselor-client work (Cohen & Collens, 2013; Knight, 2010; Tosone, et al., 2012). None of the studies explored counseling supervisor perceptions or experiences of tertiary trauma. Perceptions addressed in the literature included those of the counselor and counseling supervisee (Cohen & Collens, 2013; Jordan, 2010; Knight, 2010; Rasmussuen, 2005;). The profession of counseling will benefit from studies that examine how counseling supervisors experience and discern tertiary trauma

The research questions were:

Primary Research Question:

What is the phenomenon of tertiary trauma for counselor supervisors?

Sub-questions:

How do counselor supervisors describe tertiary trauma?

How do counselor supervisors identify the manifestation of tertiary trauma?

Understanding counseling supervisor perceptions of tertiary trauma and its effects impact future counseling supervisory practice. It is possible that some counselor supervisors perceive tertiary trauma as harmful while others may have no perception of

tertiary trauma. Understanding the perception of tertiary trauma from the counseling supervisor point of view contributes to a scant body of counseling knowledge and potentially facilitates future research examining tertiary trauma in relation to the field of professional counseling.

Framework

The theoretical framework for this study was the Krueger and Casey (2000) framework of phenomenological research. Because phenomenology addresses an experience of social concern and serves to illustrate a description of the experience as lived by the research participant, the study was designed to develop a working definition of tertiary trauma for future research based on the lived experiences of the participants. Understanding the psycho-dynamic perspective outline that an individual's perception is often related to his or her experience in a given situation was important in creating the framework for this study (Tosone, et al., 2012), it was valuable to understand the lived experiences of counseling supervisors. Hermeneutical phenomenology made the most sense for understanding the perception of counselor supervisors. To develop a textual meaning through dialogue and interpretation of the experience counselor supervisors' had with tertiary trauma, hermeneutical phenomenology focused on the experience lived by the counselor supervisor. Langdridge (2007) identified hermeneutical phenomenology as a method of understanding an experience or phenomenon through the stories that describe the lived experience. Hermeneutic phenomenology created the framework for this study and helped develop a working definition of tertiary trauma.

Definition of Key Terms

Burnout : The overall feeling of disinterest in one's career and the desire to change career paths due to dissatisfaction (Adams & Riggs, 2008; Knight, 2010).

Compassion fatigue – The lack of empathy towards others and an overwhelming feeling of dissatisfaction in career performance (Bride, Radey & Figley, 2007).

Counseling supervision - The clinical process of an individual deemed a counseling supervisor by the state licensure board or agency based on experience in the counseling profession providing supervision to other counselors or counselor trainees (Knight, 2010; Cohen & Collens, 2013).

Downward parallel process – The movement of information given to a counselor from the counseling supervisor to assist in providing counseling services to a client (Sugarman, 1977).

Dynamic unconscious – A Freudian concept which outlines the area of the unconscious holding tension and displeasure. The dynamic unconscious works to restore stasis and pleasure to the conscious mind *(*Stolorow & Atwood, 1992*)*.

Narratological model of meaning –The model outlines the individuals' personal history as a text or narrative in reference to the interpreted meaning of the individuals lived experience, linking the individuals' world view to his or her experience (Thompson, 1997).

Parallel process – The movement of information from one individual to the next (Sugarman, 1977).

Prereflective unconscious – The area of the unconscious which is shaped by organizing patterns and schemas, and determines defense mechanisms of the conscious mind (Stolorow & Atwood, 1992).

Presupposition – An assumption of hermeneutical frameworks which states individuals have his or her own truth about lived experiences, and what he or she expresses should be considered true for the individual (Berding, 2003).

Tertiary trauma – An indirect impact of trauma on an individual which creates symptomology related to traumatic experiences, being twice removed from the traumatizing event (Grossman & Born, 2000).

Unvalidated unconscious – Area of the unconscious which stores occurrences which have not been articulated or acknowledged by the person who experienced the event (Stolorow & Atwood, 1992).

Upward parallel process – Movement of information from the source onward. For example: A client tells a counselor their story and the counselor then consults with the counselor supervisor, repeating what the client said (Sugarman, 1977).

Vicarious trauma - A term identifying the impact of trauma on counselors providing direct client services. Vicarious trauma is a cumulative process which affects counselors over a course of time, causing compassion fatigue, burnout, and even physical ailments such as exhaustion or confusion.Vicarious trauma can cause self-doubt professionally and personally (Adams & Riggs, 2008; Knight, 2010; Jordan, 2010).

Assumptions

During the interview process, I assumed that counseling supervisors would answer questions truthfully regarding their perceptions of tertiary trauma. In addition to the role of supervisor, they may also be acting in the role of a counselor providing direct client services. The primary assumption was that the counseling supervisor would be willing to share their experiences, recalling details that might support establishing a working definition of tertiary trauma. It was assumed that all counselor supervisors had a master's degree or higher in counseling, and were capable of understanding all questions asked. Counselor supervisors would talk about their own experience providing supervision. Phenomenological assumptions stated the revealed perceptions of participants are the fundamental truth of the phenomenon being explored (Choi & Kim, 1999; Sugarman, 1977). Assumptions related to the methodology and hermeneutical frameworks are discussed more in-depth in Chapter 2.

Delimitations

The study was delimited to counselor supervisors who were actively providing clinical supervision to counselors working directly with trauma clients. The supervisory process was defined as including licensure supervision or clinical supervision of a counselor or counselor supervisee. The results of the study were generalized to counselor supervisors who work within the mental health profession as Licensed Professional Counselor (LPC) or Licensed Marriage and Family Therapist (LMFT).

Limitations

Phenomenological studies foundationally looked at human nature and lived experiences, specifically spatiality, corporeality, temporality and experienced human relations (Choi & Kim, 1999; Rynes, Giluk & Brown, 2007). The findings of this study were limited to the lived experiences of those participants of the study who may or may not have experienced tertiary trauma. Located within a generalized area of two states, participants were not representative of all counselor supervisors. The study focused on counselor supervisors who currently provided supervision to counseling supervisees who provided trauma based counseling, limiting the generalization of outcomes.

Significance of the Study

Implications for positive social change were unique because this research addresses an under-studied area for helping professionals. The population of counseling supervisors is vital to the continued growth of both the profession and new counseling professionals (Knight, 2010; Tosone, et al., 2012). The results of this study provide insight into the views and experiences of counseling supervisors, leading to the development of a precise definition of tertiary trauma and its effects on counseling supervisors. Exploring the supervisors' perceptions also contributed to the professional growth and expansion of practitioners' knowledge. Areas such as tertiary trauma phenomena, supervisory wellness, and the impact these aspects and wellness techniques have on the efficacy of being a supervisor are a few examples. It also explored how supervisors are impacted by the supervisory process and respond to tertiary trauma symptoms.

Summary

The intention of this study was to develop an evidence base through the exploration of counseling supervisor perceptions of the existence and experience of tertiary trauma. While each counseling supervisor brought to the counseling setting his or her theoretical orientation, they each provided input into the development of terminology related to tertiary trauma. Preliminary research on the topic of tertiary trauma appeared to indicate its relevance for counselor supervisors.

Chapter 2 addresses the detailed structure of the proposed research design, outlined the current introduction to the topic, and explored specific literature search strategies. A conceptual framework for building a working definition of tertiary trauma is presented. The chapter primarily focuses on the literature review of topics such as vicarious trauma and the parallel process and how they are connected to the working definition of tertiary trauma.

Chapter 2: Literature Review

Introduction

Adams and Riggs (2008) indicated counseling student supervisors reported having distress in response to trauma similar to trainees throughout supervision in relation to the intensity of indirect trauma reported by the trainee. When more intense reactions were reported by the trainee, the supervisor appeared to mirror that distress related to the supervision experience. Knight (2010) suggested similar experiences among faculty supervisors of practicum and internship students in a social work program. Neither study specifically explored the supervisors' experience of trauma; however both studies indicated the possibility of counseling supervisors to have a paralleled experience of those they are supervising, including the potential to experience distress within the supervisory experience.

Counseling supervisors' perceptions of tertiary trauma are of particular interest due to a gap in the literature defining the transference of trauma to counseling supervisors. This void means there is no working definition of tertiary trauma in relation to counseling supervision. Counseling supervisors act as a gatekeeper to the profession of counseling in various ways that include providing academic supervision, licensure supervision, and often clinical supervision (Knight, 2010). Each state licensure board may outline specific requirements and roles counseling supervisors have, however the American Counseling Association (ACA) provides and ethical outline for counseling supervisors (American Counseling Association, 2014). Section F of the ACA (2014) code of ethics emphasizes the expectations of the counseling supervisor to aspire to

encouraging growth and professional development of those he or she supervises. The ethical standards also imply the important role in gatekeeping the counselor supervisor has (American Counseling Association, 2014). The role of counseling supervisor is often linked to improving quality of treatment provided to clients while safeguarding those who are being supervised.

With a lack of understanding of the affect trauma has in counseling supervisors, it is questionable as to how trauma might cause distortions in the supervisors' ability to provide active and adequate supervision. It is important to learn how the counseling supervisor perceives the experience of tertiary trauma. Prior studies such as those conducted by Adams and Riggs (2008), Cohen and Collens (2013), Knight (2010), identified the impact vicarious trauma has on counselors. Considered a cumulative process, vicarious trauma permeates who the counselor is. Changes occur in the perceptions of counselors affecting thoughts and feelings of self-efficacy, job satisfaction, and can lead to compassion fatigue and burnout (Adams & Riggs, 2008; Knight (2010). As a preventative measure, counselors are encouraged by the counseling profession to seek out supervision. Counseling supervisors provide supervision in order to reduce the risk and manifestation of vicarious trauma (Jordan, 2010; Trippany, et al., 2004). Cohen and Collens (2013) and Knight (2010), suggested that supervision may assist the counselor in reducing indirect trauma. However, Cohen and Cohen (2015) and Knight (2010) noted that counseling supervisors could experience another form of trauma in a fundamentally different way. Grossman and Born (2000) outlined in the medical profession the term tertiary is an identifier for individuals who did not have direct or

secondary trauma, but instead experienced trauma through at least two buffers. If the discussion of tertiary trauma in the medical profession were to be applied towards counseling supervisors and the supervision process then, a greater understanding of the internal experiences counseling supervisors goes through might be better understood. The parallel process counseling supervisors experience in conjunction with counseling supervisees might help develop a greater understanding of tertiary trauma in counseling supervisors. However, the gap in the literature by presenting a working definition of tertiary trauma in relation to counseling exists.

Organization of Chapter

Chapter 2 includes an overview of the structure of the proposed research design and specific literature search strategies. Discussed is the theoretical foundation for building a working definition of tertiary trauma along with the conceptual framework utilized within the project. Specifically the chapter focuses on the literature review of topics such as vicarious trauma and parallel process, and how each link to the working definition of tertiary trauma.

Literature Search Strategy

Over the past five years, the expansion of research related to vicarious trauma had illuminated an interest in the effects trauma may have on counseling supervisors and the supervisory process (Adams & Riggs, 2008; Knight, 2010). The EBSCO search engine was used to identify full-text articles in databases such as *Academic Search premier*, *Google Scholar, PsycInfo* and *PsycARTICLES*. In addition, the internet was used to access professional organizations that focus on the research and development of areas

such as vicarious trauma and tertiary impact. Key terms used in the literature search included *tertiary trauma*, *vicarious trauma*, *parallel process*, *upward parallel process*, *downward parallel process*, *counseling supervision*, *compassion fatigue*, and *burnout*. I found some articles by cross-referencing citations from articles. I used the EBSCO search engine to identify full-text articles contributed by databases as *MEDLINE*, *Health & Medical complete* and *Web of Science*. Key terms were used to search the literature from other disciplines such as medical and economic professions. These terms included *tertiary trauma*, *burnout,* and *parallel process*.

Though literature search strategies produced minimal research specific to the topic of tertiary trauma, it was vital to utilize additional research sources. I used *MEDLINE, Health & Medical complete,* and *Web of Science* in order to establish the defining boundaries of tertiary in other professions. In counseling, vicarious trauma was referenced as unique to the effects of trauma on the counselor. The cross-reference of articles establishing the manifestation of vicarious trauma was utilized to develop a parallel experience counseling supervisors may have which is similar to those of counselors.

Conceptual Framework

Existing literature points to the profound effects vicarious trauma had on counselors and other helping professions. I was unable to identify literature on the particular issues of tertiary trauma or an illustration of how counseling supervisors perceive the phenomena. For this reason, there was no existing professional evidence-

based practice that I could find to assist counseling supervisors in defining tertiary trauma and the role it played in the counseling supervision process.

The gap in the literature was best addressed by exploring the needs of counseling supervisors through an examination of perceptions of tertiary trauma. Berding (2003) asserted the importance of understanding meaning stating texts are units of social discourse, and it is assumptions of what is communicated to others is understood only within that individuals' cultural context. Tertiary trauma has held a cultural context in other professions (Grossman & Born, 2000). For the profession, of counseling to establish a definition of tertiary trauma directly and intuitively in the counseling profession, the researcher must understand the cultural context of what it means to be a counseling supervisor. This understanding included his or her perceptions of a working definition of and the perceptional relationship to the development of tertiary trauma (Berding, 2003).

Hermeneutical Phenomenology

A hermeneutical framework in phenomenological research focuses on a textual interpretation and meaning of the dialogue related to of the lived experience of the participant (Langdridge, 2007; Thompson 1997). Manen (1990) stated that the phenomenological inquiry holds reflective aspect. There is a difference in perception of the topic when considered pre-reflective. A reflective grasp of a phenomenon appears after post-reflection with the researcher (Van Manen, 1990). The nature of phenomenology is transcendental, providing the exploration of understanding the lived

experience (Moustakas, 1994; Van Manen, 1990). Reflections on the lived experiences are the foundation of phenomenological work (Moustakas, 1994).

Hermeneutical phenomenology works from the techniques that formulate interpretations based on core assumptions within the framework (Thompson, 1997). These assumptions are a driving foundation for understanding an experience or phenomenon through the lived experience of the participant (Langdridge, 2007). Hermeneutic phenomenology created a framework for examining tertiary trauma from the perception of counseling supervisors, conceptually building a working definition based on those lived experiences each share through dialogue.

Thompson (1997) stated that in order to conceptualize a hermeneutical framework one must understand the working assumptions which exist within the context. The first assumption Thompson (1997) discussed as vital is the paradigm of the general world view, and how the participant describes his or her overall lived experienced. Moustakes (1994) believed perception was the primary source of knowledge. The belief that perception is the original consciousness drives phenomenological work, as perceptions provide truth to the experience being lived (Moustakes, 1994). Applying a narratological model of meaning, detailing each lived experience meant linkage could demonstrate issues relevant to the professional relationship between counseling supervisors and tertiary trauma. This application allowed for consideration to be given to the prereflective, dynamic, and unvalidated unconscious which trauma has shown to affect (Rasmussen, 2005; Stolorow & Atwood, 1992).

More importantly the acknowledgement of professional expectations of the counseling supervisor were taken into consideration and explored through the context of the participant's world view. It was assumed the professional expectations of the counseling supervisors would vary slightly from the counselors because of their expected role within the counseling profession. Counseling supervisors act as gatekeepers for the profession.

Supervisors act in various roles acknowledging a supervisee's abilities to obtain licensure as a counselor. Other functions include maintaining ethical standards, and working towards professional growth of agencies and community welfare (Bride, Radey & Figley, 2007; Knight, 2010; Rasmussen, 2005).

The second assumption outlined by Berding (2003) in the hermeneutical framework is drawing out working presuppositions of previous research in the area of interest. These presuppositions included the understanding of meaning and the methodology utilized to construct the meanings stated. Phenomenological approaches assumed researchers understand critiquing of presuppositions happens as phenomenology works from a self-conscious appreciation of his or her assumptions and biases in relation to the research conducted. Because of this understanding previous assumptions of work conducted and current assumptions of the research and researcher were necessary in constructing the framework (Berding, 2003; Langdridge, 2007).

The working assumption of vicarious trauma stated that all counselors would experience vicarious trauma (Adams & Riggs, 2008; Bride, et al., 2007; Way, et al., 2007). Because of this the implementation and encouragement of counseling and

professional wellness techniques had grown academically and professionally. Over the past ten years as a preventative measure to reduce vicarious trauma symptomology counseling and professional wellness has become a focus (Trippany, White Kress & Wilcoxon, 2004). Through the overlay discussion of the parallel process associated with counseling, the profession could see counselors often had lived experiences through the dialogue he or she has with clients. These lived experiences often were associated with the emotions and perceptions of the clients. Manifested was symptomology linked to vicarious trauma such as compassion fatigue, heightened emotional reactivity, and doubt of one's professional ability to assist others (Bride, et al., 2007; Knight, 2010). The most fundamental presupposition in addressing the needs of counselors to prevent vicarious trauma was the role of supervision. The parallel process identified the path of transference. It was assumed the role of supervision allows the counselor supervisee to discuss any lived experience working with the client to the counseling supervisor. The downward parallel process provided a track of communication where the counseling supervisor and supervisee develop a working action plan. The plan was to improve the clients counseling experience and reduce the supervisees' potential of trauma through direct client work (Knight, 2010). The counseling supervisor process of communicating with the supervisee and hearing the lived experience parallels the counselor supervisees' process of communicating with the client and hearing understanding the clients' lived experience. The assumption demonstrated a linking of the potential transference of trauma from vicarious to tertiary. It is important to remember that phenomenology functioned by the "wholeness" factor. Wanting to understand an experience from many

angles and perspectives until a unified descriptive view of the phenomenon is achieved would meet the "wholeness" requirement (Moustakes, 1994).

Key Concepts

Tertiary Trauma

Research on tertiary trauma and the role it played in counseling supervisors was scarce. Tertiary trauma was not a term unknown in other professions, specifically within the field of medicine. Tertiary trauma held both positive and negative terminology in the medical profession, and those terms were explored more extensively in order to discern the illustration of tertiary trauma in counseling. In order to better illustrate how medical terminology acted in conjunction with counseling, a demonstration of the overview of indirect trauma followed. In the medical profession, indirect trauma was described as injury caused by a blunt force. No open wounds or surface symptomology could be detected until later after the trauma occurred (Hodgson, Stewart & Girotti, 2000). For example, a concussion from a car wreck was considered an indirect trauma according to Hodgson, et al., (2000). While the direct trauma was the car wreck, the concussion was indirect trauma to the brain that was not directly touched by the trauma. In counseling vicarious trauma, also known as indirect trauma, played a parallel role in the counselor compared to the indirect trauma patients in the medical field may experience. The primary difference was the client experienced the main or direct trauma, and the counselors' indirect trauma would come from hearing the clients' trauma repeatedly told during counseling sessions. Vicarious trauma often was not detected or experienced until later after the counselor had worked with a client, experiencing the clients' lived

experience. A parallel to indirect trauma in the medical profession was the time it took to establish vicarious trauma existence (Houshian, Larsen, & Holm 2002; Trippany, et al., 2004). A similar parallel was drawn between the use of tertiary trauma in medicine as well as counseling if similarities in terms of indirect trauma identified existed in the medical profession and counseling. However, discussed was clear understandings of tertiary trauma in medicine, so further ties to counseling were created to understand how a strong connection exists.

Hodgson, et al., (2000) initially established the impact of tertiary trauma within the Canadian Medical Profession when exploring the cause of death among a sample of patients. During the period between 1991 and 1997, Hodgson, et al., (2000) identified one hundred and eight deaths which did not have a link to direct or indirect trauma. With further research, it was discovered tertiary trauma was a causal factor for the individuals' death due to no symptomology being seen. To better explain this, the study conducted by Hodgson, et al., (2000) outlined the defining terms of direct or indirect trauma. These Definitions led to the existence that the tertiary trauma had in the deaths of patients when not directly assessed and treated for a lack of symptomology. In order to do this Hodgson, et al., (2000) outlined the defining differences between direct and indirect trauma. They illustrated this by showing the autopsy data that those who had died did not fall into either category, but into the third and separate category known as tertiary trauma. Direct trauma within the medical article was articulated as a visible sign that trauma had occurred. Direct trauma was an open wound, a cut, a protrusion of a bone or bleeding but all signs of direct trauma can be visible to the treating physician. Hodgson, et al., (2000)

explained indirect trauma as injuries found in a locations other than the direct impact of the trauma. For example and individual who was in a car wreck may be diagnosed with a concussion that was considered an indirect trauma because the brain is experiencing a swelling sensation but was not directly hit. The question that arose throughout Hodgson, et al., (2000) article was the distinction of tertiary trauma compared to direct and indirect trauma. Seen throughout the autopsies conducted on the participants in the study was tertiary trauma. Unlike direct and indirect trauma, tertiary trauma medically may go unknown due to the lack of symptoms that developed early on after a traumatic event. There were not open wounds or signs of trauma compared to direct trauma, and unlike indirect trauma there is not always a physical reactivity within 24 hours such as swelling of an organ or extremity in the patient. Tertiary trauma according to Hodgson, et al., (2000) could go unnoticed for days, weeks, and even months before symptomology occurred if it ever did. Out of one hundred and eight patients who died due to tertiary trauma in the Canadian medical field between 1991 and 1997, all had internal trauma. Never diagnosed due to any related diagnosis or implication of direct or indirect trauma, the tertiary trauma went unnoticed. Only 34% of those autopsied were having found to report prior to the expiration any form of symptomology. Symptoms included stomach cramps or headaches that at the time were found to be terminal due to the length of which physical internal symptoms had been existent. Hodgson, et al., (2000) questioned if tertiary trauma could go so easily unnoticed. With a lack of symptomology initially, Hodgson, et al., (2000) stated tertiary trauma could be cumulative, slowly affecting the patient. When symptomology began to occur, the trauma done to the body was

considered severe or intense. The other question which arose was how many other individuals could be suffering from internal trauma that showed no symptomology until it was considered terminal or untreatable. Being a genuine experience, how could the medical profession better assess and diagnose the potential for tertiary trauma that Hodgson, et al., (2000) recommended further studies were needed to meet this quest.

Houshian, et al., (2002) studied the medical records of major traumatized patients admitted to one university hospital between 1996 and 1999. All patients treated had direct trauma of various stages with 786 patient records examined. While the primary trauma was treated and considered "cured," 86 patients returned for further treatment within a year due to missed injuries that were internal and showed no signs of being direct or indirect trauma related. These statistics indicated to Houshian, et al., (2002) that those who experience direct and indirect trauma also were more likely to have a form of tertiary trauma. The idea made it imperative for medical professionals to increase his or her awareness of how to assess and treat vicarious traumatization. Houshian, et al., (2002) stated in their findings that not all traumas could be identified or was visible. Out of the 786 patient records examined, 86 patients showed no symptomology for direct or indirect trauma within a 24 hours period. Over the course of the next year, patients began to develop symptoms bringing them back for treatment. If the trauma is not visible in the patient, Houshian, et al., (2002) summarized the medical professional should not dismiss the potential of a "hidden" trauma. Tertiary trauma is not as symptomatic as direct and indirect trauma. The question again arose as to how to further the knowledge and skill of identifying and reducing tertiary trauma symptoms (Houshian, et al., 2002).

Sinha, Gunawat, Nehra, and Sharma (2013) specifically looked at the cognitive, functional, and psychosocial outcomes of patients who had experienced a severe traumatic brain injury. The study conducted was in a tertiary care trauma center in India where a cross-sectional sample of patients over the past year provided data. A total of 77 patients agreed to participate in the study and were assessed in the outpatient department one year after the treated traumatic brain injury. All patients were considered to have had an indirect traumatic brain injury, meaning there was an injury to the brain due to blunt force causing a concussion. No direct trauma to the brain such a bleed or hemorrhage had occurred. The study directly looked at the cognitive and functional outcome established through the grading of good recovery or weak recovery, psychosocial outcomes, and functional levels. The statistical hypothesis of the researchers indicated there was a tertiary impact on individuals who had a traumatic brain injury. The tertiary impact went unidentified since cognitive, functional and psychosocial areas are often not addressed during treatment of brain injuries. The results of the study showed the ability to learn new things was often the most affected and only 1% of the patients in the study showed no difficulty in cognitive processing after the initial year. However, participants' simple memory appeared to go unaffected. 37% of the patients reported personality trait changes since the brain injury and 57% of the patients showed an increase of depressive tendencies. Sinha et al. (2013) indicated these domains as being within the realm of tertiary trauma. Many patients reported not being aware of the issues until taking the surveys during the study.

Patil and Patil (2013) similar to Sinha et al. (2013) considered the tertiary trauma impact of HIV-AIDs patients at a tertiary care center in western Maharashtra. Over the course of the past twenty years HIV-AIDs has been treated as an indirect trauma, identifying the direct trauma HIV-AID's has on the immune system of the patient. Patil and Patil (2013) conducted a study over a two-year span between 2009 and 2010 in western Maharashtra where 81 HIV seropositive patients of both genders presented in the study. Each patient chosen for the study met the factors of having lived with the HIV virus for more than a year. Other factors included having been taking a regimen of assigned medicine to suppress the HIV actions, and having begun to experience neurological manifestations. The outcomes of the study showed the direct trauma HIV-AIDs has on the physical body is the suppressant of the human immune system causing the body to be at risk of secondary infections such as pneumonia. However, the HIV-AIDs impact also has a tertiary level seen in the neurological manifestations caused by a virus. These manifestations include an impact on the nervous system increasing the effects of Dementia, Alzheimer's, and the overall breakdown of the central nervous system. Patients often lived for years without the knowledge or understanding the tertiary effects HIV-AIDs could have on the neurological make-up of the body, due to the medical limitations of knowing HIV as only an immunodeficiency virus. Neurological manifestations often went unnoticed, and therefore untreated, until symptoms became severe at which point damage neurologically was often permanent. The work by Patil and Patil (2014) indicated the tertiary trauma impact which can occur even during treatment of known illnesses.

After the concept of tertiary trauma was established, in 2003, Biffl, Harrington, and Cioffi (2003) developed the implementation of a routine tertiary trauma survey (TS). The survey reduced the incidence of tertiary trauma morbidity and mortality. According to Biffl, et al., (2003) the evaluation of an individual with the tertiary trauma survey had the potential to reduce morbidity and mortality of patients. The survey gave medical professionals the symptomology to look for associated with tertiary trauma medically. The cause of tertiary trauma being overlooked and under-addressed in the medical profession was associated with many factors. Factors include no symptomology reported by the patient, neighboring or distracting injuries that skew the client or patient's perceptions. There is also a delay in knowledge being disseminated to medical professionals about how to assess and address tertiary trauma as you would direct or indirect trauma. The overall outcome of the study within the university hospital that implemented the tertiary trauma survey decreased missed tertiary trauma medically to 1.5% of individuals who showed signs of direct or indirect trauma. For those who showed no signs of direct or indirect trauma the use of the trauma survey decreased missing tertiary trauma to 3.4% in patients seen. Biffl, et al., (2003) believed this emphasized the importance of training professionals about tertiary trauma and the need for routine established assessments on tertiary trauma diagnosis.

In commonality with counseling as the medical profession created and implemented the tertiary trauma survey (Biffl, et al., 2003), the counseling profession established means to assess and determine vicarious trauma. Utilizing assessments such as the ProQol, counselors could not complete a self-assessment to help identify potential

symptoms of vicarious trauma before reaching the stage of complete burnout (Stamm, 2010). However as research in vicarious trauma continued to strengthen over the past 20 years, researchers must look at the next phase of studies. The next evolution in the understanding and progression was the understanding of trauma movement into populations like counseling supervisors (Adams & Riggs, 2008; Way, et al., 2007). The medical profession had demonstrated the necessity of understanding the defining qualities of trauma in different stages. The counseling profession had also shown substantial knowledge and research in understanding the role of direct trauma in clients and indirect trauma in counselors. The next tier in professional development was the understanding and exploration of tertiary trauma in counseling supervisors building off what the counseling profession knows already of vicarious trauma. With the lack of tertiary trauma assessments in counseling compared to the medical profession, it was fundamental to understand the perceptions and experiences of counseling supervisors in order to develop a meaningful definition of tertiary trauma in counseling.

Vicarious Trauma

With the lack of an established working definition of tertiary trauma in counseling and a gap in the literature exploring counselor supervisors' perceptions, the current focused primarily on the status of vicarious trauma among counselors. Literature over the past twenty years had become saturated with the exploration of vicarious trauma and the many ways the phenomenon effected counselors and student counselors. Much of the literature revolved around understanding the parallel process of transference between

client and counselor of lived experiences and the role counseling supervision plays in the reduction of vicarious trauma.

Trippany, et al., (2004) outlined the growth of professional knowledge related to vicarious trauma prior to 1990, stating it was believed counselors simply experienced countertransference during clinical sessions. While noted countertransference may coincide with vicarious trauma, vicarious trauma has specific traits divergent to countertransference, burnout, or compassion fatigue. Vicarious trauma on its own does not occur due to emotional reactivity to a particular client as seen with countertransference and does not involve burnout from the everyday expectations of maintaining paperwork and or high caseloads. Vicarious trauma is a phenomenon that seeps into the collective thought process of the counselor. Counselors who work individually with clients who have experienced trauma are at a higher risk of experiencing vicarious trauma (Knight, 2010, Trippany, et al., 2004). On a personal level, vicarious trauma can affect the counselor's feelings of trust, perceptions of control, intimacy. Esteem needs, safety concerns, and intrusive imagery that is distinct from burnout, compassion fatigue, and countertransference are other areas affected (Trippany, et al., 2004). It is imperative to explore the research establishing vicarious trauma because it provides a foundational perspective on what counselors and counseling supervisors alike might experience when living trauma experiences associated with the profession.

Rasmussen (2005) addressed the intersubjective perspective on vicarious trauma through the intersubjectivity theory lens, attempting to develop a metatheoretical

framework to provide greater understanding of vicarious trauma and its implication for clinical practices. Rasmussen (2005) considered vicarious trauma an occupational hazard. Rasmussen (2005) argued the majority of individuals who seek out counseling have indeed experienced trauma. Rasmussen (2005) then suggested that if every person has experienced trauma, then vicarious trauma is a potential risk for all counselors. Utilizing a metatheoretical framework, Rasmussen (2005) evaluated two therapist examples qualitatively which explored vicarious trauma as lived by the counselor participants. Applying the intersubjectivity theory Rasmussen (2005) each scenario breaking down the importance of understanding the '*home of trauma'* rooted in the unconscious (Stolorow & Atwood, 1992). Each counselor reported feelings of burnout and compassion fatigue, however did not clearly identify experiences of trauma until seeking out supervision. Rasumessen (2005) identified similarly to Stolorow and Atwood (1992) that a trauma was a relationally contextual experience, not easily identifiable until placed into a meaningful context to the individuals lived experience. Stolorow and Atwood (1992) believed this was the cause for lasting trauma symptoms because an individual may live with trauma symptoms for years without clearly understanding he, or she had a traumatic experience. Rasmussen (2005) stated this similarly could occur in counselors as counselors are focused on helping the client and often overlook their internal thoughts and feelings for a variety of reasons. Rasmussens (2005) research was small, looking at only two counselor examples, and did not go into extensive exploration of the intersubjectivity theory application to addressing vicarious trauma. However, the article did stress, similar to that of Trippany, et al., (2004), the importance of supervision.

Trippany, et al., (2004) outlined that peer supervision allowed the counselor an opportunity to express the struggle, frustrations, and emotions tied to trauma based cases. Peer supervision provided an outlet and prevented the counselor from internalizing trauma-related emotions. Rasmussen (2005) emphasized the importance of counselor supervision as a way for the counselor to identify vicarious trauma experiences as it is often internalized and stored within the counselors' unconscious.

Way, et al., (2007) assessed the impact of vicarious trauma on clinicians who provided sexual abuse treatment to the client. The purpose of the study was to expand the knowledge of potential predictors in establishing who might be at a higher risk of experiencing vicarious trauma. Specifically the researchers were aimed at addressing the question of if gender, age, and childhood maltreatment history could be predictors of disrupted cognitions related to self-esteem and self-intimacy, to main areas affected when experiencing vicarious trauma. The researchers developed a quantitative research design to determine if a predisposition to vicarious trauma exists. The sample size was considerable (N=383) with male (n=150) and female clinicians (n=233). All participants recruited, came through professional organizations that specialized in the treatment of sexual abuse. Way, et al., (2007) reported the average age of participation was 46, and clinician ages ranged from 25 to 82 years, and 73% of participants were 41 years of age or older. Demographic forms completed first; participants completed an anonymous survey which included closed-ended questions. Standardized instruments such as a traumatic stress institute belief scale were utilized to gather further data. Way, et al., (2007) concluded that 76% of the participants had reported a history of at least one form

of childhood maltreatment. These forms of maltreatment included but were not limited to sexual abuse, physical abuse, emotional abuse, and emotional neglect. Self-reports identified a higher rate of female clinicians reporting an experience of child sexual abuse then male clinicians. However, an indication of how this affected self-esteem and self-intimacy cognitive distortions varied with significant changes in female clinicians but minimal changes with male clinicians. The authors were able to identify the limitations of the study. One limitation was the limit of participant recruitment to only two professional organizations. The second limitation was that the survey did not address whether participants had any type of treatment to address past childhood trauma. The study did identify an existence of differences in cognitive distortions among genders dealing with vicarious trauma. However, many factors were not addressed, such as the age difference among participants. Most male participants reported being over the age of 40 and had at least ten years' experience working as a counselor. Compared to many of the female participants who were younger with fewer years working in the profession, a large age gap existed. The study supports the understanding of the impact vicarious trauma has on counselors' and how variables play a factor in the progression or prevention of vicarious trauma. These variables include education about the topic and symptom prevention (Way, et al., 2007).

Adams and Riggs (2008) and Knight (2010) conducted exploratory studies of vicarious trauma in a 'professionally younger' generation of counselors. Both studies explored the manifestation and impact of vicarious trauma in graduate students completing practicum and internships. Adams and Riggs (2008) administered the Trauma

Symptom Inventory, Defense Style questionnaire, and an experience questionnaire to 129 graduate students in a graduate clinical and counseling psychology program. All students were master and doctoral level students completing internships to meet core course requirements for graduation over the span of four universities. Developed were two goals for the research (a) examine the relationship between vicarious trauma and counselor trainees and (b) explore the relationship between defense style and vicarious trauma. Focusing on defense style mechanisms, Adams and Riggs (2008) believed this knowledge could be an indicator as to who may be prone to experiencing vicarious trauma. Adams and Riggs (2008) research supported similar outcomes of what Way, et al., (2007) summarized. Similar results of what Way, et al., (2007) found, a third of participants reported their own experienced with child maltreatment. However, Adams and Riggs (2008) did not believe this played a large factor into the potential of vicarious trauma for counseling trainees as it was brought up and addressed during course work and supervision. Experience level and trauma-specific training, on the other hand, were significant variables in being more vulnerable to vicarious traumatization. Individuals in the early stages of an internship appeared to be more receptive to countertransference and more preoccupied with his or her achievement in graduation then direct care of the client. Adams and Riggs (2008) also stated supervision differed considerably with each program and from semester to semester depending on the student, the supervisor, and the university which could have skewed results. The results were limited to four universities and the authors identified the need for a more broad study. However results were consistent with showing students who showed less vicarious traumatization while in an

internship were those who recognized proactive faculty. Faculty identified as proactive, engaged in providing supervision allowing them to case consult, discuss their challenges, and vent frustrations (Adams & Riggs, 2010).

Knight (2010) provided similar results in the study that addressed indirect trauma of practicum students in an undergraduate social work program. Knight (2010) expanded her study by not only assessing the level of vicarious trauma among the graduate students (*n=81*) but by also administering the questionnaire to field instructors (*n*=72) overseeing practicums. Two instruments were utilized to gather statistical data, the *Professional Quality-of-life Scale (ProQOL)* and the *Trauma and Attachment Believe Scale (TABS).* Each participant received a research pack and was provided approximately three weeks to complete the assessments and return to the researcher. The results of the study indicated that all students and field instructors showed some adverse reactions associated with their work with clients according to the ProQOL and TABS assessments. When compared to previous research Knight (2010), stated participants ProQOL scores were slightly higher than professionals working in the profession. Knight (2010) addressed the way students reported reducing feelings of trauma and strain was talking about their feelings and occurrences to field instructors. Knight (2010) indicated that the faculty serving as practicum field instructors also experienced a level of vicarious trauma secondary to the trauma his or her supervisees experienced throughout the program. The majority of faculty participants stated they talked with colleagues frequently about their feelings regarding burnout, compassion fatigue, and transferences in regards to students. However, this was one of the first indications that the supervisor might experience a level

of trauma in regards to providing supervision to those working directly with clients. The Study was not without limitations. Participants were all from one university, and a more generalizable study would be more consistent in providing an accurate description of vicarious trauma in students and potentially their field placement instructors (Knight, 2010). The study did place the foundational thought that trauma does not become stagnant in vicarious form and might continue movement onward to other professionals no directly working with a client.

Recent studies by Cohen and Collens (2013), Jordan (2010), and Tosone, et al., (2012) continued the illustration of vicarious trauma and the impact it has on counselors. Jordan (2010) addressed the continued need to assess the number of trauma-based clients a counselor sees. Jordan (2010) saw several factors as ways to reduce and prevent vicarious trauma. These factors included the personal history of trauma, professional trauma, and perception of adequate training, supervision, consultation, availability of social support, self-care plan, resilience, and stress buffers. Each aspect is vital to addressing the severity of vicarious trauma. Jordan (2010) stressed the availability of social support, supervision, consultation, and adequate training as the three primary ways to prevent vicarious trauma among counselors. Toson, et al., (2012) continued the emphasis on understanding the worldview of the counselor as a means to reduce vicarious trauma, merging the way professional variables may increase the risk of vicarious trauma. Not directly associated with vicarious trauma, Toson, et al., (2012) imply the stress of large client caseloads and being overwhelmed with professional demands as triggers to the unconscious trauma. The unconscious trauma causes vicarious

trauma symptoms to increase and become more detrimental. Cohen and Collens (2013) utilized a metasynthesis of findings from previous qualitative articles. Their conclusion was that the vicarious trauma while trying for counselors to experience could also create active vicarious posttraumatic growth by encouraging counselors to make changes in their self-care plan. A large factor in what Cohen and Collens (2013) discussed was the counselors' ability to seek out supervision assisting him or her in the identification and recognition of vicarious trauma.

Theories Supporting Vicarious Trauma

Psychoanalytic Theory and Intersubjective Metatheory

Rasmussen (2005) outlined intersubjective perspective as a stable metatheoretical framework for vicarious trauma. Psychoanalytic theory presented as the foundation; intersubjective perspectives ground the framework to consider psychological development and therapeutic process in terms of relation to each other. Of particular focus are the parallels that exist between self-psychology and relational theories (Aron, 1996). Rasmussen (2005) outlined the intersubjective work of therapy as being focused on the subjective world of the observer and the observed, often relating this to the counselor and the client. A metatheory, intersubjective theory is a branch of psychoanalytic practice that outlines therapeutic actions (Aron, 1996; Rasmussen, 2005). Often considered more radical in perceptive, intersubjective theory identifies the organization of experience as rooted in one's view to her or his experience. These intersubjective experiences include what Rasmussen (2005) deemed as patterns of

personality and pathology, that develop within and have an interplay with how one reacts to his or her environment and interactions.

The theory was also formulated to identify the impact of the three realms associated with the unconscious. These realms include the prereflective unconscious which constructs and develops the subjective interpretations of experiences. The dynamic unconscious is where memories of the experience that were threatening are tied to non-lethal memories and sequestered away. And the unvalidated unconscious maintains events, emotions and other memories when not acknowledged by the individual (Stolorow & Atwood, 1992). Rasmussen (2005) suggested each area of the unconscious holds significance in understanding ones' reaction to trauma, making the experience real and valid if effort is needed to try and ignore the experience.

Intersubjective theory suggested vicarious trauma existed in the unvalidated unconscious, often leaving the counselor unaware of the impact his or her experience from client interactions. Through the active process of countertransference, the counselor has an adequate, ideational and physical response to the client and unconsciously begins to attempt to address the effects, intrapsychic conflicts, and associations related to trauma. These defenses, when looked at through the intersubjective lens, are when vicarious trauma symptoms appear. Counselors find themselves exhausted, physically affected, and disinterested in their professional field (Rasmussen, 2005; Stolorow & Atwood, 1992).

The definition of vicarious trauma provided the framework and foundation to understand the manifestation and effects doing trauma work may have on counselors

(Adams & Riggs, 2008; Jordan 2010). These frameworks in turn supported the definition of tertiary trauma, and the manifestation and effects trauma may have on counselor supervisors (Knight, 2010). Studies have shown correlations between counselors and counselor supervisors do exist in experiences. It was assumed that as counselors experience feelings similar to those of clients, then counselor supervisors experience feelings similar to those they supervise. One of the ways to reduce vicarious trauma symptomology in a counseling session was to seek out supervision (Cohen & Collens, 2013). Statistically significant results from well-designed studies have grown over the past ten years (Adam & Riggs, 2008; Jordan, 2010; Rasmussen, 2005; Tosone, et al., 2012). The studies provided an outline to the effects of vicarious trauma on counselors and the impact the phenomena has on direct client services (Jordan 2010; Knight, 2010). These studies addressed the importance of counselor wellness, awareness of one's feelings, and seeing our collaborative consultation and supervision to prevent vicarious trauma impact (Cohen & Collens, 2013; Knight, 2010). Some studies have suggested a potential for counseling supervisors to be affected in a similar phenomenon as vicarious trauma (Knight, 2010). No studies found in the literature search addressed the perceptions of counseling supervisors and how they perceive the impact and manifestations of tertiary trauma.

Vicarious Trauma to Tertiary Trauma

With the lack of exploration of tertiary trauma in the field of counseling, extracted from other professions on how tertiary trauma in counseling supervisors applied were a parallel of facts. Adams and Riggs (2008) outlined vicarious trauma often goes unnoticed

until the individual seeks out consultation, supervision or assessment at which point the supervisor or assessment identify the development of vicarious trauma symptoms. Consultation, supervision or assessment assist in the identification often due to the signs of symptoms associated with vicarious trauma such as compassion fatigue or burnout. While compassion fatigue and burnout can be standalone experiences from vicarious trauma, each can be reliable indicators that an individual is experiencing trauma-related to direct work with clients. Bride, et al., (2007) reported individuals with compassion fatigue report a sense of not caring about his or her profession anymore. Counselors struggle to find a sense of empathy for the clients he or she works with, and over all carries an "I don't care" attitude towards those around him or her. Adams and Riggs (2009) on the other hand stated burnout has a link with agency tasks that have nothing to do with direct client interactions such as being overwhelmed by paperwork or an enormous case load. Burnout was an overwhelming sense of not wanting to go into work, having no pleasure in the profession the individual works and an underwhelming sense of achievement. Factors that Adams and Riggs (2008) astutely linked to symptoms manifested with vicarious trauma, as those who have experienced vicarious trauma often report a feeling of burnout as well. It was also stated throughout the literature that vicarious trauma is cumulative in nature, often taking time to manifest and show symptoms (Adams & Riggs, 2008; Knight, 2010).

Vicarious trauma could be linked similarly to what the medical profession calls indirect trauma. The counselor is experiencing the trauma of the client through discussion; however the counselor is not having a direct trauma experience. The visibility

of trauma symptoms is reduced in the counselor when associated with vicarious trauma similar to indirect trauma in the medical field. However it was known that trauma symptoms are a potential and continued to be observed to help reduce traumatization in the counselor through active means such as receiving supervision (Knight, 2010; Way, et al., 2007). The counseling profession over the past 20 years had developed the terminology of vicarious trauma. The terminology has outlined the effects vicarious trauma has on the counselor starting with the initial discussion that counselors were experiencing indirect trauma (Knight, 2010; Tosone et al., 2012). While not a direct link to the medical profession, it did indicate a shared definition of indirect trauma. The definition suggested some symptomology is harder to identify due to it not being a direct trauma experience (Hodgson, et al., 2000; Tosone et al., 2012).

The medical profession defined tertiary trauma in a similar way as a cumulative process, not manifesting symptoms until days, weeks, or even months after the event has occurred. Symptoms were severe when they begin to show. The question of treatment comes into play on how to prevent long lasting damage (Biffl, et al., 2003; Hodgson, et al., 2000). However, tertiary trauma was not direct trauma or indirect trauma, and often went unnoticed much longer than either. Stolorow and Atwood (1992) discussed the parallel process of supervision as both an upward and a downward movement. In the upward movement, the client consults with the counselor about his or her current dilemma, and as the counselor meets obstacles in assisting the client then the upward movement continues to the counseling supervisor. Case consultations between the counselor and the counselor supervisor then occur, where the supervisory process begins

a downward parallel process. The counseling supervisor assists the counselor in developing the means needed to help the client. Stolorow and Atwood (1992) stated this could be considered a movement of supervision from client to counseling supervisor, with the counselor being the middle person or the transmitter of information. Placing the parallel process in overview of the trauma in the medical field, we could possible see the movement of trauma stages. From direct trauma having visible signs of symptomology to indirect trauma having fewer signs of symptomology; tertiary trauma has almost minimal signs of symptomology but still severely impacts the individual (Patil & Patil, 2014). In counseling, could this overview be placed in a similar fashion exploring the direct trauma which the client experienced? Showing the movement of indirect or vicarious trauma within the counselor working with the client, to certify tertiary trauma in counseling supervisors? With the expanding growth of predictors in medical science of tertiary trauma, it made sense for the counseling profession to explore the state of tertiary trauma as it related to counseling.

Summary

Found were two common themes throughout previous research into the phenomenon of vicarious trauma. One of those themes was, to the extent that all counselors have the potential of experiencing vicarious trauma throughout their professional life. Variables such as age, gender, and educational background were factors that increased or decreased the risk of vicarious trauma (Adams & Riggs, 2008; Knight, 2010; Way, et al., 2007). The variables indicated the potential for any counselor to experience vicarious trauma is in existence. The second theme found throughout the bulk

of the literature on vicarious trauma was the means to help reduce and prevent vicarious trauma. Supervision is an active response to not only the reduction of vicarious trauma, but for the initial identification that vicarious trauma is occurring (Rasmussen, 2005; Trippany, et al., 2004). The counseling supervisor plays a significant role in helping the counselor supervised to identify and address vicarious trauma.

Vicarious trauma is a lived experience for counselors who work directly with clients who have experienced trauma. As a lived experience, Trippany, et al., (2004) identified the trauma becomes as real for the counselor as it was for the client and affects the entire being of the counselor. Areas such as trust, intimacy, esteem and interpersonal skills are a few but not all of the areas that the vicarious trauma can affect in the counselor (Trippany, et al., 2004). Knight (2010) along with Adams and Riggs (2008) showed vicarious trauma can begin early in the counseling process. Starting in the stages of practicum and internship, vicarious trauma could affect licensed counselors and counselor trainees alike. How trauma sufficiently affects counseling supervisors and how vicarious trauma transitions into tertiary trauma during the supervisory process establishing meaning in the counseling supervisors life needed further exploration. Minimally explored was tertiary trauma in the counseling profession and how to ascertain its experience among counseling supervisors. The past study aimed to fill this gap in the literature by exploring counseling supervisors' perceptions of tertiary trauma and define the parameters of the phenomenon in counseling supervision. This expansion of the literature provided a foundational working definition of vicarious trauma, providing an

opportunity for future research to enhance counselor supervisor training and education further on supervisory wellness.

Chapter 3 outlines the research methodology of the study. Provided is the rationale for the use of a hermeneutical phenomenological design, along with the outline of the research design restating research questions. The role of the researcher is explicitly discussed providing limitations on any researcher biases and ethical issues associated with the proposed study. The methodology outlined by Kreuger and Casey (2000) is discussed identifying the population of interest, sampling strategy, specific procedures for data collection and review, as well as the data analysis plans. Finally, issues of trustworthiness are identified and addressed providing a concise summary

Chapter 3: Research Method

Introduction

The purpose of the proposed qualitative study was to explore counselor supervisors' perceptions of tertiary trauma. The goal was to assist the counseling profession in understanding the phenomenon of tertiary trauma and the needs of counseling supervisors. To build a working definition of tertiary trauma will develop the opportunity for future research such as, the supervisory wellness of counseling supervisors. A working definition also strengthens the understanding of how counselor wellness transitions through the supervision process from counseling supervisor to counseling student. The goal of the qualitative study was to strengthen the understanding of how counseling supervisors perceive tertiary trauma and to provide an evidence base for counseling supervisor wellness.

Organization of Chapter

Chapter 3 outlines the research design and rationale for the chosen tradition. The role of the researcher was discussed, outlining any researcher biases and ethical considerations. Methodology is discussed, describing participant recruitment, data collection, and data analysis. Trustworthiness, including the ethical protection of participants, is assessed. Finally, a summary is provided to give an overview of the main points of the transition to Chapter 4.

Research Design and Rationale

Primary Research Question:

What is the phenomenon of tertiary trauma for counseling supervisors?

Sub-questions:

How do counseling supervisors describe tertiary trauma?

How do counseling supervisors identify the manifestation of tertiary trauma?

Understanding counseling supervisor perceptions of tertiary trauma and the effects could impact future counseling supervisory practice. It was possible that some counselor supervisors may perceive tertiary trauma as harmful while others may have no perception of tertiary trauma. Understanding the perception of tertiary trauma from the counseling supervisor point of view did contribute to a scant body of knowledge and potentially facilitate future research examining tertiary trauma in relation to the field of professional counseling.

Central Concepts of the Study

The purpose of this hermeneutical phenomenological study was to explore the perceptions of counseling supervisors lived experiences of tertiary trauma. Tertiary trauma was approached as a phenomenon with similarities to vicarious trauma. Loosely defined, tertiary trauma is a phenomenon resulting from counseling supervisors' direct experience providing supervision to counselors and counselor trainees providing direct trauma treatment to clients. Parallels from vicarious trauma did show tertiary trauma may include compassion fatigue, dissatisfaction in life, and burnout (Adams & Riggs, 2008; Knight, 2010; Trippany, et al., 2004).

Research Tradition

Qualitative research is inherently suited to studies that seek to understand the textual interpretation of lived experiences from the participants' point of view. Moreover,

hermeneutical phenomenological was suited to building a working definition of tertiary trauma through the lived experiences of counseling supervisors. Phenomenology remains as close as possible to the original qualities of experience through the textual meanings give through reflective descriptions provided by those living the phenomenon (Moustakas, 1994). The focus of the approach is to keep the phenomenon alive, and illustrate any underlying meanings which demonstrate the experience lived by participants (Moustakas, 1994).

Qualitative research was the approach that allowed for an understanding unique to the counseling supervisors' point of view, making it best suited for studies building an inquiry about perception (Langdridge, 2007; Thompson 1997). For example, researchers might ask participants whether a phenomenon perceived was detrimental or whether there were any unexpected effects from particular aspects. Qualitative research allowed for a smaller focus sample in order to understand human behavior through saturation of participant responses. This in-depth information provided an opportunity for the research to collect thick descriptions of the phenomena under study.

Hermeneutical phenomenology more specifically allowed the opportunity for the study to grow and expand as data identified becomes apparent in conceptual themes. Opportunities within the Hermeneutical approach allowed new questions to be developed and for the research to be an expanding document of the participants lived experience of the phenomenon (Thompson 1997). Textural interpretation and meaning of the dialogue was a core focus of hermeneutical framework in phenomenological research (Langdridge, 2007; Thompson 1997). The nature of phenomenology was the exploration of

understanding the lived experience. Working from the core assumptions, hermeneutic phenomenology created a framework, building a working definition of tertiary trauma based on the counseling supervisors perception of lived experiences those lived experience each share through dialogue.

Phenomenology studies an experience or phenomenon that the researcher was interested in and serves to demonstrate an enriched and consistent description of the experience as lived by the counseling supervisor. Hermeneutical phenomenology made sense when addressing the question of how an individual perceived tertiary trauma. The goal of this study was to understand participant's subjective assessment of the phenomenon and how they perceive the experience (Landridge, 2007; Thompson, 1997). The study was well-suited to a hermeneutical design due to my goal of developing a working definition of tertiary trauma that might be present among counseling supervisors. While other designs such as a case study, grounded theory, or practitioner research could provide valuable insight, hermeneutical phenomenology was chosen due to focus on understanding participants' lived experiences and perceptions of tertiary trauma. A case study design would have been more appropriate if the research were trying to illustrate the role tertiary trauma has in particular supervision styles. Grounded theory would be appropriate if the aim of the study were to address counseling supervisor wellness and how counseling supervisors' attempted to resolve tertiary trauma (Giorgi, 2008).

Role of the Researcher

Acting in the role of the researcher, I acted as a reductionist, reducing data gathered into common themes and meaningful units. I translated the lived experiences of

counseling supervisors into a presentable dialogue to present the findings (Giorgi, 2008). Moustakas (1994) observed that to act as a reductionist, as the researcher, I must be willing to listen with a conscious and deliberate intention of learning about the phenomenon from the participants' perspectives.

As primary researcher, I entered this study with prior experience with the settings that many of the participants were from and as someone who was known to many of the potential participants. Any individual wishing to participate in the study who may have served in as my counseling supervisor was excluded from the study to help eliminate any dual relationships and biases. Throughout the study, I fulfilled the role of data gatherer, reductionist, and observer of participants' reactions and responses to questions regarding tertiary trauma. I did not provide counseling or therapy services to participants, but did conduct individual research interviews with the participants in order to record observations.

I brought with me my biases about what I assumed tertiary trauma was and how to identify the phenomenon. These assumptions existed based on my own experiences as a graduate intern and supervisee, working with counseling supervisors. I kept a record in a researcher's journal of any reflections and responses that I had personally to the study and the participants' experience. This journal served as a checkpoint for monitoring my biases and assumptions, through the comparison of what I recorded prior to collecting data, during data collection, and data outcomes. These comparisons and assumptions were in the final findings of the research.

Methodology

Population

The research population was counseling supervisors who provide clinical supervision, licensure supervision, or both to counselors or counselor trainees working in the specialization of trauma treatment. Counseling Supervisors had been licensed for a minimum of two years as a Licensed Professional Counselor (LPC) and had met the state requirements to provide supervision. Oklahoma supervisors met the qualifications for inclusion in the study by holding an LPC-S (Licensed Professional Counselor Supervisor) credential which outlined that he or she completed required supervisor training and have practiced as a counselor for two years beyond initial licensure. Missouri supervisors met the qualifications for inclusion in the study by holding an LPC license and having practiced for a minimum of two years prior to providing supervision.

Procedures for Recruitment

Sampling was purposive, making sure participants were representative of various counseling atmospheres that provide supervision, including larger state agencies and private practices. Utilizing supervision databases provided by the Oklahoma and Missouri state licensure boards, phone calls and emails were methods I used to recruit supervisors into the study. I contacted potential participants via email. The second wave of recruitment included phone calls. Each potential participant was provided an outline of the study.

Participants were narrowed down based on two qualifications. The first qualifier was that they were currently providing supervision to counselors, counselor trainees, or

both. The second qualifier for the study was that the counseling supervisor was providing supervision to those who are working in the specialization of trauma-based treatments. Adams and Riggs (2008) argued that all counselors work in the area of trauma-based treatments as trauma may be defined differently for each client. However, for inclusion into the study, counseling supervisors had to be providing supervision to counselors, counselor trainees, or both who provided a minimum of 20 hours per week of trauma-based services. 20 hours per week of direct client services met the Oklahoma state requirements to receive supervision for licensure, and would act as a guide that determined the minimum number of hour's practiced in trauma-focused treatment. Further determination that services being provided are trauma-focused was based on the site within which participants' were working, which had trauma-focused treatment programs. Trauma-focused treatment programs were any treatment program that had the intent or focus of treating trauma in clients and crafting treatment plans to meet clients past trauma history.

An initial screening was conducted via the phone asking the potential participant if he or she was actively conducting supervision. The interview included asking what environment (i.e. agency or private practice) the supervision was conducted at, and what area of specialization those being supervised practiced.

Exclusion from participation was based on several factors. Individuals licensed as counseling supervisors but not providing current, active supervision did not qualify for the study. Individuals providing supervision, but not to counseling supervisees in a trauma-informed treatment program also did not meet the requirements for inclusion in

the study. A minimum of 11 participants participated; however participants continued to be recruited for inclusion in the study until data saturation was reached and an enriched textual meaning of participants' experiences was seen. I was the only individual who had access to the subjects' identities in order to maintain contact with participants for the two part interview process. The dissertation committee had access to individual transcripts and recordings of the participants that were de-identified for review. I had access to the subjects' identities in order to pair the participants' responses from the first interview with those of the second interview.

Instrumentation

Participants of the research completed two interviews I conducted over the course of the research project. Each interview lasted approximately an hour and a half in length and consisted of answering questions regarding the participants experience and understanding of tertiary trauma. The second interview was conducted after the initial data was compiled, and common themes identified. Participants were provided with an initial summary of findings and the opportunity to clarify points of interests as they saw necessary. This opportunity also allowed me to ask any additional questions that grew from the initial compilation of interview transcripts.

Consent Process

I sought informed consent from all potential study participants for participation in the qualitative study. Consent occurred during the initial screening for inclusion in the study. The informed consent provided an overview and outline of the study, as well as an estimated time frame for the study. Participants' rights to withdraw from the study at any

time were outlined. I also provided resources to the participant if he or she felt the need to increase his or her self-care through counseling services.

Organization of the Interview

Interviews were at the location of convenience to the participant. All interviews were conducted in person as I used a researcher's journal to document any observations in order to reduce my bias, which is discussed further in the chapter.

Introduction to the Interview

At the beginning of each interview session, I provided information about the goals and objectives of the study. I reminded participants that each interview would last roughly and hour to an hour and a half. All interviews and instrumentation used were in accordance with the Krueger method as outlined by Krueger and Casey (2000). Recorded by a digital recorder for posterity, interviews then went through the transcription process into an electronic document. Participants were provided a release to sign providing me with permission to audio tape the interview, with the understanding the audiotape would be heard only by me and my dissertation committee. Kept on an external drive, that was password encrypted to ensure confidentiality, was all audio recordings and digital transcripts.

During the first interview, I asked the same questions to all participants allowing them to expand and provide information he or she felt pertinent to the question (see Appendix B). The questions did expand the knowledge of what was known by counseling supervisors of vicarious trauma in counselors and counselor trainees that created a baseline discussion of trauma in counseling professions. The second half of the interview

transitioned participants into defining how trauma in counseling supervisors existed and any lived experiences with tertiary trauma they may have had. Questions were added to the interview protocol as themes begin to emerge through the transcription process. Allowing for the inclusion of additional questions was meant to enrich the textual meaning of emerging themes and push the data collection process towards saturation.

Audio recordings were transcribed through the long table method, allowing me to hand type each interview. Commonalities among the interviews were identified, highlighted through Microsoft Word, and coded to identify textual themes. A written summary of findings from the initial interview outlined identified themes. At this time, I contacted participants to schedule a second interview (Krueger & Casey, 2000). The initial findings from the first interview guided the creation of questions for the second interviews. The goal of the second interview was to expand on the initial data and to increase the validity through triangulation with participants to obtain and enriched and saturated perspectives of tertiary trauma from the counseling supervisors' viewpoint. Participants were provided with a copy of the initial summary prior to the second interview to allow him or her time to review the document.

During the second interview, I allowed the participants to expand or clarify any topic in the findings that they find important. I reminded all participants of their rights as a participant in the study, including his or her right to withdraw if desired. I provided participants with an additional consent form which acknowledges the audio recording of the second interview and the purpose of the meeting to expand already gathered data. After participants provided additional information they choose to on the topic of the

study, I asked further questions which developed from reviewing the initial interview transcripts.

The analysis of the data from the second interview remained consistent with the first set of interviews, where I used a long table method. Frequent statements were identified, highlighted and coded from the audio recordings converted to digital transcripts. The findings were added to the initial summary of the first interviews. The researcher then included the observations, assumptions, and biases documented in the researcher's journal throughout the research period.

Developed Instruments

Past studies on vicarious trauma utilize instrumental methods such as the ProQOL (Stamm, 2010). The instrument has a historical background of gathering information regarding the phenomenon lived by counselors and other helping professionals (Adams & Riggs, 2008; Rasmussen, 2005; Way, et al., 2007). Better suited to a hermeneutical phenomenological framework, Giorgi (2008) and Langdridge (2007) identify the use of interview questions as a means to gather information focused on the topic of the research. Because of a lack of research found in the discussed literature search strategies, I was unable to find an instrument developed specific to the topic of tertiary trauma. Furthermore, Langdridge (2007) outlined the use of in-person interviews as a way to allow the breath and growth of qualitative research, providing an opportunity for new questions to develop based on previous answers of participants.

Content validity was established through triangulation as identified by Krueger and Casey (2000). Interview questions were revised and crafted to be more focused on

the research topic in order to strengthen the data outcomes after the completion of initial interviews being converted into transcripts and going through the review process. Interviewed for the second time, I asked participants the revised and additional questions. The second interview provided participants an opportunity to express their experience acting as participants' and their view of the study in order to strength the content validity (Krueger & Casey, 2000).

Procedures for Data Collection

I collected data from 11 counseling supervisors over the course of the study. I acted as the primary data collector, conducting each interview, transcribing interviews into digital transcriptions, and completing all cutting, highlighting, and coding of common themes. Data collection happened in a twofold process with two individual interviews with each participant. Each interview lasted roughly an hour and a half. Data was recorded on a digital audio recorder until it could be transcribed digitally at a later date. All records, audio and transcriptions, were maintained on an external hard drive that was password encrypted to ensure safety of records. Recruitment of participants was an open recruitment allowing a continuous opportunity for participants to join the study until data saturation occurred. At the end of the second interview, participants were offered the opportunity to have the results of the study shared with them electronically if they would like. I debriefed participants on the full scope of the study and what future studies I hoped to see develop. Resources for wellness techniques were provided to all participants.

Data Analysis Plan

Data was collected and analyzed in a consistent handling of that outlined in the Kreuger long table method (Kreuger & Casey, 2000). I transcribed all digital audio recordings into a digital transcription format for easier coding and identification of themes. Utilizing Nvivo 10 software, transcripts were compared and analyzed for common themes being highlighted and cut for coding. When identifying a theme, Manen (1990) outlined that a thematic analysis should consist of identifying any element that occurs frequently the transcriptions among participants. I developed inductive coding related to the topic as I analyzed the data that allowed me to identify stable descriptive meanings. The coding process was helpful in identifying the experience of focus and meaning (Manen, 1990). All data was considered vital, and not discrepant in relation to the study.

Issues of Trustworthiness

Credibility

Two methods were used to strengthen the credibility of the study. The first method which was vital to the health of qualitative research according to Langdridge (2007) was the movement of data towards the level of saturation. In order to achieve saturation, it was imperative to all of continuous recruitment of participants until new themes and codes were no longer able to be established from the data collected. Secondary to saturation, I used triangulation in order to seek clarity and further saturation by participants. The initial summary of data results was presented to each of the participants prior to his or her second interview. Each participant was asked to review the

initial results and given the opportunity to expand on any answer given during the first interview. Participants could also provide clarification to any misunderstandings identified at this time (Kreuger & Casey, 2000). I maintained a researcher's journal in order to record observations for the study in order to help strengthen triangulation measures (Shenton, 2004).

Transferability

Transferability was increased through the variation in participant selection, providing an overview of counseling supervisors who work in various settings providing supervision. Shenton (2004) stated that all data supports contextual analysis. Data included inconsistencies, contradictions, and biases in order to build a thick description of the data outcome that described the working definition of tertiary trauma.

Dependability

Addressing dependability, it was vital to outline the processes of the study in detail, enabling future researchers the opportunity to repeat the body of work if he or she desires to. Through chapter 4, the research design and its implementation will be discussed in minute detail along with what executed. The operational detail of data gathering, as well as the reflective appraisal of the research outcome, will be outlined. The comprehensive outline will provide an evaluation of the effectiveness of the qualitative inquiry and potential areas of future research (Shenton, 2004).

Confirmability

Triangulation was used to increase confirmability by reducing researcher bias that I may have and enriching the data with participants' perspectives (Shenton, 2004). A

review of initial interview findings by participants prior to their second interview will support this task. To help the reader further understand how far the data and constructs of the research go, a detailed methodological description in chapter 4 will provide an audit trail. The audit trail allowed the reader to trace step-by-step decisions made throughout the entire study (Shenton, 2004; Giorgi, 2008). In addition, I reviewed transcripts and emergent assertions in the data analysis with my methodologist.

Intracoder Reliability

In order to address intracoder reliability and provide consistency of judgment within the coding process over time, a researcher's journal was utilized. This journal did document my experience throughout the study, including assumptions, biases, mood, and carefulness in obtaining data and coding it (Giorgi, 2008).

Ethical Procedures

Recruitment occurred through the Oklahoma and Missouri state board of licensed counselors. Through the use of supervision databases provided by the state licensure boards, supervisors were given an outline of the study and asked to participate. I provided informed consent to each potential research participant, outlining the focus of the study to understand the perceptions counseling supervisors have regarding tertiary trauma in order to build a working definition. Each informed consent provided the research participants with my contact information, approval from the IRB at Walden University, and the time frame of the study so all participants were aware of time participation requirements. The inclusion of the informed consent outlined participants' option to withdraw from the study at any time with no repercussions. Informed consent was a two-page typed

document providing the complete overview of the study to participants. I provided an informed consent to potential participants prior to the first interview. A signed copy of the informed consent remained in the participant's file. A signed copy was also provided to the participant for his or her keeping.

Knight (2010) identified many counselors do not know he or she is experiencing vicarious trauma until he or she begins to talk about his or her lived experiences with other counseling professionals. An assumption that counseling supervisors experience a parallel process to counselors when experiencing tertiary trauma exists. With this assumption in place, a benefit to the research program was the potential awareness of experience and symptoms related to tertiary trauma. This awareness could lead counseling supervisors to be more aware of their wellness approaches to supervision and a heightened awareness of self-care.

The risks to subjects were reasonable in relation to the anticipated benefits to participants because of the awareness tertiary trauma manifestations. Knight (2010) stated it might be difficult for individuals formerly to acknowledge feelings and symptoms related to trauma as a helping professional. However as individuals' began to maneuver through the difficulty of discussing these feelings an awareness of self-care developed along with a self-care plan.

Data was confidential and was only be reviewed by myself and the dissertation committee as needed. I maintained the contact information for each participant associated with the initial interviews in order to complete secondary interviews after I summarized preliminary findings. I stored all digital audio recordings and digital transcripts on an

external hard drive which is password encrypted. I maintained the password for the external hard drive.

Initial findings of the research outcomes were presented to participants for further clarification and to meet the needs of triangulation as outlined by Kreuger and Casey (2000). Following the final clarification from participants, research findings were written in expected format for completion of doctoral dissertation at Walden University. Data was destroyed at the conclusion of the dissertation process. Data was destroyed by deleting all digital records that include audio recordings and digital transcriptions. All paper documents were shredded.

Summary

The research design and rationale for the chosen tradition was foundational in establishing the trustworthiness of qualitative research. In order to greater establish credibility, transferability and dependability I used techniques such as triangulation to strengthen the overall hermeneutical framework. Methodological processes were discussed to provide an outline of data collection and analysis procedures, which will be discussed more thoroughly in chapter 4. Following in chapter 4, a more detailed process of the research study conducted will be provided, giving the reader an opportunity to experience the study in a step-by-step process.

Chapter 4: Results

Introduction

On March 27, 2015, Walden's IRB granted approval (0327150117198) to conduct the study of understanding counselor supervisors' perceptions of tertiary trauma. This qualitative study implemented an explicative model, specifically a hermeneutical phenomenological approach to the understanding of participants' lived experiences. The methodological objectives of the study were a three-fold process: (a) to obtain an initial understating of how counselor supervisors' describe the phenomenon of tertiary trauma, (b) to illustrate how counselor supervisors identify the manifestation of tertiary trauma, and (c) to interpret participants' lived experiences of the tertiary trauma phenomenon through themes inductively extracted and coded from the data.

The primary research question that guided the study was:

What is the phenomenon of tertiary trauma for counselor supervisors?

Two sub-questions supported the primary research question:

(a) How do counselor supervisors describe tertiary trauma?

(b) How do counselor supervisors identify the manifestation of tertiary trauma?

The purpose of Chapter 4 is to report the research outcomes derived from the sample of counseling supervisors interviewed. Chapter 4 is organized in a specific pattern to provide an explanation of the methodological approach used throughout the study. Of particular focus were the details for recruiting participants, screening, interview procedures, sample characteristics, data collection, data analysis, coding procedures, and data protection. A synopsis of the research findings was presented, along with the

identification of the six primary themes that emerged from the data analysis process (See Appendix C; Appendix D). Each of the six themes was independently discussed, categorizing the sub-codes that support the overarching premise. Participant interviews and hermeneutical reflections were brought into a reflective dialogue to sketch a greater picture of the importance of each theme.

The participant interviews provided in-depth, participant-centered accounts of counseling supervisor experiences of tertiary trauma. Imperative to the study was participants building a foundational understanding of tertiary trauma through voicing their experiences and perspectives in their own words. Quotes from the participants' interviews were integrated into the discussion of each theme. The hermeneutical reflection was informed by the participants' lived experiences and my observations while conducting each interview. I present a review of the research questions and the answers concluded from the data. Finally, Chapter 4 identifies the ways in which I upheld the exactitudes of trustworthiness, including areas of (a) credibility, (b) transferability, (c) dependability, (d) and confirmability.

Sampling Method

I recruited prospective participants via two sampling designs during the study: purposive sampling and continuous recruiting of participants. Appropriate for qualitative research, purposive sampling allowed me to seek a more in-depth understanding of the lived experience of tertiary trauma from the counseling supervisors perspective. Phenomenological research sample sizes often remain small and focused on in-depth discussion of the phenomenon of interest. Manen (1990) discussed the drive of having a

small purposeful sample as an opportunity to gain a broader contextual view of the lived experience. To increase the potential of reaching data saturation, I followed the steps of procuring a sample size that Moustakas (1994) outlined, which was a continuous recruiting method until new themes were no longer identified.

To recruit participants for the study, I utilized the information made available to the public at the Oklahoma and Missouri state licensure boards. After seeking approval from both the Oklahoma board of professional counselors and the Missouri board of professional counselors, I accessed the online database of licensed counselors. Using the search features, I was able to filter the database to provide a list of all counselors within the state who were licensed as a licensure supervisor.

Screening Process

To be eligible for participation in the study, participants had to meet the following criteria: Actively providing supervision at either the pre-licensure level or the master's clinical level and have supervisees providing trauma focused treatment to clients. For screening purposes, I spoke with each participant who responded to the email recruitment via the phone. A questionnaire was used to provide a structured outline for me to determine if potential participants met criteria for inclusion (Appendix A). Over a one month period, I created a sample size of 11 participants by completing the recruiting and screening process. I stopped the recruiting process after data saturation was achieved.

Interview Procedures

Interview sites were selected according to the participants' convenience. Participants worked in a variety of private practice and organizational settings that could have influenced participants' experiences at the time of the study. Seven of the participants worked in larger agency settings within the states of Oklahoma and Missouri. One participant identified at the date of the study that she was overseeing a significant expansion that entailed the development of three different programs, which increased her work expectations not only as a counselor, but as a supervisor. Another participant identified his role in working with two separate agencies where he oversaw supervision as both a clinical supervisor and also a pre-licensure supervisor. All seven participants identified the stressors of expectations from his or her employer, including productivity hours, paperwork expectations, and other agency expectations that might fall outside of the role of a clinical counseling supervisor. Participants noted that while meeting at their place of employment was possible to prevent interruptions, several chose to meet at the researchers' office.

Four of the participants interviewed were in private practice settings that allowed for easy interviewing atmospheres. All four participants in private practice identified current changes in state regulations. The changes specifically regarding counseling supervisors providing pre-licensure supervision that I identified as the researcher may have influenced participants' experiences at the time. One participant outlined individuals under supervision for pre-licensure could no longer work in a private practice setting in Oklahoma, but instead had to have employment by an agency accredited by a governing

body. All four participants stated they were still providing pre-licensure supervision; however, they were no longer on site to assist supervisees or physically monitor supervisees' progress.

Sample Characteristics

The sample was comprised of 11 counseling supervisors residing in Oklahoma or Missouri. Tables 1 and 2 reflect the sample's demographic characteristics. Of the 11 participants who took part in the study, 9 were female and 2 were male. Each participant resided in 1 of 2 states, Oklahoma or Missouri, and met the licensure requirements as a licensed professional counselor or a licensed marriage and family therapist. Additionally, each participant met the requirement to be credentialed in the state of Oklahoma or Missouri as a counseling supervisor, allowing them to provide licensure supervision to counseling supervisees. To maintain confidentiality, the participants' real names were replaced by pseudonyms and the name of the agency the participant works for remained concealed.

Table 1

Sample Demographic Variables

Participant	Number of Years Providing Supervision	Number of years Providing Pre-Licensure Supervision
Amy	14	10
Kelly	8	6
Roy	20	20
Susan	9	3
Kimberly	9	4
Leslie	5	5
Eddie	2	2
Whitney	4	4
Kim	13	13
Jaime	18	15
Christine	22	15

As shown in Table 2, each counseling supervisor participating in the study had a range of counseling supervisees. Each participant provided supervision as either a clinical counseling supervisor, pre-licensure counseling supervisor, or a mixture of both. Most participants identified that the state licensure board of Oklahoma and Missouri limited the maximum number of individuals a pre-licensure supervisor could provide licensure supervision to as three; however the number of clinical supervisees was not regulated except by the agency or department the participant worked for. Supervisors were limited with the number of pre-licensure supervisees due to the amount of supervision each supervisee must have each week, and the additional support through education of techniques and encouragement to build professional identity as a counselor needed.

Table 2

Number of Supervisees

Participant	Number of Supervisees Receiving Clinical Supervision from Participant	Number of Supervisees Receiving Pre-Licensure Supervision from Participant
Amy	8	3
Kelly	0	3
Roy	15	3
Susan	0	2
Kimberly	0	1
Leslie	4	2
Eddie	5	1
Whitney	9	3
Kim	25	2
Jaime	12	3
Christine	10	0

The Participants

Eleven counseling supervisors from Oklahoma and Missouri agreed to impart their descriptions of lived experiences providing supervision for the purpose of this research. Evolving from various work environments, each participant had a unique story to tell of providing supervision, experiences with supervisees, their own internal reactions during supervision, and their perspective of tertiary trauma. All of the perspectives were distinctive; however all of the counseling supervisors shared a similar lived experience. Qualitative research creates an open platform to identify the shared experiences of participants. More specifically the phenomenology of research allows the research to assume a universality of experiences. Through the honesty of their stories, each participant demonstrated transparency in what they had to say. This allowed me to stay

true to the Hermeneutical approach, using the participants lived experiences to define the phenomenon of Tertiary Trauma. To provide insight into the phenomenology of tertiary trauma among counseling supervisors, it was significant to provide background information on each of the participants. Participants' names were changed to maintain confidentiality.

Amy

Amy had been a Licensed Professional Counselor for 17 years, and holds a master of science in counseling psychology, and a PhD in psychology. During the initial screening, Amy identified that she was not licensed as a psychologist due to accreditation issues regarding her doctorate program; however she has maintained her license as a licensed professional counselor. Amy stated she started her careerat a community mental health agency, working with children and families; however she currently spends half of her time running her own private practice and the other half of her time as a weekend clinical supervisor for an adult in-patient behavioral health facility.

Amy has been a licensed counseling supervisor, able to provide pre-licensure supervision for the past 10 years, and has provided clinical supervision for the past 14 years. Amy provides pre-licensure supervision to three individuals in her private practice and provides post licensure clinical supervision to eight individuals at the residential facility. The primary presenting problems of clients the counselors work with are foster families and the children who have been placed with them. Amy stated that all of her pre-licensure supervises have been trained in several trauma focused counseling methods because all of their clients in the foster care system have experienced a form of trauma.

Likewise, those receiving post-licensure clinical supervision from Amy have been trained in trauma focused treatment for adults to address the behavioral and substance abuse needs of the clients with whom they are working.

Kelly

Kelly holds a PhD in Counselor Education and is a licensed professional counselor. She began her career as a counselor working at a "smaller agency" as a "contract therapist" where she was allowed to set her schedule and case load based on her availability. Kelly identified this was important for her because at that time in her career she was pursuing her PhD in Counselor Education and needed to have more control of her schedule for academic reasons. During the time she was in school, Kelly stated she was asked to become a clinical supervisor over the outpatient program, and she maintained this position for two years before returning to contract work while completing her PhD Since completing a PhD counselor education, Kelly stated that she is solely working in a private practice setting. Kelly currently has 3 individuals she is providing pre-licensure to in her private practice. Kelly has been providing pre-licensure supervision for the past six years and post-licensure clinical supervision for eight.

Roy

Roy is a counselor, who has worked in the profession since prior to the state establishing counseling licensure, and holds a master of arts degree in community counseling and was active in helping establish the first counseling licensure board in the state he works in. Roy started his career as a counselor working for the agency that he still works for, and oversees a department that is focused on providing trauma based

services to children who have been physically and sexually abused. He describes the agency setting as a "large agency" with his department being 1 of over 30 different departments serving the greater community. Roy stated that at this point in his career, he finds most of his time divided among his supervisees because per agency rules he must provide supervision to each person he manages. Currently Roy provides clinical counseling supervision to 15 counselors, and 12 of those are post-licensure counselors and 3 of those are under pre-licensure supervision. Roy articulated that when he took the clinical supervisor position that it made professional sense for him to obtain his licensure supervisor credential so that he could be the most benefit to those he was working with.

Susan

Susan is a licensed professional counselor, a post-licensure clinical supervisor, as well as a registered play therapy supervisor. She began her career working at large community mental health agency after making a career change from an accounting firm. Susan stated that she obtained her master of science in counseling and knew that she wanted to work primarily with kids. Her drive to become a play therapist placed her in a clinical supervision role, providing post-licensure clinical counseling supervision within the agency she worked at while she sought out the play therapy credentials to become a registered play therapist supervisor. After 10 years at the agency, 9 that she was the clinical supervisor, Susan decided to start her own private practice. During her initial year of private practice, Susan completed the needed requirements to become a pre-licensure supervisor as well as a play therapist supervisor, and began to take on supervisees for pre-

licensure clinical supervision. Currently Susan is providing pre-licensure clinical supervision to 2 supervisees.

Kimberly

Kimberly is a licensed professional counselor who has provided clinical supervision in several different agencies in her area, and now has a private practice. Kimberly earned a master of arts in mental health counseling. She stated that she began her counseling career twelve years ago working at domestic violence shelter where she provided family counseling services to clients. Kimberly disclosed that when she was asked to become a program director she was hesitant because she was not comfortable with the idea of providing clinical supervision. Her fiancée at the time was supportive of her taking on the role, which she maintained for 3 years before becoming a program director of an outpatient program at another agency. Currently Kimberly works multiple "contract" counseling positions at several agencies while she is building a private practice. Kimberly stated that she felt it was important to become a pre-licensure supervisor after being in the role of a post-licensure clinical supervisor because it added to her skill set. She is not currently providing post-licensure clinical supervision at an agency; but her pre-licensure supervisee is working in a program that focuses on trauma focused treatments for clients.

Leslie

Leslie has been involved in providing post-licensure clinical supervision for the past four years at the agency of her employment, and earned a master of science in mental health counseling. She identified that she has moved around the agency as a

counselor and a clinical supervisor several times and has worked with various populations and supervisees. Currently Leslie provides post-licensure clinical counseling supervision to counselors working for an outpatient program focused on in home family counseling. As a supervisor, Leslie provides post-licensure clinical supervision to 4 counselors in her department, as well as pre-licensure clinical supervision to 2 supervisees from a different department of the agency. Leslie started her supervision career path at the agency after they paid for her to go and obtain her pre-licensure supervision credentials. She discussed that her background prior to being a supervisor was providing trauma based counseling services to her clients, and that a primary reason for becoming the clinical supervisor of the family counseling program was to assist the clinicians in implementing trauma focused treatment to families in need.

Eddie

Eddie earned a master of arts in mental health counseling and has been licensed as a professional counselor for four years. He stated that a year after being licensed he accepted a clinical supervisor position working at a foundation that focuses on adoption. He stated "I thought it was the progression of things to obtain my licensure supervision credential once I had met the 2 year requirement after being licensed." Eddie reported he took a two day, sixteen hour seminar on licensure supervision once he had renewed his license for the second year. After completing the seminar, he was able to upgrade his license to a licensure supervisor and currently has one pre-licensure supervisee. Beyond his pre-licensure supervisee, Eddie also has 5 counselors for whom he provides post-licensure clinical supervision.

Whitney

Whitney is a clinical supervisor for an adult substance abuse treatment program. Whitney earned a master of science in counseling psychology. She began her career working with children however, after having her first child decided she wanted to work with a population that was not as close to her own experiences of being a parent. Five years ago Whitney began working for an agency that focused on substance abuse rehabilitation, and within a year she was in a supervisory position. Whitney stated her career changes started when she obtained her licensure supervisory status and began providing pre-licensure supervision for her agency. Shortly after this happened, Whitney reported that the program director of the department made a request to move to a different department under development. Whitney stated that she was asked if she would be interested in the program director position and that after "careful consideration", she agreed. Currently she provides clinical supervision to 9 counselors, 3 of which are under pre-licensure supervision.

Kim

Kim is a counselor who provides supervision to one of the largest agencies included in the study, earned a master of science in counseling. She is a clinical supervisor for 3 departments at her agency of employment, and is also a pre-licensure clinical supervisor. Kim began working at her agency 13 years ago as a clinical coordinator and gradually worked her way up to program director over the adolescent substance abuse department. After five years of being the program director over the adolescent substance abuse department she was then moved to being the clinical

supervisor over 3 departments when a funding conversion occurred within her state. With her move two years ago to the clinical supervisor role over three departments, Kim provides clinical supervision to 25 counselors. Of the 25, 2 are also under pre-licensure supervision. Kim stated "In my role I had to address the supervision process quickly because there was no way I could meet with all the counselors every week and still maintain my other duties as a clinical supervisor. My counselors under licensure supervision I have to meet with weekly so they can maintain seeing clients and gain licensure hours. However, my other counselors have one hour of clinical supervision a month. It gives me an opportunity to see how they are doing, but of course they can reach me anytime if problems come up."

Jaime

Jaime has been conducting clinical counseling supervision for the past 18 years in various forms, and earned a master of science in mental health counseling. She has been a pre-licensure supervisor for 15 years, and currently divides her time between a non-profit agency and her own private practice. In her private practice, Jaime currently provides pre-licensure supervision to three individuals. Jaime stated "because of the licensure laws, my supervisees do not work for me in my private practice but at a different agency. However they chose to pay for pre-licensure supervision instead of having the agency provide it for them." Jaime also works full time at a non-profit agency where she is the post-licensure clinical counseling supervisor to 12 counselors. She identified that her role of balancing both a private practice and a full time position at an agency has been a

"struggle" at times for her because of the time requirements; however she stated "I enjoy them both and know it's where I need to be right now in my career path."

Christine

Christine identified that she struggled in identifying which track in her academics she wanted to take when it came to being a counselor so she decided to dual major in both mental health and family counseling. She holds a master of science in mental health counseling as well as master of art in marriage and family counseling. Christine is currently licensed as a Professional Counselor and a Marriage and Family Therapist, and is also credentialed to be a licensure supervisor for both professional counselors and marriage and family therapists. She serves as a clinical supervisor at an agency where she oversees two different departments, one department provides outpatient services to children who have experienced trauma and the other department provides family counseling services. Christine identified that each of the departments have a program director that assists her in providing both pre-licensure and post-licensure supervision. She reported that each department has "on average" ten counselors each, and to assist her program directors she provides direct clinical counseling supervision to 10 of the counselors, 5 from each department. Christine has been a supervisor for "almost" twenty-two years now and has held her credentials to provide licensure supervision for twenty years.

Table 3

Participant Demographic Summary

Participant	Number of Pre and Post Licensure Supervisees	Type of Degree	Type of License
Amy	10	M.S./Ph.D.	L.P.C.
Kelly	3	PhD	L.P.C.
Roy	15	M.A.	L.P.C.
Susan	2	M.S.	L.P.C./R.P.T.S.
Kimberly	1	M.A.	L.P.C.
Leslie	6	M.S.	L.P.C.
Eddie	6	M.A.	L.P.C.
Whitney	9	M.S.	L.P.C.
Kim	25	M.S.	L.P.C.
Jaime	15	M.S.	L.P.C.
Christine	10	M.S./M.A.	L.P.C./L.M.F.T.

Data Collection

I collected data via a semi structured, in-depth interviews of varying lengths. Interviews were conducted in the participants' professional office. Two participants chose to be interviewed at the researcher's office in order to prevent work interruptions. All interviews were conducted during the weekday between the hours of 8am and 7pm central standard time, based on the participants' availability. Each interview ranged from approximately 50 minutes to 1.5 hours. The interview protocol (Appendix B) entailed a set of questions I constructed to arouse the recollection of participants lived experiences of providing clinical supervision, experiencing symptoms of tertiary trauma, and other significant topics concentrated around the research questions. I conducted the first two interviews with fidelity to the questions as demonstrated in Appendix B; however after consulting with my methodologist and dissertation chair, I determined that a change in

my approach to data collection was needed. After reflecting on my researcher's journal entry, I identified the need to alter the order of questions asked and to allow the opportunity to ask additional questions that would allow participants to provide more enriched answers. During the interview process, I employed the use of reflective skills and paraphrasing to identify participants' emotions and to seek clarification from participants as they provided answers to those questions in Appendix B. I began to develop additional questions to ask participants as I analyzed transcripts. I incorporated the new questions in future interviews, as well as following op and asking these questions in the second interview conducted for the original two participants to gather additional information. The questions included asking the participants what their emotional reactions were when dealing with difficult supervision experiences; how they physically reacted during these difficult supervision experiences; and how they felt overall during this time. It was important for me to understand the full experience of the participants and how they described their lived experiences.

Thirteen total interviews were recorded using a digital reorder that had a built in microphone. Interviews occurred over the course of April and May, 2015. I met with participants at their convenience. All recordings were transferred in MP3 format to a password protected external drive. I used Microsoft Word to transcribe all 11 of the interviews verbatim. I transcribed each interview the day following the interview. I began the coding process upon completion of the transcription prior to the next interview. This allowed for pre and post reflective analysis, and question adjustment as needed to gain more enriched answers from future participants. During each interview, I maintained a

researcher's journal where I made notations of my observations at the time. The observations included behavioral observations of participants during the interview, including facial expressions, and changes in vocal tone when answering the various questions. Keeping the journal also provided me with the opportunity to record my own thoughts and reactions during the research process, documenting any assumptions or biases I might have had.

Data Tracking Systems

I used NVivo10 to code and manage the data after I completed the transcription process. The program's data analysis process allowed me to use the multifunctional tools to identify, track, and store the entire data analysis process. Additionally, I transcribed the notations I made in the researchers journal, uploaded the transcript in its entirety to NVivo10 and included it in the data analysis process. I electronically scanned the screening questionnaires and the informed consent forms creating a PDF file for each participant that I stored on the external hard drive, creating an electronic folder for each participant. Original questionnaires and consent forms were shredded after being scanned for record keeping.

Study Results

The primary research question "What is the phenomenon of tertiary trauma for counselor supervisors?" is best answered when looking at the responses participants provided to the sub-questions. Summarizing participant experiences, tertiary trauma is a cumulative process, similar to that of vicarious trauma, however, occurring in a nature that is slightly different for counseling supervisors compared to that of a counselor. I

found discernment consistent throughout participants' discussions was the emotional reactions and the link back to self-efficacy as a supervisor. Tertiary Trauma is a phenomenon experienced by counseling supervisors that result in feelings of "frustration" and "anger." I discovered these feelings are not towards supervisees but with oneself and the inability to be able to guide supervisees to the help that is needed or desired. To better describe the phenomenon of tertiary trauma for counselor supervisors, it was imperative for me to understand the perception of counseling supervisors in how they describe tertiary trauma and identify the manifestation of the phenomenon.

Initial Description of Tertiary Trauma

I asked 11 counseling supervisors to provide a description of tertiary trauma at the beginning of each interview and again at the end. Initially counseling supervisors grasped for a defining term for tertiary trauma, deductively identifying it had something to do with the counseling supervisor but limiting themselves to knowing a distinct defining term. Supervisors provided descriptive cues of tertiary trauma such as "I would say it's a three part type of trauma. Because if I understand what you are looking at then we are dealing with the clients' trauma, the counselors' trauma, and now the supervisors' trauma" and "Three steps away from the first trauma. So the client is one, counselor is two, and I as the supervisor would be three." Participants presented with a deductive grasp of what tertiary trauma may mean and actively engaged in conversation about his or her experience as a supervisor working with others.

However, while participants were able to use deductive reasoning to create an initial definition of tertiary trauma, participants routinely stated they had not heard of

tertiary applied to the counseling profession. Eddie who held experience as a nurse prior to becoming a counselor stated "I know I have heard of tertiary trauma in blunt force accidents like car wrecks, and that is usually where there is more than two barriers between the victim and the force causing the trauma."

When discussing this phenomenon of tertiary trauma and its defining parameters most participants initially responded with statements like "I don't know what it means but when I hear tertiary trauma it doesn't mean anything good, that's for sure" or "I'm not sure I would try to guess a definition."

Identification of Tertiary Trauma

Participants during the research process initially appeared to lack a defining concept of tertiary trauma; however emergent "symptoms" of tertiary trauma became apparent to participants as means for identification of the phenomenon. Each participant discussed a time as a counseling supervisor where there was an experience of thoughts, feelings, and behaviors that I identified as pertinent descriptors of tertiary trauma.

Emotional indicators such as fear, anger and frustrations appeared to be three of the most common emotional reactions within the tertiary trauma phenomenon that I identified from the participants' descriptions of their lived experiences. Seven of the participants reported at one point in their experiences as a counseling supervisor having higher levels of fear that would drive them worry about their skills as a supervisor. Susan outlined in her interview:

> I was so fearful working with this supervisee. I would have nightmares that I would give her the wrong the advice and it would be my fault that she would not

> get her license. I was scared that I wouldn't have the answers, which I wasn't good enough to be her supervisor. I was scared for the supervisee; I was scared for the client. I just wanted to cry at times because I never knew what my supervisees were going to bring into my next. It was a failing agency in a not so great of an area of the city. I wasn't given the option of who to supervise, was just told by the agency 'here you need to supervise them for licensure' and there you have it. I was miserable."

Fear, however, was not the only emotional reaction that participants identified as being present in the manifestation of tertiary trauma. Anger and frustration also seemed to go simultaneously hand in hand. Whitney discussed her feelings of anger:

> I didn't know where to go with how to help her and that was where I started to struggle, and yes it was in making decisions. I was mentally worn out by the time that event was done, and I wasn't looking forward to having to do any other supervision that week, much less that day. In some ways, I think I even felt angry.

When asked who Whitney was angry with, she stated:

> I was angry with her for not taking care of her. I was also angry with me for not knowing how to help her help herself. Maybe even the client a little bit for triggering all of this. It was a day where emotions were running high for everyone when this happened and in the end I really was just over it and exhausted.

Several individuals reported feelings of frustration that would lead to anger. Amy reported:

> I was frustrated at the entire situation. How could you go through an entire master's program and graduate and not know at least the minimum of how to interact with a client? It became infuriating, and when I heard her talk about her self-disclosures to her clients and how she discussed her own mental health issues, I began to resent her even coming into my office.

Jaime stated:

> It got to be too much for me time wise. This was a needy supervisee who would not only come to my office what seemed like every five seconds but would call. I tried to not be frustrated with the situation and kept reminding myself that it was a growth opportunity for us both. But eventually I just got mad about the whole thing, and I remember snapping at the supervisee on the phone. That was when I chose to not be her supervisor any longer and assisted her in finding someone better equipped to help her through that supervision process because it wasn't meant for me.

Behaviors also appeared to be strong indicators of tertiary trauma in counseling supervisors. In particular, one physical reaction that ten of the eleven participants discussed was the overall physical feeling of exhaustion. Roy stated:

> I was so exhausted by the time I was done with the supervision session that all I wanted to do was go home and sleep. The exhaustion that it does to you mentally and physically is 'unreal,' I remember going home on those days and telling my wife that all I wanted to do was just sit in a quiet room for a while. I was so exhausted having to supervise fifteen individuals in the department and maintain

> my own caseload that every time I turned around I was running into things, literally running into things and that would only make me want to cry cause I was usually hurting myself on the corner of my desk or a bookshelf.

Kelly described the feeling of exhaustion as being "a holistic experience" stating:

> Every part of me was exhausted dealing with this individual. I didn't want to talk to people, I didn't want to go out with friends or family, I didn't want to even pray because it just hurt my entire self to even think about what I wasn't able to do in order to help the situation. I struggled to even stay focused during the supervision sessions."

Other participants described physical reactions to their behaviors that had not been seen before such as having a "shorter temper" and "being more irritated with others." Roy stated:

> I was physically so tense I found myself sitting slumped over my desk and 'god help' anyone who popped in to ask me a question. Physically I could tell that I was responding to people negatively. I was closed off, wasn't relaxed when I sit to talk with other people. Physically it was uncomfortable for me to be around others.

Thought patterns indicated the existence of tertiary trauma and became more apparent as participants discussed the thoughts of believing they were not suited to be a supervisor. Susan reported:

> I felt completely useless. No matter what I tried to do or how I thought a practice might help a supervisee, it continued to fail. I continued to fail. I felt like I was the

> cause of the problem. After that experience, I thought I would never provide licensure supervision again because it was horrible. I truly thought I was a terrible supervisor. I could not think of anything I wanted to do less than sit through another excruciating hour of supervision not only with my supervisee but with myself. What purpose was I serving in there?"

All of these thoughts are similar to and parallel to the cognitive distortions that counselors experiencing vicarious trauma identified, doubting their skills as a counselor (Adams & Riggs, 2008; Rasmussen, 2005). The pervasive cognitive, emotional and spiritual exhaustion expressed by Roy is noticeably similar to the vicarious trauma symptoms that Rasmussen (2005) discussed. Feelings of isolation identified by Kelly and Amy, along with experiencing a low tolerance threshold of dealing with others discussed by Roy also mirror vicarious trauma (Adams & Riggs, 2008; Knight, 2010).

While similarities to vicarious trauma were present, differences were detected as participants continued to identify emotional reactions to supervision. The feelings identified as fear and anger was tightly associated around the counseling supervisors' perception of not feeling adequate in their role as a supervisor. Self-efficacy in the supervisory role was identified as a new variable that I had not seen in previous literature regarding vicarious trauma. Amy expanded the theme of self-efficacy beyond the supervisory role, and included the role counselor education programs have in developing professional identities for individuals moving into a pre-licensure phase. Participants reported feeling angry with themselves and not at the supervisee. This anger was because of the underlying fear that as a supervisor they did not have means to help the supervisee

in a way they felt they should have. These means were identified by multiple participants as not having a support structure as a supervisor, having a lack of training in how to seek out additional support, and minimal training in taking care of themselves. Distinct from vicarious trauma, tertiary trauma generates a splintered view of what a supervisors' role really is, creating frustration and confusion among counseling supervisors. Competing inclinations occurred between the counseling supervisor's obligation to adhere to agency requirements and state regulations, while feeling simultaneously feeling obligated to continue to assist the supervisee even though the interactions during that supervision are affecting the supervisor negatively.

Description of Tertiary Trauma

Participants were asked to describe tertiary trauma again after discussing the experience of providing clinical supervision. Rasmussen (2005) identified that vicarious trauma was identified with a reflective nature where individuals after reviewing experience with supervisors became more aware of the secondary trauma phenomenon. In maintaining the parallel exploration of vicarious trauma to tertiary trauma, it appeared to be implicative to understand the reflective meaning of tertiary trauma for the participants after they had reflected on supervisory experiences.

Participants appeared to shift their view of tertiary trauma after discussing experiences providing supervision. Initial descriptions of tertiary trauma were vague, and participants appeared to struggle in providing a working definition of tertiary trauma. However, in the reflective post stage of the interview process participants presented descriptions of tertiary trauma were more in line with the role of counseling supervisors.

"Tertiary Trauma is the continued progression of trauma from client through counselor to me as the supervisor, something that doesn't just stop because I have the title of supervisor." "It (tertiary trauma) is a process that takes a while to realize you are experiencing it, like what I would see with vicarious trauma only I don't have myself as the supervisor to point it out. I have to be aware of it, and me or it could go unnoticed for a long time." "Tertiary Trauma is the next evolution of vicarious trauma, which has a root in that baseline trauma that affects the individual. This is why it is important for us to increase trauma-informed practices because no matter what, we are all predisposed to experience trauma, even when trying to help others deal with theirs."

Description of Coding

I began the coding process at the end of the first session, after the first interview was transcribed into a digital transcription. The coding process in this study was informed by the works of Krueger and Casey (2000) and Moustakas (1994) in alignment with a hermeneutic phenomenological process. Both Krueger and Casey (2000) and Moustakas (1994) conceptual framework to data analysis involve sequestering statements from descriptions of lived experiences. Each statement is representational of enriched themes associated embedded within the participants lived experience. Moustakas (1994) stated the researchers' task is to identify a commonality among participants that outlines the embedded themes of the lived experiences.

Krueger and Casey (2000) concretized their conceptual framework by establishing a step-by-step method of data analysis designed to capture and describe the essence of the phenomenon. Keeping with a hermeneutic phenomenological principle;

the data coding process for this study was systematic allowing for deductive understanding of the primary themes. Initial coding (Appendix C) was extracted from participant statements in order to create immersion, understanding, and a synthesis of theme development. The coding occurred using the long table method discussed by Krueger and Casy (2000). All raw data, for example transcripts, was analyzed using NVivo 10. For the purpose of this research, NVivo 10 was used initially to create individual nodes as transcripts were cut into segments according to responses to interview questions. To ensure trustworthiness during the initial creation of nodes, I consulted with my methodologist to ensure initial coding was being utilized effectively.

A second review of the nodes allowed me to begin creating clusters that allowed me to deductively identify common themes among participants. This was seen by clustering codes that frequently were identified as symptoms such as exhaustion, worry, stress. Other clusters focused on knowledge of topics such as vicarious trauma and tertiary trauma, along with topics of what it meant to be a counseling supervisor. Consulting with my dissertation chair it became apparent that there was a common theme among efficacy as a supervisor, creating a separation between what we know about vicarious trauma and tertiary trauma. Through initial coding counseling supervisors worried about their abilities to provide adequate supervision and maintain high standards of practice in the counseling profession.

Overview of Research Findings

In this study, six relevant themes (Appendix C, Appendix D) emerged from the lived experiences of a sample of counseling supervisors. The themes illuminated various

aspects of the phenomenon of interest, identifying the participants' experiences of tertiary trauma, their experience as supervisors, and how they identified tertiary trauma symptoms. Direct quotes from participants are used to demonstrate grounding in the data.

Theme 1: "Base Knowledge of Tertiary Trauma"

The initial coding that I completed was the introduction to the study and results informed how I presented the conceptual information for tertiary trauma. This coding became consistent throughout the interviews. I used the coding as a way to identify the need to adjust the order of questions I asked supervisors to establish the foundation of the study so I could gather a more precise perceptional understanding from the participants. The statement initially coded in the process was "I know that you are both a clinical supervisor and you provide licensure supervision to individuals seeking to become a licensed counselor. Can you tell me about your journey that brought you to supervise counselors in their work with clients who have experienced trauma?" I identified that participants focused more on the journey each took to become a counseling supervisor compared to discussing his or her experience of tertiary trauma. I then changed the order of questions with the initial statement being coded starting as "Tertiary trauma is the topic of my research, and the experience that counseling supervisors have had with this phenomenon. Your area of specialty is trauma based treatment and you act as a clinical supervisor as well as a licensure supervisor for one of the larger agencies in Tulsa. You have a strong understanding of trauma and how it affects client, and how it can impact counselors vicariously. I'm wondering how you would define the next phase of that trauma movement and define tertiary trauma, or the impact of trauma on counseling

supervisors?" This statement was adapted to meet each's area of employment and location; however it established a critical code and overall theme of the research that is "initial definition of tertiary trauma."

Coding the initial definition of tertiary trauma participants provided a baseline understanding of what participants knew at the time about the phenomenon. Many participants provided responses such as "I do not know" or "I have never heard that term before." Roy used deductive reasoning and stated:

> Ok, so if I try to define this I would say it's a three part type of trauma. Because, if I understand what you are looking at then we are dealing with the clients' trauma, counselors' trauma, and now the supervisor's trauma.

Kim stated "If I had to give a definition that tertiary trauma is some sort of trauma that's not secondary, because we have a definition for that, but maybe something more distant from an actual trauma."

In the researchers journal I noted:

> After talking to six of the participants at this point, it is interesting to note that none have heard of the term tertiary trauma. There is a transition that happens during the discussion though where participants seem to become more aware of the phenomenon and place a defining term to it towards the end of the interview.

Theme 2: "What it means to be a Supervisor"

The emergent coding of what it meant to be a clinical supervisor became apparent when discussing tertiary trauma. Participants each had a view of what it meant to be a clinical supervisor and depending on the role, clinical supervisor or pre-licensure

supervisor; those views had slightly different perceptions. The overall theme of what it meant to be a clinical supervisor broke down into several sub-codes that included "responsibilities," "expectations," and "ethical responsibilities." Participants outlined in areas of responsibilities that the role of overseeing the welfare of both the supervisee and clients the supervisee counsels. Expectations, however, varied depending on whether the participant was working as a clinical supervisor or a pre-licensure supervisor, or in many of the instances as both clinical and pre-licensure. Clinical supervisors placed an emphasis on "agency expectations" that included meeting with a staff they provided clinical supervision to but also maintaining agency paperwork and often productivity measures by providing counseling services to clients. Pre-Licensure supervisors placed an emphasis on "ethical responsibilities" often stating ethical standards related to his or her supervisees. Christine stated:

> It is my job as a licensure supervisor to make sure my supervisee takes care of themselves. The ethical standards of both ACA and the LPC regulations say that a counselor needs to be competent, so in my view that means self-care also.

All participants in the interview process supported the congruent theme that supervisors, clinical and pre-licensure have a role in acting as a gatekeeper for the profession and maintaining the highest level of care possible for clients.

Theme 3: "Understanding of Vicarious Trauma"

Vicarious trauma and the understanding of phenomenon became an arch in the coding process. Coding included symptoms of vicarious trauma, experiences identifying vicarious trauma, and counselor wellness. Participants held strong perspectives of

vicarious trauma. Kimberly reported "vicarious trauma is the impact of a client's trauma on the counselor. It can mean so many things but it really is that point where the counselor hangs on to all that junk that the client went through." Leslie stated "vicarious trauma is going to happen to all of us."

Each participant expressed symptoms of vicarious trauma as being tired, worried about others but forgetting yourself, doubting your skills as a counselor to help others, and even more extreme symptoms of compassion fatigue and burnout. One of the identifying questions asked during the interview process was if the participant had ever worked with a supervisee who he or she saw as dealing with vicarious trauma. This experience I coded under the arc of vicarious trauma and outlined the supervisors' firsthand knowledge of being able to identify and address vicarious trauma. Participants were clear when discussing experiences with providing supervision to those who may have had vicarious trauma. Roy reported "You can't be in this field as long as I have been and work in trauma focused treatment and not see vicarious trauma." Kelly stated "I had one supervisee that became so vicariously traumatized that I didn't know what to do to help him."

The discussion of what each supervisor did to assist their supervisee through the experience of vicarious trauma resulted in many supervisors identifying their role in being a mentor in advising supervisees, pre and post-licensure supervisees', on the importance of counselor wellness. I created an additional code in identifying "the role of a supervisor in preventing vicarious trauma." One of the more prominent statements regarding the role of supervisors in preventing vicarious trauma came from Eddie who

said ”As a supervisor I can play a role of intervening, hopefully before those I work with get to the point of saying I can’t anymore.”

I noted during the interview process that all participants appeared to have a strong foundational understanding of the impact vicarious trauma could have on their supervisees. One journal entry I made after interviewing Leslie:

> It is clear that all the participants at this point know what vicarious trauma is, and all seem focused on how to assist other counselors and supervisees from not having to experience this form of traumatization. If vicarious trauma is so well known, what makes us as supervisors believe that the “title” or “role” of being a counselor supervisor prevents us from experiencing similar traumatization?

Theme 4: “Symptoms of Tertiary Trauma”

Themes began to shift as I asked participants to discuss his or her experience working with those who had vicarious trauma. I began to develop codes that included areas such as “exhaustion” “worry” “anger” “anxiety” and “dread.” Each of these codes being common statements among participants when asked “What was that experience like for you as a supervisor?” Coding continued to develop that included “stress” and “dislike of supervision.” Amy stated “I didn’t know really what to do to help her and felt lost. I was exhausted by the time everything was over…I was worried about the clinician; I was worried about the client.”

I also noted in the researchers’ journal the frequent change in expressions that occurred during this time of the interview process and coded this as “researchers’ observations.” One notation that I made stated:

> The participant appeared to be sad when talking about her experience with the supervisee that she "fired" because she felt she could not help her. This was seen by her looking down when she talked about this individual and becoming tearful. She fought back the tears, but you could see how mournful she was of this experience even some five years later.

Jaime noted:

> I was angry. I was angry that I had to waste my time every week trying to help someone who just wasn't getting it. But I felt obligated to see the process through. I became angry with myself for not knowing how to help my supervisee.

Roy was a participant who identified an initial theme of exhaustion:

> I was exhausted just thinking about having to do supervision with this person. Everything was always a dramatic case of 'what do I do' with this person. It became so overwhelming at times. I didn't know what to do as the supervisor because I was tired of it.

Eddie reported:

> It was pure exhausted feelings by the time the hour and a half of supervision was over. You felt like you had gone on a 5 mile hike with no shoes on. No matter what solutions you tried to help this person out with, it was never good enough or would help. I think I caught myself at one point even yawning during supervision because I was so worn out from working with this individual. Then it was just a feeling of dread when it became that time of the week again to provide supervision to this person.

Coding expanded into areas of "who supports the supervisor" and "supervisor wellness education." Participants were consistent in feeling they did not have anyone to turn to for support as a supervisor because they were the one that was supposed to be providing the support to others. Participants also emphasized that during their training as a supervisor they were not provided with education on wellness techniques or the importance of wellness for supervisors; however were instructed on the importance of encouraging self-care for supervisees. Each of these codes was then grouped together creating the category of "Tertiary Trauma Symptoms."

Theme 5: "Role of the supervisor"

Another emerging theme within the category was the feeling of "loneliness." With the feelings associated with tertiary trauma beginning to develop, a new role appeared to revolve around an expectation of supervisors helping supervisees prevent vicarious trauma regardless of how they felt. Many participants identified feelings of being trapped and alone when they were not sure how to assist a supervisee because they were the supervisor. One participant, Whitney, stated:

> I was it, the supervisor, the one who has to keep it all together to deal with the crisis like this when it occurs. Who else is there to deal with these things when they come up? The CEO? The Board members? A supervisor from another department in the agency? My job is to maintain the best form of treatment for the population we serve and make sure my counselors are professionally and ethically sound to provide those services.

Participants continued to identify within their role as a supervisor the feelings of "loneliness" and being "trapped" began to become embedded in who they were. Susan reported:

> I didn't feel as a supervisor I could go anywhere else. I hated providing clinical supervision at this point. I dreaded having to do anything with the counselors. I doubted their ethical calls, I doubted my own ethical calls, and I felt trapped.

Exploring the feelings of being trapped expanded into several sub-coded regions. One of those regions was the expectation to be a supervisor and to be there for the supervisee, regardless of what the participant was feeling.

Jaime stated:

> At the time I saw me being a supervisor like being a counselor. When I agree to be your counselor I am going to see you through to the end of treatment. So when I am the supervisor I am going to see you through to the end of being licensed, or till you choose to move on to a different agency or department. I always saw the option of firing a supervisee as a form of failure as a supervisor.

Kim commented:

> I was financially trapped in that role as a supervisor. I was making the most I had made as a counselor when I was doing clinical supervision. Despite how horrible it was at times or dealing with all the agency politics, it was good money. I didn't feel like I had the potential to say I didn't want to anymore.

In reflection, during the participants' interviews I noted in the researcher's journal that all the participants had an initial view of what it meant to be a supervisor. However,

after experiencing a difficult supervisee, those views seemed to become skewed regarding role obligation. Participants reported feelings of obligations to the agency they worked for, identifying expectations that they had to complete as a supervisor. However participants identified a conflict in feelings of being obligated to continue supervision when internally they struggled with a desire to discontinue providing supervision. Other variables such as rate of pay and agency expectations also imparted an essence towards carrying out the obligatory roles; however the drive to prevent supervisees from failing or the community at large from having consequences was prevalent during the interviews.

Theme 6: "Counseling supervisor wellness."

Coding supported the emerging theme of parallel experiences between vicarious trauma and tertiary trauma. In the researchers' journal, I noted professional literature outlined that vicarious trauma does not get identified until it is pointed out by an external source, such as a supervisor (Adams, & Riggs, 2008). Participants began to say statements such as those made by Susan:

> I can say that for me I'm not sure I would have ever thought of my experience dealing with the one clinician as 'tertiary trauma' or anywhere near that until our conversation today. I go to supervisor ethics every year, and we always talk about the importance of teaching wellness to the counselors and how that can help the client. But, I can't think of a single time that we have talked about wellness for the supervisor.

Roy reported that the agency he worked for had sent him to numerous counseling wellness and vicarious trauma seminars however: “I have never gone to a workshop that focused or even mentioned wellness techniques meant for counseling supervisors.”

Through the interview process it became apparent that the concept of “supervisory wellness” was not a known topic although associated with the primary phenomenon of tertiary trauma. Participants began to question and identify on their own why supervisory wellness was not emphasized when counselor wellness was emphasized as a means of addressing vicarious trauma.

Evidence of Trustworthiness

Credibility

I achieved credibility in two ways and maintained the fidelity outlined in chapter three. The first method that was vital to qualitative research standards outlined by Landridge (2007) was continuing a movement of the research study towards data saturation. The initial inclusion of participants in the study was a minimum of seven to eight participants. To make sure that I had a saturation of data, I recruited additional participants until I did not see any new emerging themes. The inclusion of other participants in the study totaled 11 participants. I used triangulation in the method of two means. The first was to continue the movement towards saturation by providing each participant a copy of his or her transcript and asking them to review the interview and provide any further feedback they might have. I did this to gather additional information that the participant may wish to provide to make sure that I had recorded what the participant wanted to express in totality. The other means of triangulation I used was a

researcher's journal. The journal allowed me to record my experience of the research, including observations I made during each of the interviews.

Transferability

I increased transferability through the variation in participants that participated in the interview process. Participants varied from the state they lived in, living in either Oklahoma or Missouri. Participants also varied in the work environment they provided supervision. Some participants worked in larger agencies that included non-profit organizations and state funded agencies while others worked in private practice but continued to provide supervision.

Dependability

In chapter three I outlined in Appendix B, each question I would ask during the interview process. During the initial two interviews, I asked questions to fidelity as they were listed, with no variation from the outline. I noted the order of the questions and the rigid structure I held during the research process was providing minimal discussion that would lead to an enriched view of tertiary trauma. I arranged the order of the questions differently after a review of the first two interviews. I was able to enter an initial discussion of tertiary trauma and the ability to assess what the participant would describe as tertiary trauma from the beginning. I was able to develop a deeper personalized discussion about each of the participants' experiences. I asked all questions outlined in Appendix E in a more person-centered approach that allowed me as the researcher to guide the participants' into a deeper discussion of their experiences.

Confirmability

I increased confirmability by using triangulation. Participants were asked to review the initial interview and provide additional feedback if they had any. An adjustment to consistency strategies was made compared to what I discussed in chapter three. I stated that participants would participate in a second interview process, and as themes began to emerge, I deemed not all participants needed to take part in secondary interviews. Two participants provided a second interview to provide a more enriched discussion of their experiences as I developed codes throughout the study. However, once data saturation occurred the need for participants to participate in a second interview did not appear to be relevant for the purpose of data collection. Additionally, both my dissertation chair and my methodologist reviewed initial transcripts and emergent assertions in the data analysis.

Primary Research Question

The primary research question of the study asks what the phenomenon of tertiary trauma is for counselor supervisors. Over the past twenty years, the counseling profession has created a well-established working definition of vicarious trauma (Adams & Riggs, 2008; Rasmussen, 2005). The understanding of tertiary trauma in relation to counseling supervision is a newer area to explore, although an experience that has existed for some time. Similar in experience to vicarious trauma, tertiary trauma is a cumulative process that manifests over time in various ways depending on the individual. Common identifiers are consistent among participants who have lived the phenomenon of tertiary trauma. These identifiers include feelings of exhaustion, frustration, and a decreased

sense of self-efficacy when providing guidance to supervisees. Participants described how they would isolate themselves, refusing to talk to others, and wanting to be alone. This was a product of the cognitive, emotional, and spiritual exhaustion among participants. An established view of how the perception of self-efficacy was diminished among participants was seen in the further discussion of emotional responses to the supervisory process including anger and fear. Frustrations peaked when participants reported they had no answers to help their supervisees and no understanding of how to find those answers. These identifiers follow similar characteristics of vicarious trauma that affect the counselor at the core, creating doubt in his or her ability to provide effect counseling, frustration with the client, and exhaustion of the profession overall (Bride, et al., 2007). However, the identifiers illustrated how experiences of tertiary trauma are more specific to the counseling supervisor, and more specific to the domain of self-efficacy.

What differentiates tertiary trauma from vicarious trauma is the distinct perception participants had about the role of a supervisor. Counselors living with the experience of vicarious trauma are encouraged to seek out supervision to help address and reduce the symptomology associated with the vicarious trauma phenomenon (Adams & Riggs, 2008; Rasmussen, 2005). Counseling supervisors participating in the research expressed feelings of being expected to be the "expert" in the counseling profession because "I am the supervisor and should have the answers." Counseling supervisors reported not having others to turn to for support and while holding a firm understanding of counselor wellness, did not appear to know how to apply wellness techniques to the

area of supervision. Tertiary trauma emerged as a confounded phenomenon impacted by multiple factors. These factors might include providing both pre-licensure supervision as well as post-licensure clinical supervision in a work setting, along with the expectation of simultaneously seeing clients as a counselor. While taking longer to identify than vicarious trauma, tertiary trauma appears to be a more comprehensive of experience than vicarious trauma. Counseling supervisors may be dealing with both the trauma of supervisees and clients creating a trauma effect that is both a secondary and tertiary level.

Summary

Tertiary Trauma is a cumulative process that manifests for the counseling supervisor in multiple ways. Creating disturbances emotionally, cognitively, and behaviorally, tertiary trauma is a phenomenon that creates new barriers to the supervisory process. Counseling supervisors have identified that the experience of providing clinical supervision to trauma counselors can lead to feelings of inadequacy as a supervisor and impact supervisory judgements. This leaves supervisors doubting their skills as supervisors, experiencing a diminished sense of self-efficacy and occasionally facilitating a desire to no longer be a gate keeper for the counseling profession.

Chapter 5 includes a more in-depth interpretation of the findings that extend the knowledge of tertiary trauma and confirm the need to have a working definition of the phenomenon. I discuss the limitations of the study as well as recommendations for future research outlining the implications for social change coming from this knowledge of work. As the researcher, I also discuss my experiences in conducting the research,

including my biases, and what I discovered through reflecting on my perceptions of tertiary trauma.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this hermeneutical study was: (a) to obtain an initial understating of how counselor supervisors' describe the phenomenon of tertiary trauma, (b) to illustrate how counselor supervisors identify the manifestation of tertiary trauma, and (c) to interpret participants' lived experiences of the tertiary trauma phenomenon through themes inductively extracted and coded from the data. Findings generated by the study are expected to inform counseling supervisors of tertiary trauma, inform future research development in reducing tertiary trauma symptoms, and develop a foundational definition of tertiary trauma. It is anticipated the study's findings will stimulate positive social change by expanding the knowledge base of the counseling profession and other human service fields interested in understanding how trauma transitions throughout the helping professions.

A sample of 11 counseling supervisors was recruited from Oklahoma and Missouri to participate in this study. The participants agreed to share their stories of providing supervision and their perceptions of tertiary trauma. Six prominent themes resulted from the qualitative data analysis: (a) base knowledge of tertiary trauma, (b) what it means to be a supervisor, (c) understanding of vicarious trauma, (d) symptoms of tertiary trauma, (e) role of supervision, and (f) counseling supervisor wellness.

Based on my analysis, the essential organizing theme was that participants discovered an existential meaning of tertiary trauma through the discussion of past supervising experiences. In addition, I found that participants' experiences with tertiary

trauma mirrored those of vicarious trauma discussed in the literature with distinctions of tertiary trauma being the phenomena focused on supervisor self-efficacy. Finally, the participants interpreted perceptions of providing supervision while dealing with tertiary trauma symptoms and the feelings associated with the lack of support for themselves and those hey supervise as a counseling supervisor.

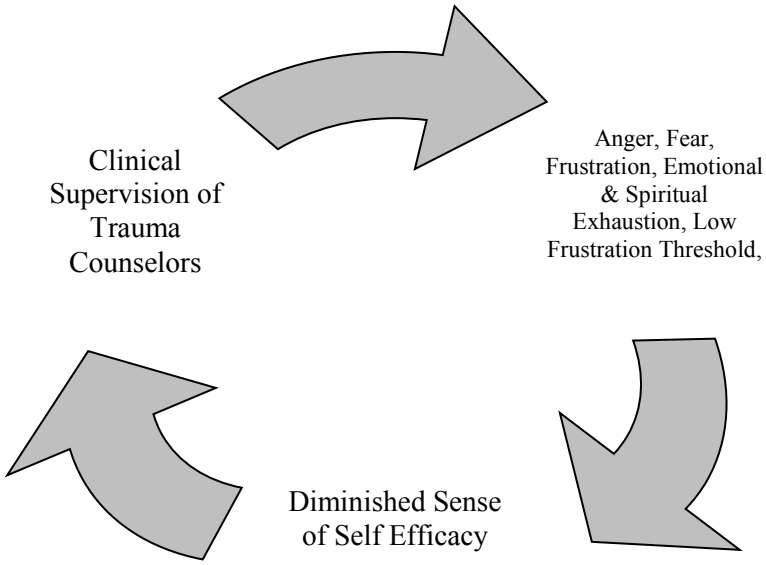
Interpretation of Findings

Overall, results of this study on counseling supervisors' experiences of tertiary trauma mirrored various findings found in the extant literature concerning the experiences vicarious trauma for practicing counselors. For example, studies indicated that many counselors do not realize they are dealing with vicarious trauma until it is identified during supervision (Adams & Riggs, 2008; Knight, 2010). All of the participants in this study reported a realization of experiencing tertiary trauma after discussing symptoms and experiences during the interview process. Regarding symptoms of tertiary trauma, I found the majority of participants identified symptoms that paralleled the symptoms of vicarious trauma such as exhaustion, dread, and self-doubt (Adams & Riggs, 2008). As the findings of this study demonstrate, counselor supervisors expressed strong emotional reactions of frustration and anger when experiencing tertiary trauma, which compared to emotional reactions associated with vicarious trauma (Tosone, et al., 2012). One distinction for tertiary trauma was that the anger identified was internally directed compared to external focus on others which is associated with vicarious trauma. Participants reported anger at themselves due decreased self-efficacy and the fear that they lacked the skills to help the supervisee succeed in the counseling profession. Fear

superseded the emotional response of anger as seen by several participants' responses but was also aligned with self-efficacy. Fear that they were not suitable to be a supervisor, that they did not have the knowledge, and that their inability to provide adequate supervision might impact direct client care weighed heavy in many participant interviews. Additional feelings of what one participant described as "being an imposter" identified how out of place supervisors experiencing tertiary trauma felt and further accented a decreased sense of self-efficacy.

Figure 1

Cycle of Self-Efficacy



In Chapter 2, the literature review included an examination of vicarious trauma and the effect the phenomenon has on counselors. Creating feelings of self-doubt, confusion about ethical responsibilities, and a movement towards compassion fatigue and burnout, vicarious trauma is a comprehensive experience that occurs over time. Research

findings indicated that counselor wellness is a means to address the symptomology and impact of vicarious trauma (Tosone et al., 2012). More specifically, techniques to prevent vicarious trauma such as a counselor wellness plan and having a strong support in supervision dominate the literature (Trippany, et al., 2004). Based on the qualitative interviews conducted in this study, p articipants in this study self-reported a lack of support as a counseling supervisor, minimal education in supervisory wellness techniques, and often feelings of being lonely and trapped in their supervisory roles.

In terms of describing tertiary trauma, counseling supervisors demonstrated pre- and postreflective descriptors. The study outcomes demonstrated that most participants did not initially have a conceptual view of tertiary trauma. However participants were having an understanding of the levels which trauma has shown to affect other professionals, prereflective, dynamic and unvalidated, and this allowed participants to move into a post reflective phase linking perceptions of tertiary trauma to lived experiencesin supervision (Rasmussen, 2005; Stolorow & Atwood, 1992). In post reflective discussion of tertiary trauma, participants were able to draw a connection between their experiences and the experiences of others dealing with vicarious trauma. Participants were able to identify similarities between tertiary trauma and vicarious trauma: feelings of self-doubt, confusion about one's role, feeling unsure about choices being made. Participants were also able to take the identification to a higher level specific to counseling supervisors. Characteristics such as expectations to have the answers and protect others from manifesting vicarious trauma were prevalent and not differentiated from research findings regarding vicarious trauma.

Identifying classifications outlined feeling stuck or trapped because of a lack of knowledge and lack of support. This process mirrored those experiences of vicarious trauma identification. Research indicated that vicarious trauma often is not identified until the individual experiences a pre and post reflective time, often associated with supervision (Aron, 1996).

Researchers have demonstrated through the exploration of vicarious trauma that counselors identify the experience of vicarious trauma through the act of having supervision (Adams & Riggs, 2008; Knight, 2010). Counseling supervisors differ in their roles as they frequently do not have supervision themselves, which limits their ability to identify tertiary trauma or have direct support systems to process their supervisory experiences. There is promising research that showed the use of self-assessment tools can assist a counselor in identify vicarious trauma (Stamm, 2010). Although no current self-assessment tools existed for counseling supervisors to identify tertiary trauma, future research is needed to develop a reliable assessment tool.

The lack of supervisory wellness was a common theme among participants when discussing the role of the supervisor dealing with tertiary trauma. This differs from the research pertaining to vicarious trauma that is saturated with an emphasis on counseling wellness. Adams and Riggs (2008) identified that a shift occurred in counseling academic programs, increasing the awareness of counseling wellness for counseling graduates. Most participants identified a need for education specific to counseling supervisors on how to use wellness techniques. Several participants (for example Roy, Kim, Susan) identified yearly training in supervision ethics; however each stated that the emphasis of

wellness was always on their supervisees and not focused on the counseling supervisor. Findings from this study indicated the need for further research into supervisor wellness techniques and education.

Trippany, et al., (2004) identified the importance of having an established wellness plan for counselors prior to the counselor working with trauma survivors. Researchers have provided an abundance of data showing how wellness techniques can reduce the potential of vicarious trauma among counselors (Adams & Riggs, 2008; Knight, 2010; Trippany, et al., 2004). Further research into supervisor wellness techniques will provide the counseling profession the opportunity to identify wellness approaches that work specifically for supervisors.

Counseling supervisors feelings of exhaustion were consistent among the narratives and were a recurring symptom linked to tertiary trauma. In the extant literature associated with vicarious trauma, exhaustion was a paralleled perception that most connect with trauma leading to burnout (Adams, & Riggs, 2008; Jordan, 2010). In fact, the bulk of the participants in this study reported feeling so exhausted that they experienced feelings of dread when it came to conducting supervision. The feeling of exhaustion can be seen both in vicarious and tertiary trauma, the extent of exhaustion associated with tertiary trauma appeared to be more comprehensive. Supervisors reported feelings of exhaustion that affected them physically, mentally, and spiritually. These in-depth feelings continued to expand leading many of the supervisors' to identify the desire to isolate.

In view of these findings, additional research should be conducted to investigate the impact of tertiary trauma on the supervision environment and atmosphere. One of the primary roles of a supervisor conducting supervision is to create a safe and confidential environment, where supervisee's feel encouraged to communicate their experiences. How does a supervisor create a safe and confidential environment to conduct supervision if the feeling of exhaustion is so pervasive that the supervisor is motivated to retreat? If a counseling supervisor is truly living with the symptomology of tertiary trauma, how does this impact other supervisees of the counseling supervisor?

Another finding of interest consistent with the literature was several participants in the study reported having fired a supervisee or transferring a supervisee due to decreased sense of self efficacy in relation to assisting the individual deal with vicarious trauma. Recent studies addressing vicarious trauma indicated that it is not uncommon to see counselors fire or transfer clients due to their own perceptions of feeling inadequate and unsure of how to address the clients trauma needs (Adams, & Riggs, 2008; Jordan, 2010). The difference from the literature was a supervisor holds responsibilities for more than one stakeholder. To fire a supervisee meant the supervisee may not be able to provide counseling services until they had another supervisor, leaving the clients welfare unattended. In addition, it can disrupt a supervisees' process of acquiring a licensure credential. A larger ripple effect could be seen among supervisors dealing with tertiary trauma compared to vicarious trauma. This was an important finding because it pointed to the need for counseling supervisors to appropriately assess and identify the role of tertiary trauma in their life. Proper assessment and wellness approaches of counseling

supervisors may help reduce the termination of supervision contracts and increase the wellness factors within the counseling profession.

In view of this evidence, it was important to examine (a) how counseling supervisors educate themselves on the transition trauma makes through the upward parallel process of supervision; and (b) develop and understand of what wellness techniques may assist them in reducing tertiary trauma experiences. Just as important, was the need to be able to identify when tertiary trauma is becoming apparent and skewing the view of the supervisory process.

In this study, most participants endorsed experiences similar to those of vicarious trauma. Findings from this study validated prior research studies that demonstrated trauma does not have to be experienced first-hand to manifest emotionally in the lives of others. This study also validated that educational background and experience does not make someone immune to the lived experience of trauma. As shown in this study, there was a lack of understanding to supervisory wellness, and a need for further exploration was apparent due to the participants identifying a need for further education in how to prevent tertiary trauma. Participants in the study identified they had no training in how trauma could affect the supervisor or the supervisory role. A lack of understanding in what techniques could be used to help prevent tertiary trauma was also abundant among the participant responses. Research has shown that interventions associated with counselor wellness are a primary directive in reducing vicarious trauma symptoms (Trippany et al, 2004). Furthermore seeking out and utilizing supervision is the most effect means to the prevention of vicarious trauma (Knight, 2010; Trippany, et al., 2004).

Based on the findings of this study, the lack of support and supervision among counseling supervisors may be a strong indicator of how deep tertiary trauma could imbed itself into the unconscious of the supervisors' experience.

Limitations of the Study

As detailed in Chapter 4, every effort was made to enhance the study's rigor and trustworthiness by addressing transferability and dependability of the study. The aim of the study was to obtain an enriched understanding of the counseling supervisors lived experiences, and to provide participants a collective voice in developing an operational definition of tertiary trauma. However, qualitative research has limitations and those limitations should be weighed against this study. The results of this study may not be norm of all counseling supervisors, as this study sought to expound and interpret the lived experiences of only 11 counseling supervisors who participated in the study.

Participants were only representative of two states, Oklahoma and Missouri, as the sampling method was purposeful and convenient for the purpose of the study. External validity may be limited due to sampling bias. The sample was specific to counseling supervisors providing supervision to supervisees' providing services to clients who experienced trauma. While the literature suggests that all clients coming to counseling have experienced trauma at some level (Jordan, 2010), it cannot be assumed the outcomes of this study apply to all counseling supervisors.

The means of data collection were in-depth semistructured interviews. Moustakas (1994) and Manen (1990) identified that interviews were more consistent in obtaining perceptual views of a topic due to the relationship that builds between researcher and

participant. But it should be noted that interviews are still a self-reporting form of data collection with no objective measures being implemented to reconcile participants' perceptions to witnessed occurrences. It was beyond the scope of this study to collect data that would reconcile participants' accounts with actual witnessed behaviors. It was presumed that participants would provide a truthful recollection of lived experiences providing supervision and tertiary trauma.

Recommendations

Based on the results of this study a number of recommendations should be projected for future research. As noted above, this study was limited to a small section of counseling supervisors and additional qualitative studies should be conducted to explore the lived experiences of additional counseling supervisors. In Chapter 2 it is identified that there is scant knowledge in qualitative and quantitative literature relative to tertiary trauma. At the same time a vast amount of literature provides evidence-based understanding of vicarious trauma both the qualitative and quantitative lens (Adams, & Riggs, 2008; Cohen, & Collens, 2013; Jordan, 2010; Knight, 2010). Future researchers should consider the areas of investigation that have been done with both the qualitative and quantitative lens on vicarious trauma. Understanding through quantitative measures the true impact of tertiary trauma on counseling supervisors will help others understand the full symptomology of tertiary trauma and guide research in developing wellness techniques. Further qualitative studies could expand the understanding of perceptions associated with tertiary trauma by interviewing counseling supervisors in other counseling specialties, including counselor educators. Tertiary trauma continues to be an

under researched area that has an enormous amount of data to continue to draw from in the researchers exploration of the phenomenon.

While a number of qualitative and quantitative studies have supported the empirical foundation over the past decade on counselor wellness, I could find no studies through the literature search strategy outlined that discussed supervisory wellness. Participants in the study identified a lack of understanding in terms of supervisory wellness, and discussed the lack of education in ways to prevent tertiary trauma and burnout. More studies should examine the phenomenon of tertiary trauma from a wellness lens, looking at techniques and means to prevent and reduce tertiary trauma symptoms.

Future research should explore the true nature tertiary trauma has in the supervisory relationship. Knight (2010) identified the beneficial factors that are present during the supervisor relationship. These factors were determinant in the reduction of vicarious trauma among supervisees. Participants in past research identified that feelings of trust and safety were imperative to allowing them the opportunity to talk openly with their supervisors about the negative experiences they were experiencing (Langdridge, 2007). Qualitative studies should be conducted to understand how the supervisee and the counseling supervisor perceive how the supervisory relationship changes when tertiary trauma begins to be part of the experience.

Quantitative studies should target the development of an assessment tool for tertiary trauma. Vicarious trauma is notably identified through the use of supervision, however a growing number of researchers support the use of assessments such as the

ProQOL (Stamm, 2010) as a means to self-assess potential vicarious trauma. The development of an assessment that mimics the ProQOL (Stamm, 2010) might provide a more in-depth understanding of tertiary trauma symptoms and the impact tertiary trauma has on counseling supervisors' longevity in the profession.

Research should also focus on the sociocultural factors impacting counseling supervisors' experiences with tertiary trauma. This study had a range of working conditions that counseling supervisors practiced in, from larger community agencies to smaller private practices. However participants were limited geographically to Oklahoma and Missouri. Researchers should examine whether sociocultural factors impact the potential for tertiary trauma among counseling supervisors. Asking how tertiary trauma compares in the United States compared to other countries among counseling supervisors is worthy of investigation. Exploring whether an individual's own sociocultural factor impacts the lived experience of tertiary trauma is another potential area of research. Examining the curriculum variance among counseling programs and whether that influences a supervisor's ability to identify or reduce tertiary trauma could be quite valuable to the counselor education field. How tertiary trauma impacts counselor educators and how the roles of licensure boards influence supervisors training in the prevention of tertiary trauma could also yield valuable data for the counseling field.

This results of this study demonstrated that many of the participants reported feeling trapped and lonely in their role as a supervisor. Most stated they did not know where to turn in order to seek help, noting that they were the ones who were supposed to provide help to others in the profession. Studies into the importance of support structures

for counseling supervisors are vital for the expansion of knowledge in the area of tertiary trauma. Who provides supervision to the supervisor? The literature supporting supervision as a means to address vicarious trauma provided concise outlines for supervision with researchers stating supervision could be by a supervisor or peer consultation. The results were the same in helping a counselor identify vicarious trauma and reduce symptoms (Adams, & Riggs, 2008; Bride, Radey, & Figley, 2007). Does a supervisor need supervision by another supervisor to identify and address tertiary trauma? Or should peer consultation be used as the best means to provide support, understanding, and knowledge on the topic?

Future empirical research should be conducted to consider the role that counselor education programs have in the conceptual lens of supervisory wellness at both the Masters and Doctoral level. Research supported the alteration of counseling programs to provide an emphasis on the role of educating future counselors on counselor wellness from the beginning of their career growth (Trippany, et al., 2004). With a lack of research exploring the margins of tertiary trauma, research needs to be conducted into how implementing a sound understanding and growth of wellness from a supervisory perspective may reduce the potential of future supervisors facing tertiary trauma.

Implications for Positive Social Change

Implications for positive social change emanate from this study's findings in a number of ways in respect to differing levels, study boundaries, methodological, theoretical, and empirical understandings. Methodologically this study adds to the knowledge of qualitative research regarding tertiary trauma. The significant gap found in

literature pertaining to tertiary trauma and the perceptions of counseling supervisors drove the need to conduct this study.

To date, I was not able to identify any phenomenological studies conducted on the lived experiences of counseling supervisor and tertiary trauma. Moreover, the definition of tertiary trauma and an understanding of how trauma transitioned from a vicarious level to a tertiary level had not been closely examined. A hermeneutical phenomenological standpoint allowed an opportunity to develop a working definition of tertiary trauma with an understanding of how the phenomenon was experienced through the lives of counseling supervisors.

Recruiting counseling supervisors for the study was not a challenge; however guiding conversation that included counseling supervisors to disclose their struggles in providing supervision proved to be perplexing. Counseling supervisors act in a gate keeping role, with the expectations of ensuring client care, ethical standards, and over all professional conduct (Adams, & Riggs, 2008; American Counseling Association, 2014). Eliciting responses that were of meaning and enriched with data meant I had to be willing to revise my own approach to communicating with participants. Adapting a client-centered approach to conversations allowed for more open discussion of the research questions, and allowed participants to maintain a level of control in building the research relationship.

Findings from this study further conveyed implications for the practice of counseling supervision. Counselor education program, supervisor training programs, and counseling agencies may distill the study's findings to develop a collaborative

intervention for counseling supervisors dealing with tertiary trauma. I found scarce literature on the need for wellness among counseling supervisors, and the mention of tertiary trauma only in other professions (Hodgson, et al., 2000; Houshian, et al., 2002; Knight, 2010). Thus, it is critical for the counseling profession to recognize the need to integrate wellness techniques into the supervisory process for counseling supervisors.

The data outcomes of the study emphasize the need for counseling supervisors to (a) understand the construct of tertiary trauma (b) consider the implications for their role as a supervisor and (c) recognize the impact their own wellness has on their perceptions of the experience of conducting clinical supervision. In greater expansion the findings accentuate the need for the counseling profession to (a) understand the importance of counseling supervisors roles as gate keepers to the profession (b) increase the training counseling supervisors have access to regarding self-care and (c) realize that the impact of tertiary trauma in a counseling supervisor might influence the entire parallel process of supervision swaying client treatment outcomes.

The findings of the study underscore the need for counseling supervisors and the counseling profession to (a) increase their awareness of tertiary trauma (b) consider the importance of supervisory wellness techniques (c) understand the role continued supervision and collaboration can have even as a supervisor (d) realize the importance of continued growth in the profession in addressing the needs of future counseling supervisors ability to reduce traumatization within themselves.

I recommend the counseling profession and counseling supervisors consider the implementation of techniques associated with the reduction of vicarious trauma, such as

mindfulness (Trippany, et al., 2004) to assist in appropriately responding to tertiary trauma. Trainings in the form of seminars and continuing education courses could serve as conduits for increased awareness, education and interventions in addressing counseling supervisors need for additional knowledge pertaining to tertiary trauma. Implementing tertiary trauma reduction training programs appears to be an under represented area of continuing education among the counseling profession.

Findings from this study have the potential to assist researchers in the development of an assessment tool that could engrain positive social change for counseling supervisors by helping them self-identify tertiary trauma. Mutual collaboration among counseling supervisors has the potential to effect positive social change for supervisors by providing an opportunity to feel connected in their profession, linked to others of like mind, and build a support structure to identify when struggles are occurring. On an organizational level, collaboration between counseling associations, counselor educational programs, and state licensure boards may result in the delivery of knowledge regarding tertiary trauma that supports the counseling supervisor in addressing their own wellness.

Conclusions

This hermeneutic phenomenological study outlined the lived experience of eleven counselor supervisors who experienced tertiary trauma when providing clinical supervision to trauma counselors. These supervisors shared their personal experiences providing supervision for the purpose of this research, revealing that serving as a counseling supervisor does not make you impervious to the experience of trauma. In the

role of acting as a gate keeper, protecting the care that clients receive while encouraging professional growth and development of supervisees, counseling supervisors often have a confounded expectation of what they must complete in a day's work. Findings from this study demonstrated that counseling supervisors have a tendency to feel isolated in their role as a counseling supervisor, and feel they have let others down when they do not have an answer to solve a problem leading to a decreased sense of self efficacy.

While the prevalence of tertiary trauma among counseling supervisors needs continued research, the response of the participants in this study began the identification of a phenomenon called tertiary trauma which now has an evidence base linking it to clinical supervision. Social change often has to begin within the source of those who create change in the lives of others. Counseling supervisors hold a great responsibility in assisting social change endeavors within their supervisees and the supervisees' clients. It would only make sense that to strengthen the skills of counselors, social change of self-care has to begin with the counseling supervisor. The findings from this study add to the professional body of knowledge that informs the counseling profession on the importance of facilitating growth for counseling supervisors that will radiate into positive change for supervisees and their clients.

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Appendix A: Screening Questionnaire

1. Are you currently providing supervision to other counselors?
2. Are you providing clinical supervision? Licensure supervision? Both?
3. How many counselors do you supervise?
4. How many are under licensure supervision?
5. How many are clinical supervision?
6. Do those you supervise have a focus of providing trauma focused treatment to clients?

Appendix B: Initial Interview Questions

1. I wonder if you can start by telling me about your journey that brought you to supervise counselors in their work with trauma.

2. As a counseling supervisor what have you seen in your counselors that suggested they'd experienced secondary or vicarious trauma?

3. I'd like it if you can share with me a story of your work with a counseling supervisee who was dealing with vicarious trauma?

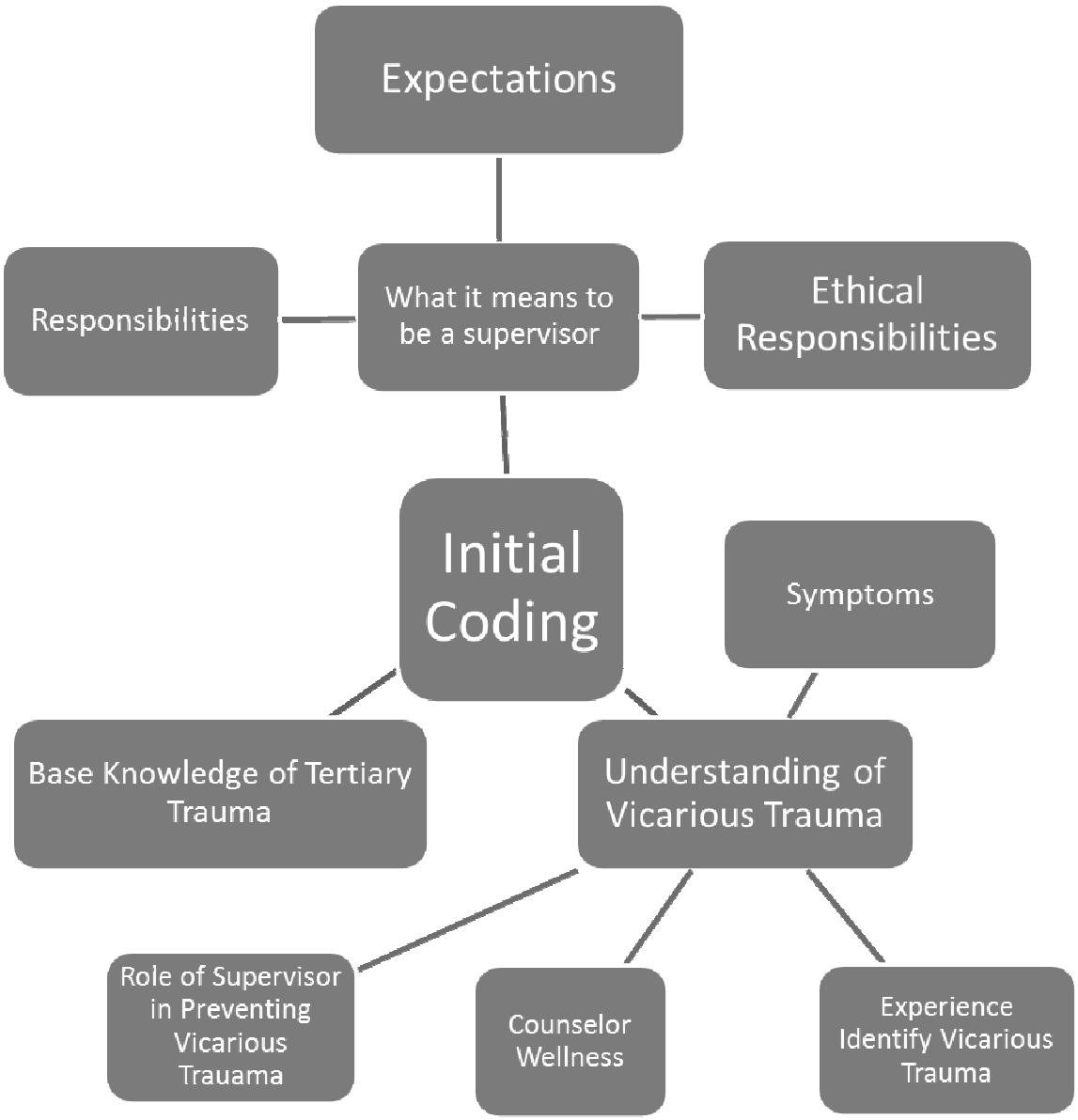
4. What was that experience like for you?

5. I am exploring the concept of tertiary trauma- which is the step beyond vicarious trauma in that it describes the impact trauma cases have on counseling supervisees. Keeping in mind experiences you have seen of vicarious trauma at the counselor/supervisee level, what does it mean to you as a supervisor to hear the phrase tertiary trauma? How would you describe tertiary trauma?

6. As a counselor supervisor what experiences do you believe a counseling supervisor living with tertiary trauma might have?

7. When talking about tertiary trauma is there anything you would like to share that you feel I have not asked yet in regards to the topic? Nope, I think it's a great question.

Appendix C: Initial Coding



Appendix D: Tertiary Trauma