

Early career clinicians' supervision experiences related to secondary traumatic stress when treating child survivors of sexual abuse

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Abstract:

In this study, we examined experiences of supervision related to Secondary Traumatic Stress responses among early career mental health clinicians treating child survivors of sexual abuse. We utilized consensual qualitative research methodology to capture the experiences of clinicians undergoing the phenomena. We report data analysis findings and implications for research and clinical supervisors.

Keywords: secondary traumatic stress | clinical supervision | consensual qualitative research | child sexual abuse | early career mental health clinicians

Article:

In the United States in 2018 there were 47,124 cases of child sexual abuse substantiated by the Department of Health and Human Services. Given the prevalence of child sexual abuse and the adverse effects often experienced, early career clinicians are likely to work with children under 18 who are survivors of sexual abuse (CSSA) and thus have exposure to the specific details of the abuse throughout the treatment process (Whitfield & Kanter, 2014). Early career clinicians working with CSSA have an increased risk of suffering from Secondary Traumatic Stress (STS; Hensel, Ruiz, Finney, & Dewa, 2015; Many & Osofsky, 2012). This risk can reduce early career clinicians' effectiveness, overall wellbeing, and retention in the field (Sprang, Ford, Kerig, & Bride, 2019). In this study, we focused on early career CSSA clinicians' experiences of STS and how they perceived their work was, or was not, supported in supervision.

Secondary traumatic stress

Scholars lack consistency in the way they define and measure STS (Molnar et al., 2017). However, emerging from systems theory, STS is commonly understood to result from indirect exposure to the traumatic experiences of clients, including child clients, during the process of helping (Ludick & Figley, 2017). The symptoms of STS outlined by Bride (2004) resemble Post-Traumatic Stress Disorder (PTSD): (1) intrusion/reexperiencing, (2) avoidance, and (3) increased arousal. Though STS responses were the focus of this investigation, vicarious trauma, characterized by a shift in worldview and cognitions, is also frequently experienced by clinicians who are indirectly exposed to children's trauma in their work (Van Deusen & Way, 2006). Therefore, the literature and findings referenced in this study may include the corresponding, or co-occurring, experiences of vicarious trauma.

For helping professionals, first responders, and clinicians, STS can be an expected hazard when engaging in trauma work (Ludick & Figley, 2017). Out of a sample of 253 trauma clinicians, 70% endorsed being at a high risk for STS (Sodeke-Gregson et al., 2013). Early career trauma clinicians with less experience, training, and low self-efficacy are at a greater risk of STS (Hensel et al., 2015). Other factors increasing the likelihood clinicians will experience STS include higher trauma caseloads and greater indirect trauma exposure in their work (Sprang et al., 2019), unresolved personal trauma history similar to the clients they are serving (Sodeke-Gregson et al., 2013), and lack of organizational and personal support (Killian, 2008). Trauma work with children can be especially challenging.

Treating child survivors of sexual abuse

Clinicians specializing in sexual and child trauma treatment have reported STS symptoms that overwhelmed their ability to cope, caused psychological distress, produced rescue fantasies about clients, and led to a desire to leave the field (Chouliara et al., 2009; Lonergan et al., 2004). McNeil (2013) reported substantial percentages of helping professionals working with CSSA experienced STS symptoms in the mild (44%) and moderate to high (31%) range. Clinicians may have ongoing contact with CSSA following the trauma (e.g., months, years), leading to clinicians' prolonged exposure of the long-term impact of sexual abuse and systemic barriers (e.g., delayed prosecution) experienced by children and families (Many & Osofsky, 2012). Clinicians with STS who treat CSSA may begin to display emotional distance and cynicism toward perpetrators, CSSA, and the responding social service and criminal justice systems (Many & Osofsky, 2012).

Furthermore, clinicians' experiences of STS could cause them to engage in dissociative and avoidant behaviors in session with CSSA, leading to feelings of hopelessness about their treatment efforts (Etherington, 2009). These clinicians also may have countertransference responses that could lead to ethical boundary crossing (e.g., clinicians feeling they need to protect/rescue a child client from further harm may make themselves available at all times by phone; Etherington, 2009). Clinicians may have shame and guilt about these responses that, when left unexpressed within supervision, could lead to personal and professional impairment (Knight, 2013). The contribution of these unique experiences to STS responses in clinicians working with CSSA lead to the necessity to further investigate supervision experiences of early career clinicians that may mitigate these responses.

Supervision and secondary traumatic stress

Supervision is frequently suggested as an essential component to combat STS responses in clinicians (Knight, 2018; Whitfield & Kanter, 2014). Knight (2018) conceptualized trauma-informed supervisors as holding the roles of teacher, counselor, and consultant in providing vital information to supervisees regarding managing their role as a trauma clinician and providing effective trauma treatment interventions. Trauma-informed supervisors possess trauma treatment competency along with an ability to identify indirect trauma responses in clinicians (Berger & Quiros, 2016). They help mediate STS symptoms through increasing supervisees' self-efficacy and self-awareness (Ortlepp & Friedman, 2002), establishing a strong, supportive supervisory alliance (Harrison & Westwood, 2009), and creating a safe, collaborative, and empathic supervision environment (Ling et al., 2014).

These and other authors (e.g., Courtois, 2018; Knight, 2018) have described supervision practices that could mitigate clinician STS and related responses in a variety of clinical contexts (Knight & Borders, 2018). Qualitative researchers studying trauma clinicians with a wide-range of years of experience have reported perceptions of (a) vicarious trauma (Harrison & Westwood, 2009); (b) post-traumatic growth (Bartoskova, 2017); (c) compassion fatigue, burnout, and self-care (Killian, 2008); (d) trauma counseling narratives (Sommer & Cox, 2005); (e) growth and development in trauma counseling (Lonergan et al., 2004); (f) and ability to overcome challenges of trauma therapy work (Ling et al., 2014) as helpful. Within these studies, trauma clinicians shared perspectives about the influences and benefits of supervision in their ability to manage indirect trauma exposure responses that may co-occur with STS (e.g., compassion fatigue, burnout, vicarious trauma), and identified avenues for overcoming challenges faced in trauma counseling (Harrison & Westwood, 2009; Ling et al., 2014; Sommer & Cox, 2005).

None of these researchers, however, explored the experiences of early career trauma clinicians working with CSSA, early career CSSA trauma clinicians' experiences of STS, or how STS and counseling CSSA were addressed in early career supervision. Such a focus is increasingly important as early career clinicians are at a greater risk for STS (Hensel et al., 2015). Therefore, the purpose of this study was to explore experiences of early career clinicians working with CSSA and experiencing STS responses, and how their supervisors addressed, or did not address, their experiences of STS. The following research questions guided this study: What are the experiences of early career clinicians working with CSSA? What are the experiences of early career clinicians with STS responses while providing treatment to CSSA? What are the supervision experiences of early career clinicians related to STS while providing treatment to CSSA?

Method

We used Consensual Qualitative Research design (CQR; Hill et al., 1997, 2005) for the purposes of exploring and analyzing the wide-ranging supervisory and STS experiences of early career clinicians treating CSSA. CQR is rooted in grounded theory, phenomenology, and comprehensive process analysis qualitative approaches (Hill, 2012; Hill et al., 2005). We selected CQR for this study due to the consensual processes as well as rigorous, consistent data

collection and analysis methods inherent to the design (Hill et al., 2005). Using CQR, we aimed to gain an in-depth understanding of the participants' inner experiences with STS responses, as well as their attitudes and beliefs about supervision received regarding their work with CSSA and STS (Hill, 2012; Hill et al., 2005).

The research team

The research team included one third-year, one first-year, and two second-year counselor education doctoral students (first-fourth authors) from a large southeastern university at the time of the study. We identified as White females ranging in age from late 20s to early 30s. We varied in professional training (e.g., clinical social work, mental health counseling), professional experience, as well as additional cultural characteristics (e.g., sexual orientation, disability, religious affiliations). Two counselor education faculty members at the research team's university served as external and internal auditors; each had extensive training and experience in CQR design. The internal auditor (fifth author) identified as a White female in her mid-30s, the external auditor (sixth author) as a White male in his mid-30s. The internal auditor was involved following each phase of data analysis, while the external auditor was involved following the final phase of data analysis (Hill, 2012).

Positionality and trustworthiness

Acknowledging positionality is an important component of CQR (Hill, 2012). Two of the four research team members had extensive experience working with CSSA, with one member identifying with STS responses during work with the population. The auditors did not have experience with STS or counseling CSSA. However, all authors believed that STS was likely to be commonly experienced in early career trauma counseling with CSSA. We also expected that it was likely that STS experiences would not be widely shared or acknowledged in supervision due to the stigma surrounding having such responses within the field and in organizational contexts (Sprang et al., 2019). Further, we acknowledged our training and clinical experiences with supervision may have influenced our biases surrounding the expected importance of the supervisory working alliance and essential components of supervision in alleviating STS responses. Finally, the coding team may have had increased responsiveness to auditors' feedback due to the existing power differential of the faculty-student relationship.

Before beginning the study, we bracketed expectations and biases regarding the phenomenon (Hill, 2012) and created consensus process rules (e.g., continually returning to original data, rotating leadership in facilitation of consensus meetings; Hill et al., 2005) to manage any disagreements during data analysis. Throughout the study, we engaged in trustworthiness measures to increase reflexivity about the impact of our positionality (e.g., continuous discussions about biases during consensus meetings, reflective notetaking throughout data collection and analysis, use of auditors; Hill, 2012). We used member checking procedures by having participants review their transcripts for accuracy and review the findings for feedback following cross-analysis (Hill, 2012).

Participants

In line with Hill et al. (1997), we used criterion-based sampling and snowball sampling methods (Creswell, 2008) to identify and recruit a homogenous sample of 10 early career clinicians. Inclusion criteria consisted of the following: (a) minimum of a provisional license in counseling or related mental health profession (e.g., LMSW, LPC-A), (b) currently receiving supervision (agency or licensure clinical supervision), and (c) at least one-third of caseload made up of CSSA aged 18 and under (previous studies of similar constructs required criterion of 40% caseloads of trauma clients; e.g., Bartoskova, 2017). We did not include screening for STS responses as an inclusion criterion since this information could have led to pre-established ideas or assumptions about participants' STS responses (Hill, 2012), which were likely complex, diverse, and variable (Sprang et al., 2019). Given that STS is considered an unavoidable response to indirect trauma exposure (Ludick & Figley, 2017) and early career clinicians are at the greatest risk of STS (Hensel et al., 2015), it seemed logical to conclude that the clinicians likely had experienced some STS responses to their work.

Participants ($n = 10$) were early career licensed counselors (six) or licensed clinical social workers (four) currently providing therapy to CSSA clients in four southeastern states and one northeastern state in the US. They reported an average of 10 CSSA clients under 18 on their caseload at the time of the interviews, with approximately one-third to one-half of their caseloads made up of CSSA. They had an average of four years of clinical experience, with eight of the 10 within their first five years of practice, and were working in community mental health centers, private practice, child advocacy centers, and a rape crisis center. All had post-graduate training in child trauma therapy interventions (e.g., Trauma-Focused Cognitive Behavioral Therapy, Child and Family Traumatic Stress Intervention). Six of the participants were currently receiving licensure supervision and all participants were receiving agency clinical supervision. Supervision frequency ranged from one to two hours per week to two hours per month. All identified as White females ranging in age between 25–34.

Procedures

After approval from the university's institutional review board, we recruited volunteer participants using snowball sampling methods (Creswell, 2008) via e-mails to agencies and early career clinicians we knew who worked with CSSA. Before the interviews, clinicians completed informed consent, inclusion criteria and demographic forms; they were instructed not to include identifying information of CSSA clients in responses. We conducted one audio-recorded, semi-structured telephone interview, lasting approximately one-hour each (Hill et al., 2005). We used telephone interviews to increase participant privacy and reduce hesitancy to answer sensitive questions; Hill (2012) reported no empirical evidence for prioritizing face-to-face over phone interviews.

We developed the semi-structured interview protocol based on relevant literature. Trained interviewers followed three scripted, open-ended prompts, along with several suggested probes. To provide a general framework for participants to openly share (Hill, 2012), we prompted participants to tell us about (a) experiences working with CSSA, (b) experiences with STS responses, and (c) experiences in supervision regarding work with CSSA and identified STS responses. Based on participant responses we followed-up with open-ended questions about challenges working with CSSA and strategies they used to overcome these challenges (Ling et

al., 2014); their experiences with STS symptoms (e.g., intrusion, avoidance, arousal, emotional/daily functioning impairment [Bride, 2004]); and supervisory relationships, helpful/unhelpful supervision experiences, and beneficial supervision practices regarding STS responses and their work with CSSA (Knight, 2013). Given that the interviewers were licensed clinicians who were able to empathically respond to participants (Hill, 2012), we conducted check-ins with participants at the completion of each interview to ensure cognitive and emotional stability and provided potential referrals for any current STS responses.

Data analysis

Initially, all research team members except the auditors immersed ourselves in the data through conducting the interviews, reading the transcribed data, and writing extensive data analysis notes (Hill et al., 2005). We utilized three steps as outlined by Hill (2012) and Hill et al. (2005): (a) developed start list domains from the interview protocol which were later expanded to six domains following internal auditor feedback and reevaluation to remain close to the data, (b) developed core ideas from participants' words which were summarized and matched to corresponding domains, and (c) created categories and subcategories during cross-analysis that captured the most frequently represented main ideas within the data. In line with Hill (2012), we labeled the categories and sub-categories in frequencies of General (found in the majority of cases, nine to 10), Typical (six to eight), Variant (two to five), and Rare (one case). Following a final internal and external auditor review, we eliminated rare categories and collapsed categories and subcategories to remain consistent with participants' experiences.

Findings

Below we describe the six domains and general categories that emerged from the data analysis and provide examples of supporting participant quotes. Due to space limitations, written findings describe typical or variant categories and subcategories within the context of each domain. The names of all categories and subcategories are found in Table 1.

Table 1. Early clinician's experiences (n = 10) with CSSA, STS and supervision

Domains and Categories	Frequency
Domain I: Early Clinicians' Challenges When Working with CSSA	
Category 1: Caregiver Response	General
<i>Subcategory 1: Lack of Support</i>	<i>Typical</i>
Category 2: Efficacy and Boundary Setting	General
<i>Subcategory 1: SA Stories Difficult to Hear</i>	<i>Typical</i>
<i>Subcategory 2: Competency Concerns</i>	<i>Typical</i>
Category 3: Social Welfare Systems Involvement	Variant
Category 4: Child Response	Variant
Domain II: Effects on Early Clinicians When Working with CSSA	
Category 1: Intrapersonal Disruption	General
<i>Subcategory 1: Altered Worldview</i>	<i>General</i>
<i>Subcategory 2: Affective Responses</i>	<i>General</i>
Category 2: Interpersonal Disruption	Typical
Category 3: Somatic	Typical
<i>Subcategory 1: Altered Worldview</i>	<i>Typical</i>

Domains and Categories	Frequency
Domain III: Early Clinicians' Growth Experiences Related to Trauma Work	
Category 1: Post-Traumatic Growth	Typical
Domain IV: Protective Supervision Factors for Early Clinicians	
Category 1: Supervision Structure	General
<i>Subcategory 1: Predictable Supervision Format</i>	<i>Typical</i>
<i>Subcategory 2: Supervision Interventions</i>	<i>Typical</i>
<i>Subcategory 3: Supervision Accessibility</i>	<i>Typical</i>
Category 2: Supervision Relationship	Typical
<i>Subcategory 1: Strong/Close Supervisory Relationship</i>	<i>Typical</i>
<i>Subcategory 2: Supervisor Traits</i>	<i>Typical</i>
Domain V: Inadequate Supervision Experiences of Early Clinicians	
Category 1: Administrative Aspects of Supervision	Typical
Category 2: Clinical Aspects of Supervision	Typical
Domain VI: Early Clinicians' Experiences of Wellness Practices	
Category 1: Support System	Typical
Category 2: Self-Care	Typical
Category 3: Agency Culture	Variant
Category 4: Peer Consultation	Variant

Abbreviations in the title are child survivors of sexual abuse (CSSA) and secondary traumatic stress (STS). In line with Hill (2012), categories are labeled as General (nine to 10), Typical (six to eight), and Variant (two to five).

Domain I: early clinicians' challenges when working with child survivors of sexual abuse

Participants consistently described working with CSSA as both professionally and personally challenging. They described feeling ill-prepared by their graduate programs to navigate the complexities of trauma counseling with CSSA, particularly as their child clients were not always able to comprehend the experience or treatment process. One participant endorsed feeling overwhelmed when initially working with CSSA: "I felt like way in over my head on how to respond if somebody [a child] was like disclosing or were really talking about details." She further described that, while she felt comfortable teaching clients generalizable coping strategies, she continued to feel discomfort and uncertainty around how to empathetically respond to detailed disclosures related to child sexual abuse. Other participants also discussed how hard it was to hear children recount the details of sexual abuse experiences. One stated, "working with kids who are survivors of sexual abuse is hard. It's really difficult to kind of sit with them and listen to them recount their stories." One reported, the "majority of them [children] are kind of little ... and to hear them talk about how perpetrators would tell them that they would kill them if they told anybody ... it's difficult to try and listen to that and keep a straight face." Participants discussed challenges of navigating when it was appropriate to encourage the child to talk about the trauma when avoidant symptoms were present. One shared, "Because of the nature of the abuse, it can be very challenging because you also don't want them [children] to feel like, 'Oh great, well now I'm like forced to, you know, talk about it.'"

Participants described needing to find ways to adapt counseling to meet the needs and developmental level of each child client. One described addressing this challenge by talking openly with the child about the sexual abuse and giving the child "complete control over how we talk about this." Another described providing psychoeducation because "young kids that I see have no personal safety, no sexual abuse, no sex education understanding information at all,"

adding that adolescents also had inaccurate information, such as “believing that some deviant sexual behaviors are more normal.” Participants reported feeling challenged by additional trauma symptoms such as “sexually reactive behaviors,” “self-stimulation,” and “behavioral outbursts.” They also described the difficulty of navigating social welfare systems when working with CSSA due to their own lack of preparation and knowledge as well as poor communication between agencies. A participant disclosed initial surprise that part of her responsibility was “... to have to work with legal systems, which isn’t something I was expecting with counseling.” One participant reported the challenge to “facilitate communication between all parties.” Another reported feeling as if the child’s voice was lost: “I think the frustrating part with children is that you have so many other people in their lives that are making decisions for them and nobody rarely asks the child what they want.”

Category 1: caregiver response

Most participants expressed having personal challenges when caregivers were unsupportive following disclosures of sexual abuse. One reported, “I’ve also worked with children who don’t have that support at home, and it makes things so much harder in the healing process just because there’s no validation at home.” Another described the difficulty of finding caregiver support for clients in foster care: “I’ll be working with a foster parent or with a family member ... and who has custody at the end is a whole new person.” Participants described added difficulties for the child’s healing due to impacts of trauma on parents. One stated, “Their [children’s] parents are very overwhelmed and emotional themselves and not really in a place to be a support person,” saying this impacted the child because “it makes the child feel shame.” Participants reported this challenge was exponentially more difficult when the perpetrator of abuse was within the family. In these cases, they described spending a significant amount of time counseling the parents and providing education to increase support for the child.

Category 2: efficacy and boundary setting

Participants described feeling unprepared to navigate the complexity of work with CSSA early in their career. They consistently endorsed that, when first beginning work with CSSA, it was difficult to set boundaries and separate professional and personal life. One reported, “It would be kind of overwhelming the things that the children had gone through ... when I first started working with that population, I was very nervous ... it was hard not to take it home.” Participants were professionally challenged initially due to their low self-efficacy to provide trauma counseling to CSSA. One participant described,

I would stay with the kids, and I would be like “Oh my God, this is like way over my head. I’m not experienced enough for this” At some points it really got me down on myself ... to feel like you’re incompetent at your job is really difficult.

Another participant reported feeling concerned about her lack of training because when “you get a child who has had sexual abuse you could kind of trigger them or regress them in their treatment if you don’t know what you’re doing.” One described recurring feelings of low self-efficacy: “there are still days where I feel like sexual abuse is completely like out of my realm and I have no idea what I’m doing.”

Domain II: effects on early clinicians when working with child survivors of sexual abuse

Participants described varied early career experiences of interpersonal, intrapersonal, and somatic disruptions from their work with CSSA. For example, one reported feeling “... frustrated, overwhelmed, burnt out, lots of things.” Another noticed disruption in her perception of the world and distrust “just of people in general ... it makes me extra cautious with my own child.” It was clear that participants identified with STS regardless of the level of intensity or diversity of symptoms experienced. When the interviewer read the definition and symptoms of STS, one participant responded, “Oh my god that’s so me.”

Category 1: intrapersonal disruption

Participants commonly identified the following intrapersonal disruptions: altered worldview, emotional instability, desensitization, and experiencing intrusion in the form of recurring thoughts and nightmares about traumatic events their CSSA described. One reported changes in her parental caregiving and decision-making: “He won’t have sleepovers ... The reason for seven and a half years between kids is because of that altered view of the world ... We live in such a sick, screwed up world, I don’t want to bring another kid into this.”

Other participants noted feeling desensitized when child clients spoke about their trauma, so that they sometimes struggled with offering empathy. One mentioned, “There are a lot of times where I do feel like desensitized to what [child] clients are telling me.” Another described this struggle by reporting,

The kids would be talking about their stuff and you show emotion towards them, but you don’t want to become overly emotional because you don’t want that to feel like I can’t talk to you ... and so trying to keep your guard up, yet show compassion, empathy, it’s really draining at times.

However, some felt overly connected. One clinician reported “... having nightmares and my nightmares were me as the victim, but experiencing things that I was hearing in the forensic interviews” Another reported that she began to “think about how many kids are out there that are suffering, and like feeling like you can’t do enough.”

Participants reported experiencing various emotions associated with their early career work, often including anxiety. One described anxiety when she had to tell a parent that a child client disclosed sexual abuse in session: “My heart was racing, I could not breathe, I got through telling her what I needed to do and then I think I had what was an anxiety attack ... I had to go home.” Another shared that when seeing certain CSSA clients she would feel “really jittery like I had too much caffeine ... and it usually takes me a good 10 or 15 minutes to come down from those sessions.”

Domain III: early clinicians’ growth experiences related to trauma work

Throughout the interviews, participants described professional growth that occurred as a result of early career trauma counseling with CSSA. They described growing in self-efficacy as they gained experience with this population. Over time, participants described finding meaning in their work. One shared, “I get to help them [children] talk about it [sexual abuse] and life isn’t so bad. I get to be here to do that.” Participants also described finding meaning in their work due to seeing “just how resilient they [children] were.” A similar response was endorsed by another participant: “It’s like those kids, something happened to them when they were little, but we are getting a chance to talk with them ... they’re in a new setting, and they have a new chance.”

Regarding growth in self-efficacy, one participant stated, “I definitely think I am a little bit more competent that like I can kind of handle things that they [children] talk about, but that definitely ... it took a long time for that to happen.” Another described her growth in confidence working with CSSA: “Now ... I feel very confident working with children that have been sexually abused. In fact, my favorite clients.” Others identified changes in themselves, such as being more patient and empathically present with CSSA. One participant described being “more sensitive to kids,” stating that when she first began she “would get really frustrated with the kids, so like ‘just talk to me, just tell me what’s going on,’ and like after working with this population I feel I’ve learned to be a little more patient.”

Domain IV: protective supervision factors for early clinicians

Participants discussed elements of supervision they felt supported their role as an early career CSSA trauma clinician, which included protective supervision structures (general category; n = 9–10) and supervision relationships (typical category; n = 6–8). Participants commonly referenced facilitation-style supervision sessions, the supervisory relationship, and supervisor traits as important factors in their ability to manage challenges related to early career counseling CSSA. One stated it was helpful when her supervisor would give her space to vent about her work with CSSA while the supervisor remained “ ... very present and, you know, engaged and validating and, you know, normalizing the experience, all those different things that I’ve always done for clients.” Another described a similar response from her supervisor when she would debrief with him after CSSA sessions:

Just being able to be very honest with him and not feeling judged ... he always expressed confidence in me and that helped, and being able to be pretty real with him about what I was experiencing ... just like that’s really sticking with me ... it’s hard to get it out of my head ... and process with me.

One participant described her supervisor consistently checking in with her about her emotional well-being and how this helped reduce impacts of early career work with CSSA: “Just knowing that ... if things get too heavy, I have this extra support was huge ... having that supervision just made it seem more manageable, and I think it affected me less overall.”

Participants reflected on the importance of the supervisory relationship and trust in their supervisor, as this allowed for more open discussions of their needs and experiences when working with CSSA early in their career. They also reported supervisor validation led to their being more engaged, validating, and normalizing with their own CSSA clients. One shared an

experience in which her supervisor compared this clinician's personal responses to working with CSSA to what her CSSA client was exhibiting in session, thereby increasing her empathetic understanding of her client. She described the supervisor saying, "You know what you're feeling right now, like that's what that [child] client feels all the time, so this is their world ... ' she was able to kind of ground me when everything seems really heavy."

Category 1: supervision structure

When discussing how supervisors facilitated supervision sessions, participants discussed several facets of their supervision they felt supported their needs as early career CSSA trauma clinicians. These facets included supervisor accessibility, supervisor experience counseling CSSA, and supervisor-supervisee collaboration. Participants discussed the value of supervisors who were able to share interventions and techniques they had used when counseling CSSA. One stated that, through the supervisor's knowledge and experience, they were able to offer "... different interventions to use with them [children] like what therapies have worked, you know, what doesn't work, um how to get the family engaged ... that has been really helpful." Participants also described the importance of supervisor accessibility during times of need or crisis, maintaining regularly scheduled supervision sessions, and the supervisor's willingness to remain flexible in their approach to supervision sessions.

Domain V: inadequate supervision experiences of early clinicians

Inadequate clinical and administrative supervision experiences related to participants' early career work with CSSA emerged from the data with typical frequency (n = 6–8). Ineffective clinical supervision aspects, opposite of above supportive experiences, included the supervisor not providing direction in session, lack of rapport with supervisee, and having no experience working with CSSA. A participant shared an early experience with having a lack of supervisory support in managing court proceedings for a CSSA client: "I had to give a deposition for one of my little girls ... and I had no direction or help." Another shared how she felt about her supervisor, who lacked experience working with CSSA, stating, "He didn't really have feedback on that specific population ... because he didn't know how to work with children." Another echoed this experience, stating her supervisor had "no idea what you're dealing with, ... they don't understand children. If they don't work with children, they are not going to know how to help you."

Participants also shared inadequate administrative supervision experiences, describing managerial tasks taking supervision time, dual relationships, and lack of safety to disclose STS experiences. One participant reported, "She's [the supervisor] wearing like 100 hats and is a little less accessible." Another shared that supervision and support being inaccessible exacerbated impacts of early career work with CSSA: "the fact that there wasn't really any support and there was just a lot of tension in the workplace ... and then you're experiencing secondary trauma symptoms." One participant described feeling unsupported in supervision when working with CSSA early on: "I used to get so angry ... I gave up on trying to get help." Another described guarded disclosure in supervision due to an administrative dual role: "My supervisor was a part of the greater agency ... I was concerned about privacy." Participants also reported having their

experiences “minimized” or being told to “push through it” when they did disclose personal impacts related to doing early career trauma work with CSSA.

Domains VI: early clinicians’ experiences of wellness practices

Participants reported wellness practices both in and out of the work setting. They endorsed the value of working in an agency that allowed and supported them in setting professional and personal boundaries to promote wellness when managing a caseload that included CSSA early in their career. One described the importance of having an agency that allowed flexible scheduling and time away from work: “I stay at my job ... because I can move my schedule around ... they don’t give me any problems with that. It’s my choice how many days a week I work ... it’s very, very flexible.” Another discussed feeling supported by her agency as being vital to her ability to maintain her early career work with CSSA, stating, “If I didn’t have a support system like this, I would probably not be able to do the job ... because that is a huge part of why I can do as much as I do.” Participants also shared details related to the role and value placed on peer supervision and consultation within their agency, which allowed them to feel supported and like every case is a “team effort.”

Participants also discussed engaging in enjoyable activities outside of work and setting boundaries between their personal and professional lives. Participants described the importance of self-care. A participant reported “taking care of yourself is really important,” and another stated, “I really make self-care a huge part of my existence.” Participants described how valuable it was to have a strong support system consisting of healthy professional (e.g., supervisors, colleagues) and personal (e.g., partner, friends, family) relationships. One shared how vital this aspect of wellness was for her, stating, “I have a really supportive group of people that I work with and then strong support at home ... if I didn’t have that, I think that it might be hard to not carry some of the [children’s] stories home.” Overall, participants shed light on self-care practices, healthy limit-setting, supportive relationships, and agencies that promote wellness as essential to maintaining practice with CSSA.

Discussion

Early career clinicians in this study, who were counselors and social workers, illuminated the challenges of working with CSSA while experiencing STS responses, as well as supportive and nonsupportive supervision conditions. First, we discuss the findings related to early career STS responses and challenges of working with CSSA within the context of previous literature. Though participants endorsed experiences that co-occurred with STS (i.e., vicarious trauma) in prior studies regarding clinical work with adult sexual trauma populations (Chouliara et al., 2009), our study provided new perspectives about STS experiences of early career clinicians working with CSSA. The nuances and challenges participants described, as specific to early career counseling CSSA, included the following: (a) personal and professional impacts associated with hearing children process graphic sexual trauma experiences; (b) the need to adapt treatment interventions based on the developmental level and unique needs of CSSA (e.g., foster care placement instability, sexually reactive behaviors); (c) challenges navigating communication with child welfare and judicial systems, (d) efforts to ensure CSSA’s caregivers’ needs were addressed in treatment in order to elicit support for the child’s healing process; and

(e) altered worldviews leading to feelings of distrust toward people and concern about the safety of children and the pervasive impact this had on their own families and social interactions (e.g., not allowing their children to go to slumber parties, not wanting to have more children, hypervigilance at normative outings). These results contrasted with those of more experienced trauma clinicians, who described an ability to separate their clients' experiences from their own realities (Lonergan et al., 2004), having improved interpersonal relationships (Bartoskova, 2017), and a more positive outlook on life (Harrison & Westwood, 2009).

Early career CSSA clinicians in this study described feeling physically and emotionally impacted in session when hearing child sexual trauma narratives, even having feelings of panic when sharing sexual abuse disclosures with CSSA parents. Participants felt unprepared and sometimes unable to empathically respond to children's accounts of sexual abuse. In contrast, experienced trauma clinicians described having an ability to cope with indirect exposure by using mindfulness, emotion regulation, and cognitive coping skills in session that allowed them to be more empathically present (Harrison & Westwood, 2009). Our findings enhance the scholarly work surrounding the nuanced impacts of early career counseling with CSSA (e.g., intense emotional and physiological responses in session, difficulty with empathic presence), while studies of more experienced trauma clinicians highlight the developmental changes possible if critical early career challenges of new clinicians are addressed.

Although Many and Osofsky (2012) wrote about the challenge of CSSA clinicians navigating multidisciplinary teams in the justice system, early career participants in this study described lacking awareness, supervisory support, and training in their master's programs to assist them in understanding the intricacies of the child welfare system and their role as multidisciplinary team members in cases of child sexual abuse. Participants described feeling both shocked and overwhelmed by this added responsibility. They felt ineffective in offering support and advocacy for their child clients within this system, so that they often felt they were not doing "enough" to ensure their clients were safe. In contrast, more experienced trauma clinicians have reported feeling able to cope with the barriers within the system by seeing themselves as positive agents of change and feeling capable of making a difference (Bartoskova, 2017; Lonergan et al., 2004).

Second, we describe the findings in comparison to existing literature regarding early career CSSA clinicians' supportive and unsupportive supervision contexts in relation to STS. Given these challenges and potential for positive development highlighted by experienced trauma clinicians, this study highlighted the supervisory needs and supervision practices participants perceived as beneficial when working with CSSA and managing STS responses early in their career, as well as what supervision practices helped sustain them in their work. Findings pointed to a need for more consistent supervision focused on avenues for working with CSSA in relationship with supervisors competent and experienced in providing evidence-based trauma treatment to CSSA. These findings echoed Berger and Quiros (2016) reports of supervisors' emphasizing competence in trauma-informed practice. Participants in this study also felt less likely to disclose STS experiences with supervisors who lacked professional experience with CSSA due to feeling that inexperienced supervisors would not be able to understand their experiences working with CSSA, or be able to assist them in providing strategies to overcome clinical challenges. Participants wanted supervisors to provide a safe space for identification, processing, and validation of STS responses along with conversations about ways to manage

these responses, as previously endorsed by Knight (2018). Our findings underscored the importance of the supervisory relationship for early career CSSA clinicians to process and manage the emotional, cognitive, and professional challenges specific to counseling CSSA. They needed supervision that helped them build self-efficacy and sustainability in working with this vulnerable population, a significant need due to low retention of early career child trauma clinicians (Lonergan et al., 2004) and the potential for increased professional satisfaction and longevity when feeling competent in trauma work (Bartoskova, 2017; Harrison & Westwood, 2009).

Participants also described protective supervision factors that could provide an environment conducive to exploration of potential countertransference responses. Previous scholars have conceptually described the need for clinicians to disclose and address countertransference responses in supervision to reduce the potential for impairment and ethical boundary crossing when working with sexual trauma survivors (Etherington, 2009; Knight, 2013). Participants emphasized non-administrative, nonjudgmental, supportive supervision relationships in which they trusted they could process and learn ways to manage countertransference reactions experienced in their early career work with CSSA (e.g., clinician discomfort with children's sexual trauma disclosures, desensitization and avoidance of empathic connection in session, and feeling overly responsible for the child client). Experienced trauma clinicians' narratives regarding supportive supervision, enhanced self-awareness, and effective coping support the need to address these supervision needs early. Those advanced clinicians described having developed clear boundaries and limit-setting between personal and professional life, reduced feelings of over-responsibility for client outcomes, and stronger empathic presence with clients (Bartoskova, 2017; Harrison & Westwood, 2009; Lonergan et al., 2004).

The present study also highlighted the potential for early career CSSA trauma clinicians' growth, development, and increased wellness (Ling et al., 2014) within supportive supervision experiences. Their descriptions illustrated the potential for early career trauma clinicians to experience increased self-efficacy, improved sense of well-being, and healthy professional and personal boundary setting. They also described finding meaning in their work with CSSA as a result of witnessing children's resilience. Similarly, previous research reported trauma clinicians found growth through increasing the understanding of self, a greater appreciation of life, and making a difference (Bartoskova, 2017). Though Lonergan et al. (2004) describe a supportive supervisory alliance as having the potential to cultivate these larger growth and development experiences described by our participants (e.g., improved well-being, finding meaning in the work, setting boundaries), our early career participants attributed only growth in self-efficacy to their supervision experiences.

Participants also highlighted the power of peer, social, and organizational support. They shared these supports provided an outlet for connection, collaboration, and reduced isolation, especially when they did not have a trusting relationship with a supervisor. Previous scholars have endorsed the importance of organizational and social support for trauma clinicians (e.g., Killian, 2008) and within social work practice contexts (Martin et al., 2020; Newell, 2020). Participants in this study emphasized more ease in setting personal and professional boundaries when organizations implemented wellness enhancing policies (e.g., taking time off, control over scheduling), which was also highlighted by Newell's ecological systems framework for self-care in social work

practice. Organizations that offer this level of wellness support for early career CSSA trauma clinicians could help reduce boundary crossing dilemmas and countertransference responses (e.g., rescuer-role; Etherington, 2009), as well as reduce organizational barriers to self-care (e.g., unmanageable workloads, turnover, ineffective policies effecting clients, self-sacrificing work cultures; Martin et al., 2020). These findings also highlight the need for supervisors to advocate for the cultivation of wellness-enhancing organizational practices and support early career CSSA trauma clinicians' implementation of these practices.

Limitations and future research

Despite the consensus of the research team and other trustworthiness measures taken in the data analysis process (Hill et al., 1997), data coding and identification of domains could vary in another research team. Although all interviewers had the same level of training and experience, their probes and interview style may have differed and elicited variation in participant responses (Hill et al., 1997). Second interviews may have provided further insight into participants' thoughts, feelings, experiences, and reactions to the first interview (Hill, 2012). Our positionality, expectations, and previous experiences may have had some influence on data collection and the analysis process. However, we attempted to mitigate these limitations through the aforementioned trustworthiness measures (Hill et al., 2005).

To date, scholars have inferred the negative influence of STS on trauma treatment effectiveness (Molnar et al., 2017), and we agree. It also would be beneficial, however, for researchers to investigate educational practices that could better prepare early career clinicians to work with CSSA (Foster, 2017; Kenny & Abreu, 2015). Furthermore, it is vital that researchers investigate trauma-informed supervision and organizational interventions for preventing and reducing STS impacts on early career clinicians working with child – and adult – trauma populations to develop evidence-based best practices (Sprang et al., 2019). Such investigations could cultivate more ethical and effective treatment providers in the field of CSSA trauma counseling earlier in their careers.

Implications for clinical supervisors

The current study contributes to clinical supervisors' knowledge about supervision practices that may benefit early career clinicians, within counseling and social work fields, who are experiencing STS during their clinical work with CSSA. Participants shared the essential aspects of supervision, including having an open, safe space to process the impacts of the work through dependable and regularly scheduled supervision with an accessible supervisor. Participants also described certain aspects of supervision that were inadequate to meet their needs: only receiving administrative supervision, having supervisors in dual roles that led to inaccessibility of the supervisor and unclear boundaries, and having a supervisor who lacked professional experience with CSSA populations.

In particular, participants wanted supervisors who shared knowledge from their own experiences working with CSSA and helped them build their skill set through education about evidence-based interventions and approaches to utilize with CSSA. Participants consistently endorsed the importance of having a strong, collaborative supervisory alliance, enhanced by supervisor traits

of openness, validation, non-judgment, non-intimidation, support, welcoming presence, and accessibility during crisis. They needed supervisors to provide education about STS and related responses to indirect trauma, encourage wellness practices, and help them find meaning and purpose in their work to maintain longevity in working with CSSA. They also highlighted a need for supervisors to regularly inquire about, validate, and monitor for STS responses, as well as allow space and time to engage in self-reflection and processing. In these ways, preparation and supervision of early career clinicians who work with CSSA could be enhanced, for their betterment and the growth of their clients.

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