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Cristina Bloom
Social Work Professional Ethics, as Affected by the Concept of the *Wounded Healer:* An investigation into the Gatekeeping Practice of Clinical Social Work Supervision

ABSTRACT

The objective of this exploratory qualitative study was to assess how the field of social work currently maintains and preserves professional social work ethics in the clinical practice field. This study sought to understand how, in a field where the *self* is one of the main tools utilized, the field ensures that the practitioner's *self* is fit to practice and to do so ethically. This is of particular significance in a field that research indicates that high percentages of people are attracted to because of challenging personal life experiences (Lackie, 1982; Marsh, 1988; Vincent, 1996). More specifically, this study centered its research around social work professional ethics as affected by the concept of the *wounded healer*, a concept that holds that the personal vulnerabilities of practitioners (also referred to as their *woundedness*) plays an important role in not only motivating them toward the field of clinical social work but plays a potentially integral role in their ability to help people in clinical treatment to heal. Twelve clinical social workers who supervise other clinical practitioners were interviewed for this study specifically about their role and responsibilities as so-called gatekeepers to professional practice (gatekeepers being those who help to maintain and preserve the conduct of ethical practice). The overarching impetus for this research was as follows: How do clinicians who supervise other clinicians know if the wounds of the supervisee have healed enough so that they do not interfere with that practitioner's ability to maintain ethical practice? Because clinical supervisors hold the important position of gatekeeping in the profession, the findings of this study suggest that

clinical supervisors and their gatekeeping practices inherent in and to that role could benefit from an expansion of knowledge around the *wounded healer* concept. Hopefully, the findings from this study will help to strengthen and standardize the supervisory system and promote more ethical practice.

SOCIAL WORK PROFESSIONAL ETHICS, AS AFFECTED BY THE CONCEPT OF THE *WOUNDED HEALER*: AN INVESTIGATION INTO THE GATEKEEPING PRACTICE OF CLINICAL SOCIAL WORK SUPERVISION

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2016

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CHAPTER I

Introduction

The National Association of Social Workers (NASW) stands as the largest membership organization of professional social workers, and exists to enhance professional growth and development for its members as well as to create and maintain professional standards for the field of social work at large. In great part, the preservation of such professional and ethical standards comes through the writing and administration of the *NASW Code of Ethics*, originally written and put forth in 1960, helping to not only legitimize the profession but additionally to embody certain professional principles of behavior for the social worker in all professional relationships and with those he or she serves.

The statutes begin with a statement for the primary mission of the social work profession, which sets out "to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty" (NASW, 2008). This study took its cue from the word "vulnerable" just utilized to describe the population whose well-being lies at the heart of the social work tenet. However, for this study, the focus of this work -- or rather, state of affairs --has been turned toward the potential vulnerability that may exist in the social workers themselves, which, for purposes of this study, is referred to as *woundedness*.

The concept of woundedness - or as it applies to the social work practitioner, *wounded healer* - motivated the choice to focus this research on the personal vulnerabilities of the worker.

The *wounded heale*r concept, first introduced into psychotherapy by the psychoanalyst Carl Jung (1951), who posed that only "the wounded can heal," suggests that *wounded healers* possess a familiarity with the struggles that people face and an ability to aid the healing process for others, because they too have experienced and (hopefully) worked through their own struggles (Gil, 1988).

Building on the research and current professional literature, which shows a high percentage of people drawn to helping professions like that of social work have often gone themselves through a journey that involves pain and suffering (Barnett, 2007), this study interviewed clinical social work supervisors to assess if, as gatekeepers in the clinical field, they can discern whether a practitioner calls on that experience (*woundedness*) such that it enhances, as Jung suggests, rather than interferes with his/her clinical work with patients and more specifically, whether it enhances rather than impedes the conduct of ethical practice.

The NASW Code of Ethics (2008) states that supervision has a role in preventing "personal problems, psychosocial distress, substance abuse, or mental health difficulties" from interfering with "professional judgment and performance, or jeopardize the best interests of those for whom the social worker has a professional responsibility" (Article 4, Part 5, *Impairment*). With a methodology composed of 12 interviews, clinical social work supervisors discussed their supervisory experiences around this area of *woundedness* and their response to this phenomenon in their role as well.

Psychodynamic literature in the field of psychology has explored to a fair degree the concept of *wounded healers* in psychotherapy (Hayes, 2002; Miller & Baldwin, 2008; Wheeler, 2007; Zerubavel &O'Dougherty Wright, 2012). However, less attention has been placed

specifically in the social work literature on the implications that such *woundedness,* positive or negative, may have on clinical social work practice; hence, this exploratory study.

Ultimately, this study sought to discover in what ways, if any, *woundedness* impedes social workers from implementing ethical practice as outlined in the NASW *Code of Ethics* and through that exploration, to identify the support (or lack thereof) to carry out the often demanding yet important work of helping those who are often the most vulnerable and oppressed of society. Finally, it sought to learn more about the kind of support that clinical supervisors may also need in order to carry out their important gatekeeping roles as well. With an eye to setting the stage for exploring these research questions, the next chapter presents a review of the related literature in both the fields of psychology and social work. The third chapter describes the methods used to conduct the study. That chapter is followed by one on the actual findings of the study, both in terms of the sample (characteristics of) and substantive findings. Finally, the last chapter discusses the findings and their implications for practice and further research.

CHAPTER II

Literature Review

In an effort to promote more ethical practice in the field of clinical social work, this literature review primarily focuses on research related to the concept of the *wounded healer*, and what for the purpose of this study will be called the continuum of *woundedness* in clinical social work practitioners. Ultimately, this review aimed to provide a framework for understanding the study that is reported in this document and to call for further discussion around the provision of more solid *gatekeeping* practices as well as stronger support services for clinical supervisors and ultimately their supervisees.

While topics covered in this review cross over and support one another, organizationally the chapter is divided into four sections. Section one briefly discusses ethics and gatekeeping practice in the field of clinical social work; section two presents the theoretical framework for the *wounded healer* paradigm and the *use of self* concept in clinical work; section three explores conscious and unconscious motivations toward the professional field of social work; and section four addresses the idea of personal therapy for the therapist and examines the clinical notion of countertransference.

Please note, this literature review is written from a psychodynamic perspective and tends to cover literature influenced by psychodynamic thinking from both the fields of clinical psychology and social work. In the broadest sense, psychodynamic thinking approaches psychology through the exploration of mostly unconscious processes in a person, along with the

examination of earlier life experiences and such experiences influence on psychic tensions within the patient (Freud, 1910). Sigmund Freud (1910) is believed to be the "father" of psychodynamic thinking and early psychodynamic treatment approaches, which involve the exploration of the unconscious and the uncovering and working through of early life experiences that may contribute to psychic tensions.

Ethics and *Gatekeeping* Practice

In 1960 The National Association of Social Workers (NASW) put forth a code of ethics that set to embody certain "professional standards of behavior for the social worker in his professional relationships with those he serves, with his colleagues, with his employing agency, with other professionals, and with the community" (NASW, 1994, p. V). The original 14 responsibilities outlined, revised and expanded over the years, were and are meant to ethically "guide professional social workers in the various roles and relationships and at the various levels of responsibility in which they function professionally" (NASW, 1994, p.VI).

Within the Code of Ethics of the NASW (1994), stated under major principle number one, The Social Worker's Conduct and Comportment as a Social Worker, within article B, in reference to Competence and Professional Development, part three states:

> The social worker should not allow his or her own personal problems, psychosocial distress, substance abuse, or mental health difficulties interfere with professional judgment and performance or jeopardize the best interests of those for whom the social worker has a professional responsibility (p. 3).

Part four follows and elaborates as follows:

> The social worker whose personal problems, psychosocial distress, substance abuse, or mental health difficulties interfere with professional judgment and performance should

immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others (p. 3).

These articles are a part of greater codes that have helped to define the responsibility of the social worker and ultimately, to work toward the legitimization of social work as a profession. How such ethics are in fact upheld and responsibilities actually carried out -- or not -- in the profession is far less defined (or monitored, for that matter).

The task of *gatekeeping* in social work is a process carried out in great part by clinical supervisors, designed to help ensure that those who practice in the field are carrying out the codes of ethics and interacting with clients, colleagues, and the community in an ethical and competent manner (Miller & Koerin, 2001). In other words, they watch the gate that separates non-professional actions from professional practice on the other. How do they do this? In social work, those who supervise others (incoming) carry out their *gatekeeping* responsibilities through teaching and mentoring. Social workers are encouraged to work with a clinical supervisor to help monitor and analyze their work; however, the supervisory relationship often is not mandated outside of agency work, nor after completing one's MSW training, the acquisition of a clinical license, or while working in the private sector. Thus, these *gatekeeping* practices, like the code of ethics themselves, are loosely and inconsistently monitored in the clinical social work field, increasing the possibility for practice risks that affect not only the possibly vulnerable clinicians but most importantly the people who they serve as well.

How then does the clinical field ensure that practitioners are working ethically and responsibly, taking, as part four of article B states above, "appropriate remedial action" when needed "by seeking professional help, making adjustments in workload, terminating practice, or

taking any other steps necessary to protect clients and others" (NASW, 1994, p. 3)? How does the clinical field ensure that the needs and healing of clients remain the primary focus and that all clinical practitioners receive the support they need to first notice and when necessary take "appropriate remedial action" to protect the needs of those they serve and themselves? This question – one of establishing and maintaining ethical conduct -- is an important one for professional practice.

Particularly, as much of the professional psychology literature reviewed in subsequent sections states, such "personal problems" (as cited above in article B) are believed to be a great part of what motivates many people, both consciously and unconsciously, toward the helping and caring profession of social work in the first place. Additional bodies of psychology literature to follow in the review often refer to such "personal problems" as the *woundedness* of the clinician, existing as part of the *wounded healer* paradigm, soon defined below -- a paradigm that stands not only as a part of what often motivates one toward the field but is believed to be an integral part of what contributes to the ultimate healing of the patient as well.

Wounded Healer **Paradigm and the** ***Use of Self*** **Concept**

The *wounded healer* construct has existed for over 2000 years with origins in Greek mythology and shamanism. The construct can be traced back to the mythological character of Chiron, a healer, emotionally wounded from the start (Telepek, 2010). Hayes (2002), who explores the concept of *wounded healers* in his writing on countertransference, writes: "[I]n older healing practices such as shamanism, woundedness is seen not as evidence of vulnerability but as the mark of knowledge" that aids the healing process of others (p. 94).

While images of the *wounded healer* have saturated religion, philosophy, and art throughout history, it has had a place in psychotherapy as well, signifying, as Zerubavel and

O'Dougherty Wright (2012) write, "a duality of woundedness and healing within the therapeutic relationship" (p. 483). In reference to the vulnerability of the therapist, Wheeler (2007), who explores the "dilemma" of the supervisor and the *wounded healers* they supervise, writes of the term's first association with psychotherapists by Jung (1951), drawing on his description of the *wounded healer* archetype. This archetype suggests that "a healer's own wounds can carry curative power for clients" (Zerubavel & O'Dougherty Wright, 2012, p. 482), as "the wounded healer embodies transformative qualities relevant to understanding recovery processes" (Zerubavel & O'Dougherty Wright, 2012, p.482; Briere, 1992; Miller & Baldwin, 2000). In their writing on *wounded healers*, Miller and Baldwin (2008) cite Jung (1951), who refers to the *wounded healer* paradox when he states, "Only the wounded doctor can heal" (pg. 141), encapsulating the ultimate "paradox that lies at the heart of the healing process, of one who heals and yet remains wounded" (Miller & Baldwin, 1987, p. 140).

In a field where the main tool utilized to help others is one's *self*, it is of great importance for the field to be able to asses and ensure that one's *self* is actually fit to practice. As noted by Hayes (2002), "the personal equation is all important in counseling, as counselors can work only through themselves" (p. 94). It is therefore essential that "this self be an effective instrument" (May, 1939/1989, p. 131), particularly a self whose personal vulnerabilities, or wounding, as the *wounded healer* paradigm proposes; and as many studies to be cited later show, makes her well suited for the work in the first place. As Miller and Baldwin (2008) state, "the use of the self in therapy relates closely to the paradigm of the wounded-healer," a paradigm that holds "deep within each healer lies an inner wound which may not only play an important role in vocational choice, but constitutes a significant if not essential factor contributing to healing in the patient" as well (p.139). This suggests that a clinician who has gone through a journey of struggle in his

or her own life -- and ideally mined insights and wisdoms from that experience -- may then in treatment with patients pull from that personal experience and wisdom. Through doing so, the clinician may not only more easily enter the life experience and struggle of the patient (empathize), but additionally, may be more apt to facilitate a journey of healing for that patient, having hopefully gone through his or her own journey of healing as well.

According to Dewane (2006), who contributes ideas about a clinician's *use of self* to social work literature, a therapist's personality and personal experiences influence the overall development of professional knowledge and the incorporation of technique into practice; and "while techniques and theoretical orientations are tools, they come out differently when utilized in different hands" (Baldwin & Satir, 1987, p.19). Elson (1986) remarks a combination of sentiments mentioned earlier by both Hayes and May: "The practitioner has only one (true) tool and that tool is herself" (p. 3). Dewane (2006) continues, "[T]echniques are rarely separate from a practitioner's own style and behavior" (p. 544), and the "hallmark of skilled practice" comes from "(m)elding the professional self of what one knows (training, knowledge, techniques), with the personal self of who one is (personality traits, belief systems and life experience)" (p. 543). However, while research and review of meta-analyses by Ahn and Wampold (2001) demonstrate that "the person of the therapist accounts for more viability in outcome than do treatment specific factors" (Hayes, 2002, p. 95), very little research exists on the actual effects of the clinician's life experiences on his or her psychotherapy practice (Hayes, 2002). This kind of research seems important, however, considering that such life experiences (as studies below illustrate) often involve experiences of struggle, which leave practitioners potentially more vulnerable in practice, bringing back into focus the question mentioned earlier of how to establish and

maintain ethical conduct where the clients remain the main focus and that all clinical practitioners receive the support they need to use their own wounding in the service of the work.

As Wheeler (2007) notes, while the clinician is "a person with his own life history, traumas, wounds and difficulties…such wounds have much to contribute to the therapeutic endeavor" (p. 247). Further, while unexamined or unexplored wounds can also inhibit the therapeutic undertaking, when utilized skillfully, the clinician's personal wounds can act as a "conduit" to a deeper understanding of a client's wounds and thus, allow for greater empathic attunement (Wheeler, 2007, p. 255).

Barnett (2007), who explores therapists' conscious and unconscious motivations toward the healing and helping profession, states that, "wounded healers are those who have usefully explored their own motivations [toward the field] and [have] gained sufficient insight to help others" (p. 262). As Park (1992) notes, however, "they must be people who have suffered enough themselves to understand other people's pain but are no longer controlled by their disturbance" (p. 26). Thus, as Hayes (2002) notes, in order to use his or her self effectively as an instrument, it is of critical importance that the clinician be able to acknowledge his/her own *woundedness* (p. 96). As Gelso and Hayes (2007) go on to say, only with such awareness can s/he make it of use in understanding the wounds of others and facilitate recovery through "empathic connection with clients and the positive use of countertransference in therapy" (Zerubavel & O'Dougherty Wright, 2012, p.482). An exploration of countertransference follows in a later section.

However, as Barnett (2007) argues further, "the important thing is not that therapists have [themselves] been wounded but how they have dealt with those wounds (p. 262). Yet, while Briere (1992) offers "sufficiently recovered wounded healers may make uniquely talented therapists" (Zerubavel & O'Dougherty Wright, 2012, p. 483), "there has been very limited prior

research addressing how therapists' own recovery processes influence the work they do with clients and how therapists know that they have healed sufficiently to practice responsibly" (Zerubavel & O'Dougherty Wright, 2012, p.482) -- or for that matter, how supervisors know. Thus, the discussion returns to the earlier question of how social workers prevent their "own personal problems, psychosocial distress, substance abuse, or mental health difficulties" from interfering with their "professional judgment and performance or jeopardize the best interests of those for whom the social worker has a professional responsibility" (NASW, 1994, p. 3). Even further, how to properly approach this question while simultaneously considering the *wounded healer* concept, which holds that the "personal problems" outlined above in the code of ethics -- while potentially problematic as well -- are in fact an important part of what makes a social worker an effective healer and composes a large part of the draw to social work in the first place?

To further understand the concept of *woundedness*, it is helpful to understand some of what the professional literature says motivates therapists toward the field of psychotherapy and for this discussion more specifically, toward clinical social work.

Conscious and Unconscious Motivations

Several psychodynamic studies have taken place to explore motivations toward helping and caring professions like that of social work (Lackie, 1982; Marsh, 1988; Vincent, 1996). Looking to identify how particular antecedents may consciously and unconsciously influence and motivate people toward a profession oriented around the mental health and caring of others, such studies have shown that high percentages of people are attracted to a career as a therapist because of challenging personal life experiences (Lackie, 1982; Marsh, 1988; Vincent, 1996). For example, Telepak (2010) states in her research on the topic that "histories of woundedness or exposure to mental and/or emotional disturbances as children have been cited as primary motivations for many decisions to become a psychotherapist" (p. 7; Barnett, 2007; Sussman,

1992). Wheeler (2007) in her writing on *wounded healers* references the research of Guggenbuhl-Craig (1999), stating that "therapists are both motivated to become healers and strengthened in their capacity to empathize with others by painful life experiences that fuel their vulnerability" such that these experiences and vulnerabilities "contribute to their skill, sensitivity and insight that makes them effective therapists" (p. 245). Gil (1988) adds that this kind of life experience is important, because *wounded healers* are "familiar with the difficulties that survivors face, having experienced these difficulties themselves and having worked through them" (p. 275). Wheeler, in *Nurture or Nature* (2002), additionally contributes the idea that if one accepts the research evidence that trainees have their own "unique psychopathology that has driven them into dedicating their lives and careers to working with others who seek to heal themselves, then consideration must be given to ways in which psychopathology can best be harnessed and used for the benefit for the client" (p. 438).

Psychotherapist Michael Sussman, who titled his book on the unconscious motivations for practicing psychotherapy, *A Curious Calling* (1992), suggests (as several studies already mentioned have) that "those who seek to become therapists themselves have suffered traumas in their own lives that contribute towards their capacity to heal others" (Wheeler, 2007, p. 253). However, in a follow up book titled *A Perilous Calling* (1995), Sussman speaks further to the dangers and risks such a calling can have on the well being of the clinician practicing, perhaps even more so for those personally vulnerable (wounded) to begin with. As already discussed, while a therapist's personal struggles are believed to have unique benefits, the vulnerability of *wounded healers* and the continuum of their *woundedness* -- and ideally healing --needs further attention in social work research, with particular attention to "stability of (personal) recovery,

difficulty managing countertransference, compassion fatigue, and/or professional impairment" (Zerubavel & O'Dougherty Wright, 2012, p. 482); hence, this study.

Within social work research, studies on motivations to enter the field have focused mostly on family-of-origin experiences. Lackie's study (1983), for example, which looked at the early family experiences of social workers in an attempt to identify the range of family experiences that might explain the choice of a social work career, discovered that "those who become social workers appear to have been assigned and to have played roles that promote self-sufficiency: the parentified child; the over responsible member, the mediator or go between; the good child; the burden bearer" (Vincent, 2008, p. 64). Vincent (2008), who, like Lackie (1983), also explored how family-of-origin experiences in the lives of social workers may unconsciously influence their professional choice, found a possible link between early childhood separation and the choice of social work as a career, with 42% of her sample having experienced significant separation from one or both parents. Vincent (2008) goes on to postulate, "when our needs have not been attended to in childhood… we may be driven in our adult and working lives to attempt to meet the needs of others in an unconscious attempt to satisfy our unmet needs" (p. 65). Barnett (2007) too, in her review of literature on the motivations of those who move toward the helping and healing professions such as psychotherapy, found two main themes for analysts and therapists, "both concerning experiences of loss and deprivation, especially in early life, and the failure of carers [those who care for them] to meet the normal narcissistic needs of childhood" (p. 259).

In her own psychodynamic writing on the subject, Barnett (2007) emphasizes the importance of understanding and exploring not just the conscious motivations that move people toward the helping and healing work of psychotherapy but of exploring unconscious motivations

and gratifications as well. As she puts it, “if motivation for choosing this work remains split off in the unconscious there is a very real danger that clients may be used in some way by therapists, rather than helped by them” (2007, p. 259).

For purposes of this study, the working hypothesis postulates that unconscious, unacknowledged, or unexamined motivations toward the helping profession of clinical social work may correlate with unconscious, unacknowledged, or unexamined wounding, each tied to some degree with self-awareness and levels of self-reflexivity in the therapist. This, to argue even further, is ultimately crucial in recognizing countertransference (to be explored in the next section) and using the self, as May (1939/1989) posed earlier, as an “effective instrument” of help. A lack of either, each in its own way, may pose a threat to not only the treatment and well-being of the client, but potentially to a clinician too vulnerable to practice as well, risking what might stand as less than ethical practice in the field of social work.

Countertransference and Personal Therapy

Countertransference

Self-awareness of a clinician’s wounding or personal vulnerabilities and how it impacts his or her clinical practice is an important part of what separates a *wounded healer* from what Telepak (2010) refers to as an “impaired professional,” “one who is wounded and whose distress adversely impacts his or her clinical work…” (p. 6). Beyond any self-awareness that may already exist by the clinician prior to moving toward the field, the supervisory relationship serves as an opportunity for worker self-awareness to develop and expand further. Therefore, additionally important is the sensitivity and awareness of a clinical supervisor, who, ideally as a part of his or her gatekeeping function, notices when a supervisee’s *woundedness* may act more

as an impairment than enhancement of practice; this is particularly important when this awareness exists outside that of the supervisee.

How might a supervisor distinguish between impairment versus enhancement of practice in a supervisee? A supervisor may do so, likely through exploring with a supervisee what is called countertransference, a clinical term rather broadly used to cover all of a therapist's reactions to a client. As Cain (2000), who conducted a study on *wounded healers* and countertransference defines the phenomenon in her writing, "Countertransference involves the therapist's personal experiences that affect the therapist's reactions and responses to the client" (p. 23). She goes on to share, "this definition of countertransference recognizes that the therapeutic process is focused on the interaction between the subjective constructions of reality of therapist and client" (Cain, 2000, p. 23). Cain proposes theoretically an inter-subjective stance here, one that considers the subjectivities of both parties in the therapeutic relationship. This stance takes into account all the life experiences that both client and therapist bring to the therapeutic relationship, all the beliefs about themselves and others, as well as all their unresolved issues, that together, each consciously and unconsciously influence the other; often in ways neither realizes (McHenry, 1994). This stance differs from classical Freudian (1910/1959) analytic techniques, which encourage the clinician to assume a posture of neutrality and objectivity in the therapeutic dyad, holding differing beliefs around the role of countertransference in the therapeutic relationship as well.

Historically, Freud (1910/1959) introduced the term countertransference "to refer to the analyst's unconscious and defensive reactions to the patient's transference" (Hayes, McKracken, McClanahan, Harp, Hill & Carozzoni, 1998, p. 468). The term transference characterizes the phenomenon of a patient's reactions to and feelings for the therapist, which speaks to the

unconscious redirection of feelings the patient has from one person -- often an earlier object (person) in his or her life -- to the therapist. Freud (1910/1959) believed that countertransference was something for the therapist to overcome, as he alleged it had adverse effects on the therapy, and as just cited, was only in reaction to the patient's own transference.

More contemporary theory and ideas, however (e.g. Atwood & Stolorow, 1997; Mitchell, 1988), understand the clinician to exist as more than an objective bystander in the therapeutic dyad, beyond the 'blank slate' initially encouraged in Freud's earlier works (1910/1959). These more contemporary theoretical evolutions see feelings that go on within the therapist as information important to understand and when activated in the room with a patient, being able to impair the worker's responsiveness and effectiveness (Woods & Hollis, 1990). While the complete objectivity Freud earlier proposed is not fully possible to maintain in the role of clinician, a more objective stance can be achieved through the recognition and fine-tuned awareness of the therapist's own subjective experience and how his or her own origin experiences ultimately influence and shape this subjectivity when in the room with patients. Bringing back in the concept of *woundedness* and how such personal vulnerabilities can both color and influence such subjectivity.

Aron (1991), in *The Patient's Experience of the Analyst's Subjectivity*, takes issue with the term countertransference itself, stating the term as "a serious mistake," one that proposes the "[t]hinking of the analyst's experience as 'counter' or responsive to the patient's transference [and encouraging] the belief that the analyst's experience is reactive rather than subjective, emanating from the center of the analyst's psychic self (p. 32; McLaughlin, 1981; Wolstein, 1983). This is a psychic self that more inter-subjective theory believes undeniably exists in the room with the patient, bringing with it all prior life experiences and potential *woundedness* as

well and actively both participating and influencing the relationship and ultimate treatment process.

Thus, from this stance, if left out of awareness, what impact might the *wounded healer's woundedness* have on one's clinical social work practice? All clinicians have clinical 'blind spots, also known as countertransference problems -- issues and feelings that may arise in treatment with patients, triggered, so to speak, by material that a patient presents and which potentially resonates in a personal way with the therapist. These issues may lie too close to home, preventing a clinician from not only noticing that his or her issues may have been triggered but also preventing the effective use of feelings that are in fact stimulated toward the treatment of the patient.

In relation to a study conducted on therapists' perspectives of countertransference, Hayes, McKracken, McClanahan, Harp, Hill and Carozzoni (1998), state, "By virtue of their humanness, all therapists possess issues that are unresolved to various degrees" (p. 469), and as much literature previously mentioned suggests (and the paradigm of the *wounded healer* proposes), these issues can enhance identification with and understanding of a client; however, they also can interfere with the therapeutic process, particularly when out of awareness, resulting potentially in "distorted perceptions or defensive reactions on behalf of the therapist" (Hayes, McKracken, McClanahan, Harp, Hill & Carozzoni, 1998).

Not only do countertransferential feelings hold important information that can lead to a deeper level of understanding for the patient's experience, but they also can help the clinician develop greater self-awareness, which, as previously stated, serves the therapist's *use of self* most optimally. Through the exploration of countertransferential feelings stimulated in sessions by the patient and engagement in practice, the clinician has the opportunity to gain deeper insight

into herself and her subjective experience. However, when not recognized or understood for the wisdoms that such feelings carry, when left to the unconscious of the clinician or pushed aside as something that need not be in the room, such feelings can interfere in the therapeutic relationship and the treatment process, possibly stalling the treatment, or even, depending on the issue, resulting in an even more destructive effect.

Thus the need for another perspective is helpful -- for example, that of a clinical supervisor, who might assist effective treatment by helping the clinician gain some clinical distance and who can first notice and then help bring awareness to clinical blind spots. The opportunity to have another set of eyes, ears, and experience to observe a clinical case or nature of approach taken stands as both a basic form of support to help the supervisee develop clinical ideas further. Additionally, it can promote the advancement of the supervisee's self-awareness, ever sharpening the self, which again exists as one of the main tools utilized in this work.

Countertransferential feelings of the supervisee inevitably surface through the presentation of clinical material in supervision. Entangled with these feelings, the wounds of both the supervisee and the client reveal themselves to the supervisor (Wheeler, 2007). The supervisory relationship, therefore, exists as an important place where the complexity of such feelings can be untangled and explored; where ultimately, through the examination of countertransference, clinical social workers -- with the assistance of their supervisors -- can prevent their own *woundedness* or issues from hindering the progress of patient's treatment. This examination can help keep a *wounded healer* from practicing as an impaired professional or from conducting less than ethical practice.

However, through the exploration of countertransferential feelings, the question of the extent to which material of a personal nature for the supervisee shall be explored in and by the

supervisory relationship stands as an important one. How supervisors handle the boundary between the role of supervision and personal therapy comes down to a matter of personal style, each defining that boundary and the importance of it in his or her own way; and as Wheeler (2002) states, "while the supervisor cannot be the therapist, the personal life of the therapist cannot be ignored, … [and] supervisors have an important role to play in recognizing and attending to the wounds of the healer" (p. 255). It is generally proposed, however, that the supervisor should not be the therapist for the supervisee (Barnett, 2007; Gelso & Hayes, 2007; Macran, Stiles & Smith, 1999; Miller & Baldwin, 2008; Norcorss, et al., 1988; Woods & Hollis, 1999) even though practitioners can benefit greatly from having their own therapists.

Personal Therapy

Wounds may surface through the countertransference in supervision; however, the real tending to, working through, and healing of such wounds takes place within the personal therapy of supervisees, with the personal therapy of a worker serving as another ideal place for advancement of clinical self-awareness and reflexivity to take place. This is a place where unlike supervision, the therapist and his issues are the main focus, not just the space where the wounds of the supervisee and patient meet. However, the therapeutic relationship -- while a unique sort of one -- still is a relationship, and as Woods and Hollis write, "personal therapy can increase understanding of one's own reactions, prejudices, and relationship patterns" (1999, p.240), all of which, as previously mentioned, ultimately influences the client patient relationship and treatment process.

Social work literature is less robust than psychotherapy literature on the topic of personal therapy for practicing clinical social workers, perhaps because personal therapy for clinical social work is not required in training. This is not to say, however, that personal therapy should merely be, as Norcross (1988) notes, just "a required intellectual or training endeavor" (p. 40).

Barnett (2007) seems to agree, stating, "training is not a substitute for therapy" (p. 270), and that "therapists need to be able to acknowledge the client in themselves" (p. 269).

The *wounded healer* paradigm supposes after all that not only does a healer (clinician) have an inner wounded patient within herself, but a hidden inner healer, as well, and that for real cure to take place, the practitioner must get in touch with -- and receive help from – his or her own *inner healer* (Miller & Baldwin, 2008, p. 141). Thus, in the therapeutic dyad, the healer and patient cast mutual projections upon each other based on their hidden parts, and until these projections are acknowledged and withdrawn (the responsibility of the therapist), it is difficult for the patient to make contact with his or her inner healer and for true healing to take place. As Gelso and Hayes (2007) explain, "therapists who deny their own conflicts and vulnerabilities are at risk of projecting onto patients the persona of the 'wounded one' and seeing themselves as 'the one who is healed'" (p. 107), interfering in this process of the patient's accessing his or her own inner healer. Part of the job of the therapist is to help facilitate a patient's connection to her own inner healer. However, the therapist's inner wounded one does so through empathy, connecting to the wounded one within the patient and then through the assistance of the therapist's inner healer, helping the patient to make contact with her own inner healer.

While the therapist's own wounds inevitably become activated in the client-patient relationship, they ideally are used to encourage self-healing in the client. Thus, as Barnett (2007) states, "if the person of the therapist is the instrument of change, it follows that the therapists' level of consciousness of their own shadow is of considerable significance" (p. 260). How one learns in great part about their own "shadow," which Barnett calls unconscious wounding, and uses it most effectively in practice with patients, reveals itself in great part by participating in personal therapy.

Macran, Stiles, and Smith (1999), who conducted a study looking into how personal therapy affect therapists' practice, found that in general, personal therapy is very useful and helpful in practice for therapists. For example, those who seek personal therapy frequently report "(a) increased awareness of the personal relationship between client and therapist; (b) awareness of transference–countertransference issues; and (c) increased empathy, patience, and tolerance" (Macran, Stiles & Smith, 1999, p. 420; Macaskill & Macaskill, 1992; Norcross et al., 1988).

Many surveys have taken place that sample large pools of therapists, mining their experience and opinions of personal therapy (e.g., Garfield & Kurtz, 1976; Guy, Stark, & Poelstra, 1988; Macaskill & Macaskill, 1992; Norcorss, Dryden, & DeMichele, 1992; Norcorss et al., 1988). They all show that personal therapy is popular, with an estimated two thirds to three fourths of therapists in the United Stated and the United Kingdom having received some form of personal therapy (Macran, Stiles & Smith, 1999). Macran, Stiles and Smith (1999) go on to share in their writing about the increased effectiveness of clinicians who partake in personal therapy by stating how it "can improve therapists' awareness of their own problems and areas of conflict, and so help to prevent these problems from interfering with their work with clients" (Macran, Stiles & Smith, 1999, p. 419).

The relative importance attached to personal therapy, however, studies show seems to vary systematically with the clinician's treatment history and theoretical orientation (Norcross et al., 1988). For example, clinicians trained in cognitive behavioral practice are less inclined to see the importance of it, utilizing the concept of *use of self* not so much in the treatment of the patient. However, within psychodynamic orientations, personal therapy is often seen as essential for recognizing and dealing with countertransference (Macran, Stiles & Smith, 1999). The

“therapist who has come to terms with his or her anxieties, resentments, and other personal problems,” it is general thought, “is presumably able to work more effectively” (Macran, Stiles & Smith, 1999, p. 429). This is not to say, however, as Jung (1951) stated, that the personal therapy of a clinician “is capable of banishing all unconsciousness forever. The analyst must go on learning endlessly” (p. 116; Wheeler, 2007).

Conclusion

Psychodynamic literature has explored to a fair degree the concept of *wounded healers* in the field of psychotherapy often noting, as we have done in part here, the positive effects and more transformative experiences one has from personal wounding and commonly leading one toward profound growth both personally and professionally. However, while some discussions have been around countertransference, less discussion in psychodynamic literature has centered on the potential negative effects that *woundedness* may have on clinical practice. Even less attention has been specifically placed in social work literature (or studies) on both the concept of the *wounded healer* or the positive or negative implications that *woundedness* may have on clinical social work practice. Through examining the supervisory relationship and gatekeeping practice of supervision, this thesis sought to explore the potential risks that may exist as a result of what the *wounded healer* concept calls the *woundedness* in supervisees and to investigate any implications that such risks may have on ethical practice. In the next chapter the methodology employed for this study is discussed and analyzed.

Chapter III

Methodology

Through researching the gatekeeping practice of supervision, this qualitative exploratory study sought to examine professional social work ethics in the field of clinical social work today. Guided by the concept of the *wounded healer* (Jung, 1951), the study explored with clinical social work supervisors what, for the purpose of this study, I call the continuum of *woundedness* in supervisees and how, for the sake of ethical practice they (the supervisor) respond to this phenomenon in their role. The study ultimately sought to understand how well prepared or supported supervisors feel to perform and carry out such gatekeeping responsibilities, particularly as it relates to *woundedness* in their supervisees, and even more specifically, how such wounding may interfere with professional ethical practice. Findings from this study may help develop not only a better understanding of how to best support *wounded healers* in the field, so that they may draw on their *woundedness* in the service of healing rather than be impaired by it, but additionally, to help to support the supervisors who aspire to promote ethical practice through their service of support and teaching as well.

Sample

The sample population focused specifically on clinical social work supervisors. To be eligible for participation, individuals had to meet the following criteria: (1) licensed clinical social workers; (2) performing at the time of study in the role of a clinical social work supervisor for at least five years, and (3) practicing at the time of study in the role of clinical social work

supervisor. Practitioners who did not specifically meet all of the aforementioned inclusion criteria were excluded. Persons of all races, ages, and sexes who fit the profile and who lived and worked in the United States at the time of the study were encouraged and allowed to participate.

Convenience sampling and then snowball techniques (Engell & Schutt, 2013) through professional social work networks were utilized to recruit subjects.

Participants

Twelve supervisory practitioners (n=12) who fit the eligibility criteria were interviewed for this qualitative study. There was a small quantitative element in the beginning of the interview to explore demographic information (See Appendix E).

Of the 12 (n=12) supervisory practitioners interviewed, six identified as female and six as male. Ten of the 12 identified as white or Caucasian, and two participants declined to racially identify. The age range of participants fell between 47 and 71, with an average age of 58. The average number of years of experience in the role of clinical social work supervisor at the time of study was 18, ranging from five to 35. Ten participants obtained their MSW degrees from private graduate schools of social work, while two attended a public institution.

Throughout the numerous years in practice as a clinical supervisor, participants assumed the supervisory position in a wide variety of practice settings, including but not limited to the following: agency settings (community mental health; substance abuse; foster care; LGBTQ community support; adoption; domestic violence, etc); outpatient and inpatient mental health; hospital settings; analytic training institutes, and graduate school supervision.

At the time of the interviews practice settings fell into the following four categories, with some supervisors having their duties in more than one category:

(1) analytic training institutes, where five of the 12 supervised persons who were training in analysis and psychodynamic psychotherapy;

(2) private sector, with nine of the 12 stating they engaged in their own supervisory practice, performing what several additionally referred to as "private consultation" outside of any formal agency or employing institution;

(3) outpatient clinics, with four of the 12 currently supervising MSW students and other social work employees in more formal agencies; and

(4) graduate school, where one supervisor worked with persons who attended the graduate school at which she was employed at the time of study.

With regard to training beyond that of the MSW degree, seven of the 12 participants had psychoanalytic training, having had a multi-year and multi-level training program at one of several training institutes; and three have a PhD in social work. Six of the 12 noted supervisory training as a part of their additional training (this is not to say others did not have this, they just did not mention this in response to this question). Five out of 12 noted continuing education units (CEUs) as a part of additional training. Five participants noted extensive training in one or more of the following practice modalities: Eye Movement Desensitization and Reprocessing Therapy (EMDR), Cognitive Behavioral Therapy (CBT), or Dialectical Behavioral Therapy (DBT).

Recruitment

Recruitment began through staff contact and connections at the training institute where the researcher partook in an internship during the academic year 2015-2016. Staff and trainees at the institute received a recruitment letter in their mailbox at the institute describing the study and recruitment process (see Appendix B). Announcements were then made at various weekly team

meetings that took place for staff as reminders in the event that letters were not retrieved or received. In an effort to get a wider more representative population of clinical social work supervisors, an email was also sent out as well to the professional social work contacts of the researcher (see Appendix B; same text as recruitment letter). From that point forward staff at the training institute or other professional contacts notified the researcher of potential interest or passed along the contact information for others to contact her. Snowballing techniques were effective from this point forward, as one participant connected the researcher to another respondent within his or her own professional network.

Upon contact the study was described to participants, along with any potential risks and benefits of participation. Participants were informed of their right to discontinue participation within an appropriate time frame. Participants were told about the structure and time frame of the individual interview, and a time and/or place was then scheduled to review and sign the consent form prior to the interview. In cases where interviews took place remotely, on the telephone or through video chat, an electronic consent form was sent. In-person interviews took place at a quiet place chosen by the participant that allowed for privacy and convenience; aside from the three cases conducted remotely, the office of the participant was chosen as the interview location for all in-person interviews.

Data Collection

For participants living in the New York City area, data were gathered via semi-structured, in-person interviews (see Appendix E). For participants living elsewhere or not capable of meeting in person, interviews were conducted via the telephone or through video-chat. Once the Informed Consent form (see Appendix C) was reviewed and signed (electronically via email in the cases of remote interviews), the inclusion criteria were reiterated to confirm eligibility, as

was the participant's rights to withdraw from the study for up to two weeks after the interview. The Informed Consent (see Appendix C), which details the study, was again briefly reviewed at the time of the interview just prior to beginning the interview.

Individual interviews were semi-structured, following an Interview Guide (Appendix E), leaving room for some flexibility in narrative and allowing participants a chance to expound on their professional and personal experiences in a free-flowing manner. The Interview Guide (Appendix E) begins with basic demographic data including age, gender, and race, etc. Subsequent questions engaged participants in a discussion of their professional experiences as a clinical supervisor in the social work field. This portion of the interview includes 12 open-ended questions, which were intended to bring forth their experiences around the concept of the *wounded healer* and what they encounter around supervisees' personal "wounding." The aim of these questions is to explore how "wounding" may or may not interfere with practitioners' professional and ultimately ethical practice as social workers and to explore how supervisors handle such "wounding" in the supervisory relationship. Each interview lasted 45 to 60 minutes.

All interviews but one were audio-recorded using a hand-held audio recording device. Written consent (Appendix C) of the participants to audio record the interview was obtained prior to recording. Ten of the 12 interviews took place and were audio recorded in person. In the one case where the interview took place remotely over video-chat, the video-chat was audio-recorded on my end, again with a hand-held audio recording device. In the other case when the interview took place over the telephone, there was an audio recording made of the conversation on my end of the line over speakerphone.

The personal identity of all participants was protected in a number of ways. A pseudonym was assigned to discuss responses and to protect identity of all participants. I was

the primary handler of all data collected. An outsourced transcriber has temporary access to the recorder interviews. He signed a Non-Disclosure Agreement (NDA) (Appendix D). All identifying information was removed from transcripts, after which my research advisor had access to the data collected during the interview, including any transcripts or summaries created, without identifying information about respondents. Further, I will keep the audio record, the transcripts, consent forms and other data in a locked and secure environment for three years following the completion of the research, consistent with Federal regulations. After that time, all material will remain locked and secured if still being used or destroyed if no longer needed. Should this study be presented or published at any time, the data will be presented with all identifying information disguised and pseudonyms used.

Data Analysis

Once interviews were transcribed, I used content analysis (Moyse Steinberg, 2004) to explore the interview data. The transcriptions were coded, major themes were sought within each transcript, and then, commonalities and differences in theme were sought among participants. With the analytic model of grounded theory (Glaser & Strauss, 1967), ultimately leading to the development of a theory (story) that responded to the research question at the heart of this study, which was as follows: *What implications does the concept of woundedness in social work supervisees have on ethical social work clinical practice and how is this phenomenon responded to in the supervisory relationship?*

Chapter IV

Findings

Through investigating the gatekeeping practice of clinical social work supervision, this study sought to explore professional social work ethics in the field of social work today. By interviewing 12 clinical social work supervisors about their role and personal experience as gatekeeper, the researcher attempted to take the temperature in the field for how a clinician's (or supervisee's) earlier life experiences or personal vulnerabilities--or what has been referred to as the *woundedness* of the clinician, inspired by the concept of the *wounded healer*--might impact professional practice with clients or more specifically ethical practice in the field today.

The sample of 12 participants interviewed came to the study via professional networks of clinicians located at the researcher's field placement site, snowballing out from there, mostly by email to further potential participants. Interviews were conducted mostly in person, with three taking place over the phone or video-chat due to geographic distance. Audio recordings of the interviews were transcribed by an outsourced transcription service and then coded by the researcher.

The interview consisted of two sections. Section one included demographic information for each participant (see Appendix E). Section two involved the main bulk of the qualitative research and took place through the use of the Interview Guide (see Appendix E). This section consisted of 12 separate questions, each of which sought to elicit information about the perceived role of the clinical supervisor. Topics for the first part of section two included, but were not

limited to the following: inspiration toward the role of clinical supervisor, perceived responsibilities in carrying out that role, and nature of the supervisory environment. The remaining questions, making up the last part of section two, centered on material of a more personal nature in the supervisory relationship and what each participant understands to be the place and role of such feelings in supervision. This portion of questions attempted to cover as well how each supervisor handles such feelings when presented with them by supervisees or any akin feelings that are acted out more subtly by supervisees.

Ultimately, all questions asked sought to mine the perspectives and experiences of the participants in their roles as gatekeeper in an attempt to better evaluate how they can know about or identify a supervisee's *woundedness* and its potential impact on the conduct of ethical practice.

Findings: Section 1

Demographic Information

Of the 12 participants six identify as female and six identify as male. Ten participants identify as white or Caucasian, and two declined to racially identify. At the time of study the age range of participants fell between 47 and 71, with an average age of 58.

The average number of years of experience in the role of clinical social work supervisor at the time of study was 18, ranging from five to 35. Ten participants obtained their MSW degrees from private graduate schools of social work, while two attended a public institution.

Throughout the numerous years in practice as a clinical supervisor, participants assumed the supervisory position in a wide variety of practice settings, including but not limited to the following: agency settings (community mental health; substance abuse; foster care; LGBTQ

community support; adoption; domestic violence, etc); outpatient and inpatient mental health; hospital settings; analytic training institutes, and graduate school supervision.

At the time of the interviews, practice settings fell into the following four categories, with some supervisors having their duties in more than one category -- for example, supervisory responsibilities at both a psychoanalytic institute supervising students in addition to supervising in the private sector:

(1) analytic training institutes, with five of the 12 supervised persons who were training in analysis and psychodynamic psychotherapy;

(2) private sector, with nine of the 12 stating they engaged in their own supervisory practice, performing what several additionally referred to as "private consultation" outside of any formal agency or employing institution;

(3) outpatient clinics, with four of the 12 currently supervising MSW students and other social work employees in more formal agencies; and

(4) graduate school, where one supervisor worked with persons who attended the school at which she was employed at the time of study.

With regard to training beyond that of the MSW degree, seven of the 12 participants had psychoanalytic training with a multi-year/level training program at one of several training institutes; and three have a PhD in social work. Six of the 12 noted supervisory training as a part of their additional training (this is not to say others did not have this, they just did not mention this in response to this question). Five out of 12 noted continuing education units (CEUs) as a part of additional training. Five participants noted extensive training in one or more of the following practice modalities: Eye Movement Desensitization and Reprocessing Therapy (EMDR), Cognitive Behavioral Therapy (CBT), or Dialectical Behavioral Therapy (DBT).

Findings: Section 2

Motivation toward the Role of Clinical Supervisor

Participants were asked what inspired or motivated them to become clinical social work supervisors. All participants have been given pseudonyms in this report to protect confidentiality. Eight of the 12 cited having been initially asked by a superior or employer to assume the role of supervisor, with one, Shelly, stating that it came to her "without my necessarily looking for it." The duty in most of these eight cases existed as an extension of ultimate responsibilities for a position already held, a natural progression and growth for that position or point in professional career. While perhaps motivated by something other than what Shelly alluded to as the desperate fashion of her employer at the time, where she exclaims, "the job was sort of thrust upon me," all these cases appear to involve having initially been "given" the role of supervisor rather than having pursued it. The other four more actively pursued the role, which seems to have motivated their move toward this level of responsibility.

For example, Teresa, who taught young children before her profession in social work, spoke of the pleasure she took in teaching and mentoring then and currently in this role, or, as she put it, a desire to "help guide people." In fact, at least five of the 12 mentioned previous teaching experience prior to social work and having found the elements of teaching and mentoring in the role of supervisor satisfying. At least three, who did not note a previous career in teaching did still note, however, that the teaching and mentoring aspect of supervision as draw toward the supervisory role. For example, Karyn noted, "I enjoy it and I feel like I have something to offer."

On a related note, Teresa stated for herself a similar motivation toward the role of supervisor to that of moving toward clinical social work, "I have a very strong part of myself,

which I think has always been there for me to nurture, to teach to help…so I think for me it's a natural extension of the work." This is a sentiment shared by several others; for example, Jon stated, "I love the field (social work), I love the helping aspect, and I wanted to help others help." Andrea also spoke of how she finds the supervisory position to be an extension of her social work role, stating, "It's another way to use yourself as a social worker." She finds this role less formal than that of clinician, she also noted, and when she took up the supervisory role at the psychoanalytic institute where she herself had graduated, she thought the role would be "interesting and fun."

When asked to elaborate on "interesting and fun," Andrea spoke to the intellectual exercise in the task of helping others to develop themselves clinically, which gives her a chance to evaluate her own ways of thinking. Peter similarly noted the opportunity to supervise as a chance to enhance his "own learning process and my ability to continue to expand my knowledge base… It also helps me in working with supervisees to conceptualize my own approach and how I deal with those clients."

Katherine, one participant who appeared to move toward supervision without being asked, spoke of her own experiences in supervision and how they motivated her to take on the role of supervisor. Referring to a particular supervisor from her own past, she shared:

> It felt like she was constantly flailing. She didn't have any sense of grounding and didn't know what she was doing. She was lost out in the field, and when she was working would break down and start crying, it was that difficult for her. And often I heard horror stories from other people that had the same experience, where they just weren't getting adequate supervision.

> I would discuss cases with her and she would get this sort of deer in headlights look. There was this inability to take it apart and to be able to think about...put theory to each case and know what to do next. And or take it at apart and, piece it back together and know how to formulate a treatment plan, know how to... what recommendations to give me, how to work with it, how to manage it, how to help me navigate.

Shelly similarly spoke of supervisory relationships in her own training, one as "disastrous," and one "wonderful." Continuing, "I learned quite a few things from the disastrous relationship as well" she added, "so I felt like I had a sense of what was supportive, at least to me, and growth producing and what wasn't."

While Scott did not explicitly state dislike of the role, he spoke about his role as supervisor at an agency in this way, "I have always most enjoyed doing the practice of psychotherapy. I don't… *not* enjoy supervising, but given my preferences, I always wanted to work with people in the therapeutic encounter." Even though Scott appeared more obliged than desirous of taking on supervisory responsibilities, the other 11 participants seemed to enjoy the supervisory role and intentionally chose to continue forward in the role.

Danielle, for example, who had been a social work teacher at an educational institution prior to supervising MSW students there, noted the motivation that pushes her to continue this work:

> [A]s a practitioner, I really enjoyed hearing about all these different areas and to the work that's being done, the gaps in the areas as well. And I also realized how much these students probably need, the students need a lot more help, you know, a lot more assistance in really becoming good practitioners. It's one thing to go to school and learn

from a textbook… I felt like students just needed more. I felt very confident to deliver that information and help them with what they were learning.

Peter, who also supervises MSW interns as well as employees, noted that initially the role was "just mandatory, the part of being a manager" but that later, it became a choice:

> [W]hen we get some really good intern … it really becomes somewhat of a two-way street. I mean you're invigorated and not only by the person you're supervising, but also it just seems to keep things fresh. I think it probably really prevents burnout in many ways when you're dealing with a lot of continual trauma focus treatment, substance abuse related illnesses, the chronically mentally ill, and dysfunctional family systems.

Responsibilities Included in the Supervisory Role

Descriptions for what responsibilities participants include in their role as a clinical social work supervisor varied from general to specific, abstract to concrete. Nine of the 12 participants supervise in the private sector where practitioners seek supervision outside of an employment setting or training program; and all but three participants had supervised either completely or partially at some point in that sector. For this reason, participants were encouraged to speak to supervisory responsibilities in both types of practice settings.

Carl, who does most of his supervision these days in the private sector, spoke rather concretely to agency based practice and the responsibilities he had previously as a supervisor in that type of setting, describing his responsibilities in the following way:

> There's the teaching component, there's guidance and there's evaluation of the performance. There's administrative responsibilities, making sure the person is doing their paperwork, is performing the administrative aspects of their job properly, being

> there on time, getting along with other people there, being professional and being courteous, and then the other aspects of their performance.

Those "other aspects of performance" to which he refers speak to the more clinical aspects of supervision that he sees as a part of his responsibility as well, helping his supervisees develop all the "generic skills and setting specific skills." He further explained the teaching of these skills and guidance differs depending on the setting, where for example in a hospital he taught skills more related to medical social work. He also shared his experience in supervising what he called the more "generic core skills" involving "assessment and interviewing…diagnosis, treatment planning…modality based stuff." Getting more specific again, Carl talked about the skills that he helps supervisees to develop around specializations, such as individual treatment, couples treatment, and group treatment. Many participants emphasized more generally the responsibility they carry in their supervisory role to "teach," "guide," "mentor" and "act as a role model."

Peter, who worked in an agency setting at the time of study, supervising both MSW students and clinical social work employees, spoke more explicitly about his supervisory responsibility orienting supervisees to their role in the agency setting:

> My role, I believe, is to orient the clinicians to the program -- to understand what it is that we do here, what our philosophy is, to help them in their own journey… We want somewhat of an ability to kind of hit the ground running, so you want them to have some basic fundamental skills that they can utilize, and [my role is] to help identify what those are - what the strengths are… what their needs are in terms of continued growth.

Stewart, who supervised at the time of study both in the private sector and in an agency spoke specifically to the differences between the responsibilities in the two sectors. While there is always effort to keep the focus of on clinical aspects of work, he has found that he is more able

to focus on those aspects in the private sector. In his agency work, he noted, he has found the need to split his energy between this kind of activity and administrative aspects of supervision, such as making sure agency rules and other rules, such as HIPPA, are followed.

Teresa spoke at some length, in fact, about the differences between agency-based and private supervision. While she placed an emphasis on "helping people grow" and "helping them do effective work" in both settings, she noted that "in private practice you don't have an administrator role and in fact you can get away from all that." In agency-based practice, she elaborated, "there is so much of an imposition of the administrative demands on the supervisor," where, "you have a role to play in relation to that agency, [so] there isn't a real separation of administrative and clinical." Teresa spoke further to the difficulty of agency-based supervision, such as being forced to wear multiple hats and the need to consider administrative responsibilities of all employees along with fostering clinical development. She referred to such difficulty as "constraints" of the entire system, including but not limited to managed care, and spoke to these constraints on both clinical social workers and their supervisors in the agency setting in the following way:

> [All] the recording keeping, and the amount of time you are even allowed to see people, the waiting list, it just goes on and on. How quickly you get people in and out, there is a lot of that, there are many constraints [on clinical practice]. So as a supervisor what I have found… is a kind of justifying, that the clinical work people are doing…it's almost like it's good enough, and you have to let go, because there are things we have to do in order to keep this program going. It's one of the reasons I left… because it drove me crazy!

> So I wouldn't go as far a to say that there are unethical things that have to come out, but it certainly impinges on [practice]... It's not the luxury of what you would want to do. It's what you feel this person really needs, and you can't provide it.

Shelly, who similarly at the time of study mostly supervised privately and through a psychoanalytic training institute, alluded to her experience of supervising in the agency context as well. She spoke of "feeling freed up [as well] from all the paperwork, numbers, productivity and issues like that." Ultimately stating with her private supervisory practice, "at this time, I feel sort of lucky that I really just get to focus on the clinical piece." The "clinical piece," as she says it, can be understood as all that pertains to the clinical relationship between supervisee and his or her client/patient involving assessment and implementation of treatment.

Several participants who specifically focused their answers on this "clinical piece" spoke of responsibilities related to safety and well-being. As Katherine stated:

> I'm responsible for these supervisees and all of their cases -- all of their work. And I take that very seriously. So what they do, I need to know ... I need to know that they are treating their clients with care and they are doing professional work and doing the best that they can.

Derek included not just the safety and well-being of the client but that of the clinician, as well:

> [I]t's my responsibility to try to keep both the supervisee and their clients safe… to try to make sure that the supervisee is taking care of themselves in the work and also making sure that they're monitoring what's happening with their clients -- to make sure they get the self-care that they need… A lot of people feel like they never can give enough and then you really can exhaust yourself or extend yourself too much.

Danielle elaborated on the importance of monitoring safety and care for both clinician and client in her role as supervisor with both MSW students and employees when she spoke about the importance of self-care in this way:

> I think that in general, even if you haven't had too many struggles, you know, it's very hard to find anybody who hasn't had struggles in their life…in this work you really need to take care of yourself and have that balance…you have to practice a lot of self-care, which is just not done enough…people [clinicians] who are coming in [towards the field] who have these life experiences, they are going to help because they know the missing pieces, but how much help are they getting to really do the work?

Derek continued about how he takes on the responsibility of helping supervisees establish appropriate boundaries, both for the well-being of the client and practicing clinician:

> It happens with some frequency that people [clinicians] will just do whatever their client says they need without considering whether or not the client actually needs it and without considering how much it is impacting them in their lives. We're [supervisors] trying to encourage them [supervisees] to notice all that and to have boundaries where necessary and appropriate.

Part of noticing appropriate boundaries in the work, as Derek shared, happens through the development of self-awareness and what several participants referred to as the *use of self*, both skills several supervisors claim to be a major part of their role in helping their supervisees to develop. As Andrea, a supervisor at a psychoanalytic institute, shared:

> I'm responsible to help students know themselves… and so it's my responsibility to help the person see where they need personal work and to help them understand themselves… I mean, I believe a lot of social work, comes from inside yourself that you have

identified… [and you need to be able] to differentiate when it's your issue and when it's a patient issue.

Danielle strives to develop greater self-awareness in her supervisees as well, most of whom are MSW students and employees in an agency. She uses process recordings, as other supervisors noted using as well, to increase supervisees' self-awareness and *use of self*. In fact, much of her work involves "trying to figure out ways for them to increase their self-awareness, like what effect is that client having on you, and what are you bringing into the relationship?" Without such questions, she finds that many people become involved in "over helping, wanting to save the client, just going above and beyond, and it's not just for facilitating change, and it's obviously doing for different reasons." Sam shared that he believes strongly in addressing the skill of *use of self* with supervisees and in fact that he "tries continuously to encourage supervisees if they are willing to look at their emotional reactions with clients and then use that diagnostically."

Support Found to Carry Out Supervisory Responsibilities

Across the board, participants spoke of informal support in carrying out their supervisory responsibilities, particularly those in the private sector, where they primarily relied on trusted colleagues or peer-supervision groups for supervisory support and alternative perspectives. Shelly discussed it this way:

> [S]upervision [for me] doesn't happen within an institutional setting. That said, I am connected to groups of friends and colleagues who also supervise or who like myself might be on faculties of an institute or whatever. [I]f I felt concern and I really needed to talk a situation through, there are a number of people I could go to right away. So I don't have any formalized support but I know where I could get help if I need to.

Several others who had been in the field and this role for such a long time or at such a high level of organizational command expressed feeling that there is no real need for external support. As Teresa put it:

> Basically, I've been in the field for such a long time, and I've had very responsible roles in the field, so I don't mean to sound arrogant in any way, but I do rely heavily on myself and my knowledge for doing supervision. So I very rarely need to reach out to someone else. But if I did… it would be legal counsel…people at the NASW.

Carl spoke about his many high-ranking positions throughout his career, which often placed him at the top of the chain of command and, as a result, feels that he occupied the usual position of support for others. Thus, like Teresa, if he needed to address a supervisory issue, support was once again found with trusted colleagues.

In contrast, participants who supervise in psychoanalytic training institutes have communities of support and systems, which help to evaluate supervisee/analytic trainees. For example, Derek, spoke of it in the following way:

> One advantage of being [at] the [institute] here is there are a lot of other people that I can go to for support and help if I need to and so that way I'm never alone. I can always go talk to … any number of people who are here that I know for a long time and respect. So there's definitely plenty of collegial support if I need it.

He, like Carl and Teresa however, rarely feels the need to "go outside my office…it hasn't really happened that I feel like something is bigger than what's happening here." When asked what something "bigger" might look like, he put it this way:

> Well, I suppose if somebody was doing something I thought was unsafe or unethical and seemed unwilling or unable to stop and that would be of real concern. I mean ... I

happen to have some authority here, so if I really thought that was the case I could do something myself anyway, but certainly I would probably go for some advice and support before I suspend someone's privileges if it's something more serious. And it would have to be something pretty serious, I've never really seen someone that was both fixated on doing something that's seemed dangerous or harmful, or crossing the boarders, and also so unaware they would let me constantly know about it, I don't know. It hasn't happened.

Two supervisors referred to their own supervision as an important place of support to help carry out their own supervisory responsibilities. Katherine, who privately supervises mostly early career MSW graduates, referred to it in this way:

> I have my own clinical supervisor… She also supports not just the clinical supervision, but also it helps with all of the business stuff too . . . part of managing this as well. [Things] come up [with supervisees]… [for example], late on payments regularly, [which] can be symbolic of other things…something that they're trying to convey... [T]hey might not be valuing the work at the moment, or that kind of a thing, so it helps that I can talk with my clinical supervisor about these things.

Only one participant noted a situation in which, in retrospect, she felt that she could have received more support.

Finally, Teresa, who supervises only in the private sector at the time of study, spoke of her earlier experience in agency-based work and the level of support she found to exist at the time she began her supervisory career, some 30 plus years ago:

> I was very fortunate, because I had a lot of help in becoming a supervisor and I don't think it exists as much now…While I was a beginning supervisor, I had group supervision; I also had individual supervision for bringing supervisory issues that were

> emerging for me doing supervision, to someone, where it was a more experienced social worker, that's how I learned how to become a supervisor.

The support and training Teresa outlines here was provided by the organization she worked for at the time, where “everything was about growth, professional growth” that “not only the clients benefitted from,” but “it was [just] quite an amazing office,” an atmosphere of support and training she seemed to emphasize not existing these days around supervision.

In conclusion to this portion of findings, Danielle noted some of these issues that exist around the supervisory role in the field of clinical social work today, alluding as Teresa just did, and others, to the lack of formal supports in the field today for supervision despite the importance of this role. The field, she suggested, needs much more help to ensure a strong professional gatekeeping practice including greater training for supervisors to address the psychological and emotional issues of people in supervision. “Too many corners are being cut across the board,” she suggested, such that practitioners do not receive adequate supervision and supervisors do not receive enough support. “[A] lot of it boils down to money and time,” she noted, and “they just can’t do it,” referencing a hospital placement where the only supervision is group supervision for 15 students led by one social worker in contrast to a graduate program with individual supervision, which she believes is so valuable. The reality behind this situation, she believes, is the degree to which the concept of managed care and its related budgetary-oriented constraints:

> I work at an online program, so I'm getting a little bit worried here and there too about the students who are online for their classroom and then going into the field and what the supervision is like there. And that's why my role is a very important role - to make sure that they are getting a solid supervisory experience… I've seen really good experiences,

because we're so strong about making sure that they are only placed at places where they're really being watched and things are really being explored… But the stuff we're talking about right now can easily be glossed over because there are so many other and "more important issues" that have to be addressed, although this isn't in the time to work on it [so] unless the student is grossly inappropriate, they're not addressing maybe some issues that [actually] need to be addressed.

Types of Supervisory Environments

Participants were asked what sort of supervisory environment they seek to create for and with supervisees. Answers appear rather consistent from one participant to the next; however, as is the case with aforementioned findings, the setting (private versus agency-based) influenced participant responses. For example, there was a general consensus amongst participants about the importance of creating a "safe," "supportive," "trusting," "warm," "inviting," and "nurturing" supervisory environment. In various ways, participants spoke to the effects such an environment has on the overall usefulness of the supervisory relationship and toward a supervisee's professional and clinical development.

When describing the sort of environment he aims to create, Derek shared the following observation:

I want it to be really safe, and I want people to feel comfortable making mistakes, where [it's ok if] they don't know what they are doing. I think the most important thing is to create an environment where you can explore the places where you're weak or the places you might have done something you think you shouldn't have done. If you don't have that, then you can't learn.

Several other participants spoke about “mistakes” and the importance for supervisees to feel like they can make them and to feel comfortable enough to share them with the supervisor. Carl, for example, put it this way, “You don't want to prohibit them from telling you about situations because they are afraid to tell you about mistakes.”

Danielle, again who does most of her supervising with MSW students and employees in an agency, noted, however, that no matter how comfortable and open an environment she seeks to create, she can still see a fair amount of “defensiveness, especially with employees” in the agency setting. She continued in this way:

> [T]hey feel like there’s this need to be professional and be ready to go right away. And I mean, in this field it takes years and years, and years to feel comfortable in your skin. And so, I think there has been an undue expectation that the social workers do put on themselves right out of school to be ready to go and have it all together, and really it takes a lot of time.

Several participants also spoke about the balance that they aim to strike between “supportive” and “challenging.” Shelly spoke to this balance when she talked about an advertisement she placed in the New York City chapter of the NASW (National Association of Social Workers) publication to seek private supervisees. At the time she wrote it this way: “Are you looking for a supportive and challenging environment?” Thus, she, like many of the other participants always hopes to establish an environment that feels “warm, inviting, and safe,” elaborating that she realizes that this “doesn't happen overnight and that it doesn’t happen in the first meeting” and further acknowledging that “people need time to get to know each other and expose their work.” She also feels, however, that “people wouldn’t be hiring me or paying me if

they did not want to learn something, and so I want to offer a kind of challenging environment " where substantive learning can take place.

In bringing up this matter of hiring, Shelly speaks to a key difference between private and agency-based supervisory practice. For example, the choice one has of supervisor - or for that matter, the ability to choose to participate in supervision or not - differs significantly in these two areas. In the private sector all supervisees come to supervision of their own volition with, what many respondents expressed feeling themselves, a sense of active engagement and desire to learn and grow clinically. This is not to say that someone who is mandated to participate may not have similar goals, but the fact that someone may be forced to have supervision and thus has less choice in the matter certainly raises an issue for thought.

This matter regarding "choice" expands to that of the supervisor as well, and crosses with what Teresa describes in her private supervisory practice as the "luxury of being able to really decide for myself," that is, the "feel" of the supervisory environment. Expressing control over "how I'm going to do that, [because] nobody is telling me what I have to do… It's what I know is a positive thing and what works" versus, for example, an environment where the employing agency dictates the supervisory goals, which ultimately may end up influencing the feel of environment the supervisor ends up establishing with supervisees.

Stewart, in agency-based work, spoke about the lesser degree of choice that supervisees have in agency-based supervision and the greater degree of "control" that he feels he has over supervisees in that setting. In the mandated environment, he stated, he finds himself able to really evaluate the work of a supervisee and to "tell a person what to do" (what might be problematic) as opposed to the private realm, where, he said, "I don't have control over what they do, they don't answer to me." At the other end of the spectrum, Katherine spoke to the

difficulty that this can pose in the private sector, where she supervises mostly recent MSW graduates who are working toward licensure. She finds herself, she noted, having to walk a bit of a tightrope in order to not offend supervisees with her evaluation or suggestions; for example, she would like to make personal therapy mandatory for supervisees, but “I know that if I required [this of] any of them… I would lose most of them.” They would, she believes, simply “fire” her, which raises an important question (discussed below in more detail) about the effect of supervisory “tiptoeing” for the sake of maintaining business and income on the ability to be an effective professional gatekeeper.

Katherine, for example, has 14 private supervisees, but only one undergoes personal therapy. Around the topic of personal therapy for the supervisee, to be elaborated further in a subsequent finding, many of the participants cited supervisees’ engagement in their own therapy as crucial to not only helping a supervisee use the self effectively in treatment with patients but also useful in helping maintain the important distinction needed for a supervisee in understanding what takes place in supervision. Supervision, for example, exists as the place to explore all that pertains directly to the client versus personal therapy, where content explored by the supervisee may affect treatment with clients but ultimately relates more personally to the life and development of the clinician and therefore needs its own place for such exploration.

Returning to descriptors frequently utilized by participants like “safe” to describe the kind of environment they try to create, Derek shared this observation: “I think [it’s] the same thing in therapy; you want to create a safe environment where anything can be brought up.” Teresa also touched upon the safety she hopes to establish for supervisees in supervision, which, like Derek, she believes can have a similar feel to what a patient experiences in a more therapeutic relationship:

> [I]t's not therapy, but it's the same kind of environment, which is a very, very safe one, one in which the person I'm supervising feels he or she can open up, and talk about their work in a way that enables me to really get close to [their] client's experience and [to] be able to effectively help that worker understand that client…If you do create that kind of environment [however], it makes it safe for people to share their own experiences as well... so [a safe enough environment] in which … the self for the worker can be shared, but it also has boundaries around, so that it's always back to the work, and it doesn't become therapy.

Jon, elaborated on these boundaries in the following way:

> There is a fine line between being a supervisor and being the supervisee's therapist, and I find it very important to make sure that we both, the supervisee and I, understand where the supervision ends and therapy begins.

As example, he shared the following, which he believed illustrates how he navigates and draws this line between supervision and personal therapy:

> We have been very clear about when she brings in her countertransferential stuff, we will explore that in relationship [only] to the work she is doing with an individual or a couple. If it gets more into her countertransferential stuff personally, I then say, "You know what, maybe this is something that you can talk to your therapist about." I don't dissuade them from talking about some of it to me, but I frame it as, "How is that going to benefit or not, the couple or individual you are working with."

The importance of this distinction repeatedly came up for participants throughout the interviews, particularly as the interviews moved into the next area of inquiry on the topic of the place of supervisees' personal material in the supervisory context.

Findings: Part 3

Personal Material of Supervisee within Supervisory Context

The remaining questions from second half of the Interview Guide (see Appendix E) centered on material of a personal nature presented by practitioners in their supervisory relationships and what each supervisor understands the place and role of such feelings in supervision. These questions attempted to cover as well how each supervisor addressed such feelings or any similar feelings that supervisees might act out subtly. The goal of these questions was to explore the ethical implications of such feelings in terms of how they are addressed in supervision and the ultimate impact on clinical social work practice.

For the following findings all respondents had answers that fell consistently along a rather similar spectrum. Whether expressed in response to a question about the importance of knowing factors that motivate people to become clinical social workers or one about responses to personal material revealed in supervision, answers often involved phrases including: “yes, to a certain extent,” “yes, within limits,” or “yes, but with boundaries.”

In terms of the usefulness of knowing the personal motivations of supervisees for entering clinical social work, most participants noted that they do not lead with a need for this to be revealed from the outset of supervision. However, most do feel that such information inevitably reveals itself as the supervisory relationship evolves. Most participants shared that personal motivations tend to be revealed as the practitioner shares his or her clinical cases and his or her approach to treatment or when he or she discusses countertransferential feelings. Further, all but one participant believes that the surfacing of personal material and motivations of supervisees do add value to both the work of supervision and the work with clients.

Derek, for example, who shared that he does not need to know from the outset of supervision made this observation:

> I definitely need to have my antenna open for what they are either doing in session [with their clients] or what they are avoiding doing in session…So I don't necessarily need to know what their traumas were in their background, but I will always notice eventually what they are not dealing with well… And it will come up when we talk about it; there'll be something in their past or something from their personal history that makes such and such a thing difficult for them - either certain feelings or certain personality types or certain experiences, and it's important to create an environment where you can have that come up, and I intend to try to reflect that it's okay, but that is something you need to talk to your therapist about.

In his response to similar questions, Carl spoke as well to the ways in which personal material reveals itself in supervision through the discussion of case material and of countertransference, feelings stimulated for the clinician or possibly stirred up by clients in the therapeutic dyad that can be tied to a particular personal issue of the clinician/supervisee:

> [I]t's one thing if you have a very distressing situation and you get upset… That's one thing, and there's nothing wrong with that... But if something is more… well [if] there's more of a pattern developed [by the supervisee], and it doesn't get resolved in supervision, it needs to be resolved at the appropriate place.

That appropriate place is, according to all of the participants, the supervisee's own therapy, which, as noted by Katherine earlier, can pose a problem when, as is the case in her private practice, the practitioner is not in therapy.

Noteworthy to this discussion, and particularly in this context, recall that Katherine is the only participant who consistently does not feel that personal material has a place in supervision at any point or to any degree. She additionally did not discuss the phenomenon of countertransference at all in her answers. Rather, she spoke about personal material of supervisees in the following way:

> [H]opefully, I won't know that much about their past, so that their work with their client [what I'm looking at] is just how well and not well they're doing… And I can either help them make corrections or keep cheering them on so that … I can just address whatever they're doing.

In her private supervisory practice, Katherine mainly described feeling the personal material supervisees brought into the room as something "from outside the room." What she saw as unrelated to their clinical work, and as "high drama…in their [personal] life." She feels open to working with and discussing personal issues related to what she described as "burn-out" but maintains a hard-and-fast rule that if supervisees "bring up something personal, then, I say, 'Great, this is a time for you to take that to your therapist,' because that's where it should be taken."

Teresa spoke in her interview about the role of shame in supervision and the attempts that she makes as a supervisor to avoid inducing that feeling or similar ones in her supervisees. She noted that she wants all parts of her supervisees to come into the room (that is, into the process) without "shutting them down." She does, however, feel that when those parts do enter the dialogue - particularly very personal parts - they have to find the place of that material in relation to the patient; and she perceives her role as helping to find that link. She elaborated in this way:

> [You] are a complete person, and you use the depth of who you are in the work… So… it's not that you're bad for having brought that in or that you should ever feel humiliated [or] shamed that you shared this in supervision, but more 'okay,' well now I know, and we'll see where that all fits [in relation to the case work].'

With regard to personal therapy for supervisees, many participants noted how personal therapy can help to keep supervision as just that - supervision, and not therapy. Supervision, they all agreed, needs to have at its focus the clients and his or her needs; and while personal material of the supervisee likely will find its way into the supervisory room, all but one participant, still find it useful as long as the insight ultimately ties back to the supervisee's own practice, and in due course, the well-being of his or her client. Or as Jon stated:

> I don't want a supervisee to come in and go, 'I'm not sure if you're my shrink or if you're my supervisor.' I want to make it very clear to them I'm your supervisor, but if you bring in stuff and there are hurdles for you, most of the time those hurdles are historic. Those hurdles are hitting psychodynamic aspects of your own history, [so] let's just touch on those to see how they relate to the work you're doing and see if we can see any parallel [but] that's as far as I'll go.

Andrea feels that personal information that inevitably comes out from case material has a place in supervision to a certain extent as well, which she believes helps her to develop an understanding for a supervisee's "thinking and visceral experience," which, in turn, helps her understand how that thinking impacts or plays into the work with the supervisee's clients. This, she believes, gives her a window into what might be going on behind closed doors, as it were, with a supervisee and his or her patient. She further believes that discussing personal material exists as a crucial part of countertransference, the exploration of which constitutes a part of good

supervision, she states. However, she also emphasizes the importance of being able to differentiate between what is called *subjective* countertransference (that which is related more personally to one's own life and history), and *objective* countertransference (that which any individual would feel in sitting with that particular patient, for example). Or as Jon put it:

> Countertransference, I believe is recognition that "Oh, something is being induced in me. I understand what is being induced in me. It's hitting a nerve for me. How do I recognize it, how do I work with it?' The person who comes in and goes… "I'm freaking out, I'm freaking out, I'm freaking out" when there's no connection in the countertransference… that's when it becomes more of the pathology of the supervisee, and that's where I would say… "Are you asking me to help you deal with you, or are you asking me to help you deal with the situation that has been brought up in the work you're doing?"

The emphasis here, like in many of the other participant answers, lies in the exploration of countertransference and personal material "to a certain extent." When Andrea, for example, finds a supervisee getting more emotional or moving too deeply into subjective countertransference and thus away from the client, she encourages them (as do all the other participants) to bring that to their own therapy sessions. By bringing the personal therapy of supervisees continuously into the room (or the need for it up when appropriate) many participants believe that over time, greater self-awareness develops for how practitioners' personal vulnerabilities, or "wounds" can impact their work, moving ultimately toward the utilization of such "wounding" in supervision and the therapeutic dyad as a tool to help people (clients) rather than using it to work out one's own issues (i.e., pathology). As Teresa put it:

> [I]t's understanding that experience of your history, of yourself, of who you are as a person and how that got stimulated in the work with this client and what that tells us

> about the client and also what your tendency would be to [perhaps] not do what the client needs because of your own experience or to be guided by that in a positive way because you understand, you have some empathy for the client's experience.

Peter, in the following way, additionally spoke to the value that personal information and issues can provide when brought into supervision in its ability to provide the supervisor with the opportunity to help supervisees increase their own self-awareness and to better understand their countertransferential feelings:

> [I]t's always important for us to identify our own reasons [for doing something] and making sure that when we're speaking with clients that we know what our motives are…I've said [about myself], "I'm anxious to baseline." So if I'm sitting with a client and all of a sudden I'm starting to feel uncomfortable, I can't always assume that that's where the client's coming from. So I have to always stop myself and say, "How does that feel right now?" Versus assuming that there might be anxiety going on in the room just because I'm experiencing it.

Many of the participants spoke to the varying degrees of self-awareness that can exist for supervisees around personal issues and their potential impact on practice; and all but Katherine believe that a key responsibility of supervision is to help practitioners to increase this awareness toward appropriate behavior in practice as well as solid clinical boundaries.

Teresa, for example, had this to say about what happens when a supervisee's issue finds its way into the room without explicitly sharing it and how she, as the supervisor, addresses such cases:

> I had workers who have been in therapy and they share openly, but then there are instances - and even with those same social workers - where you're hitting on a wound [in

talking about clinical material], but they haven't said what it is… And you just feel it… you just sense it. There's some impasse, or there's something there that you just kind of feel [as a supervisor], and so there … I'd say something like, "Have you noticed anytime we have spoken about this issue, I am beginning to feel like I'm hitting up against something here, do you know what that might be?"

Danielle spoke to a similar sort of resistance, or lack of self-awareness that she sees in supervisees, particularly with practitioners she supervises in her agency-based practice:

> [In] general, people are… fairly guarded about deep stuff that's going on unless it pops up… [in a way] that they can't control; but the thing is, it just doesn't come out [otherwise]. And you just don't know if they've been in therapy [or] they feel very comfortable with talking about their issues and [can in fact do it] in a "healthy" way.

She continued by speaking of the "defensiveness" that she finds can exist in general with the supervisory process in the more mandated realm. As someone who conducts all of her supervision with MSW students or employees of agencies, she spoke more thoroughly to this "defensiveness" than did the other participants, who mostly supervise in the private realm.

Danielle shared an example of working with a supervisee who she believes had boundary issues. In particular, an issue around appropriateness of dress kept coming up over and over again, both at the supervisee's field placement and in her supervision. The supervisee, a female MSW student, who had been working with teenagers in a school setting, continued to wear what the supervisor and others thought was clothing too provocative for the work setting; "low cut tops," for example.

Part of the work for Danielle, she felt as a supervisor, was trying to explore with the supervisee her understanding of her impact on her work environment, which Danielle felt

reflective of an understanding for boundaries in general. Ultimately, the supervisee “just couldn’t see the effect it was having on teachers and students” and in fact, began to “fear supervision, avoiding supervision, calling in sick, acting very anxious and very guarded - defensive. She was avoiding me.” The supervisee did not ultimately develop an awareness for the problematic effect that her dress had on her environment, nor was she able, apparently, to grasp the idea of appropriate boundaries. Danielle felt this inability indicative of a greater inability to notice and expand her overall clinical awareness in general and for other possible blind spots or personal issues; not that personal issues are the problem, but the problem may be what one does with (or about) them.

Eventually, Danielle brought this case to another supervisory level - meetings with the graduate school where the supervisee’s appropriateness for the field was evaluated. The student did ultimately graduate, although Danielle felt that she should not have been allowed to yet. Sharing further that she believes it very difficult for schools to prevent graduation or, as she put it, that “schools just let them go… let them through a little easier than they should.” Elaborating:

> I think it takes gross neglect or gross ... I guess behaviors, to really not graduate…and so then the question is, when will it be caught? I don’t know and let’s say that student graduates and then goes on to get a job somewhere, and what are the chances that they’re going to have a supervisor there who really corrects those things that are [an issue].

Katherine spoke to a similar problem she found with graduate school gatekeeping practice and the way that the gatekeeping practice of supervision is currently set up in the training field. For her, she sees the effects in the private sector, where she once supervised a new MSW practitioner attempting to accumulate clinical hours but who was “far too anxious” to be in the field, needed a lot of “hand holding” and was unable “to think critically on her own feet.”

Katherine found this supervisee to be emotionally immature and underdeveloped, not equipped to work with the low-level functioning of her clients, and felt that this situation required something "beyond suggesting personal therapy. It was too much for her to be in therapy…and it was too much of a liability issue for me because I am off site." For Katherine, she found the following the most distressing part to be as follows:

> [W]hat's happened with her is she has been pushed through the system. People along the way have told her that she has done well. I mean, she's graduated; she's made it this far, so no one has really told her that she is not good enough… So here I am… saying "No," … like this gatekeeper who's saying, "I'm not going to let you pass through," and that's very confusing [for her].

Further, because the student was in private supervision with Katherine, she (the student) had the option to seek supervision elsewhere, which speaks to the "tiptoeing" and "tightrope" mentioned earlier many supervisors walk to keep supervisees in their private practice. As Katherine noted about the supervisee described above, "She wasn't having it… [expressing,] 'This isn't… We are just not…,' so I just said, "This is what I'm recommending… remedial help, some training, some therapy…," and I don't think she'll do any of it.

Conclusion

Regardless of supervisory practice setting, all participants at the time of study stated feeling fortunate in their supervisory role to have not encountered any "gross" unethical issues in a supervisee's practice (e.g., substance abuse, sexual misconduct with patients). Most participants did include a disclaimer however, sharing having seen over the years what might not be deemed, or defined by the NASW Code of Ethics as outright unethical or impaired

professional practice, but as definite cases where the subtle ethics of a supervisees practice felt questionable, along with the ability to truly conduct effective therapy.

All participants spoke to memories of at least a couple supervisees whose suitability for the field at that time of supervision was put into question, with several pointing to fundamental issues a supervisee had with boundaries, or an inability to separate oneself from his or her client; utilizing, for example, the therapeutic space to work through, or ultimately on one's own issues, instead of keeping the focus on the healing of the client.

While many found this problematic, and spoke to the limitations and ultimate "talent" lacking for that supervisee in the role of clinician, they did not feel it constituted what the NASW calls impaired professional practice, or as unethical practice. Andrea, for example, when speaking about a supervisee at a psychoanalytic training institute who had a very critical mother along with the patient's, and a difficulty separating her situation from that of her patient's, shared, "She was okay to go on…I don't think she would hurt anybody…, [but] she was not talented…and I wouldn't make a referral to her."

Scott spoke further to this fine line that can exist between ethical and unethical practice, "gross" misconduct, or for example, more subtle issues with boundary in the following way, stating, if supervisees "meet the standard for [practicing] therapy: maintaining the frame; working with the goals; not taking over the agenda; being a constant object to the clients; understanding their own inner world, vis-a-vis the people; keeping it fresh with no memory, no desire, that's all that can be asked for."

Teresa, who has only supervised professionals post MSW, shared that by the time she sees her supervisees she presumes that "hopefully the gate keeping person of [that] person into the profession to begin with" has done his or her job; possibly accounting for the lack of "gross"

misconduct she encounters with supervisees. This stands in contrast however to what Danielle shared, and others have agreed, as the all too relaxed gatekeeping practices that can exist within MSW programs around training prior to entering the professional field mentioned earlier.

In summary, all felt for the most part that they have been able ultimately to help practitioners develop greater self-awareness and professional ability toward effective utilization of self as a tool for ethical practice and client treatment. Outside of what many called the "gross" ethical misconduct defined by the NASW, participants still spoke to the difficulty they face in carrying out their gatekeeping role fully with every supervisee, either because issues already mentioned throughout this chapter, tied either to the setting (private versus agency-based), or the difficulty in truly understanding what goes on behind the closed doors of the treatment room. Derek spoke to the difficulty of carrying out the supervisory role in this way, "Unfortunately it's like any other field that you want to look at, there's no way to stop people who should not be practicing from practicing. Whether it's a priest or a journalist or a politician or a therapist or a plumber or whatever you get incompetence, unethical people everywhere. There's no way to totally prevent that." He speaks of being able to go only as far in his role as gatekeeper as it relates to the analytic training institute where he supervises, stating he can prevent someone from "being able to say I graduated from [this] training institute, but it wouldn't stop [one] from going somewhere else and/or going to get job and/or hanging a shingle."

Findings from this chapter will be analyzed in the following *Discussion* chapter, and the implications such findings have on ethical practice and further research will be explored as well. Additionally based on findings presented in this chapter, suggestions will be made for the

fortification of the gatekeeping practice of supervision and its role toward promoting and maintaining greater ethical practice in the field.

CHAPTER V

Discussion

The objective of this qualitative study was to assess how the field of social work currently maintains and preserves professional social work ethics in the clinical practice field. This study sought to explore how, in a field where the *self* is one of the main tools utilized, the field ensures that the practitioner's *self* is fit to practice and to do so ethically. This is of particular significance in a field which research indicates that often individuals are drawn to it because of their personal life struggles (Lackie, 1982; Marsh, 1988; Vincent, 1996).

More specifically, this study centered its research around social work professional ethics as affected by the concept of the *wounded healer*, a concept that holds that personal vulnerabilities-- or for the purpose of this study what has been called a practitioner's *woundedness* -- plays an important role in not only the motivation toward the field of clinical social work but in the ultimate healing of patients. Through interviews with clinical social work supervisors about their role and responsibilities as gatekeepers in the clinical field, the aim of the study was to discover the ways in which the field helps to ensure that such vulnerabilities --or *woundedness*-- of those who practice are utilized toward the enhancement rather than impairment of practice.

Divided into four sections, this chapter discusses the findings presented in the previous chapter as follows: Section one reviews the key findings in relation to the previous literature; section two outlines the implications of the findings for social work practice, discussing as well

how the clinical field might incorporate such findings, and for the importance of this research in field of social work; section three puts forth recommendations for future research in this area of professional social work ethics; and finally section four briefly discusses the benefits of the study, and offers concluding remarks.

Key Findings: Consideration and Incorporation of the Previous Literature

As previously discussed, psychodynamic literature in the field of psychology has to a degree explored the concept of *wounded healers* in psychotherapy (Hayes, 2002; Miller & Baldwin, 2008; Wheeler, 2007; Zerubavel & O'Dougherty Wright, 2012). However, less attention on the concept has been placed specifically in the social work literature and even less (outside of countertransference references) on the implications that actual *woundedness* -- positive or negative -- can have on clinical practice. Divided into the following two subsections, this section discusses the results of this study as it relates to literature covered in Chapter II. First, ethics and gatekeeping practice are covered; and then presented together are *woundedness*, the *wounded healer* paradigm, the *use of self* concept, and the clinical concept of countertransference.

Ethics and Gatekeeping Practice: Responsibilities of Supervisors, as Outlined by Participants

The results of this study indicate that all 12 participants carry out their role as *gatekeeper* with a fundamental understanding for the responsibility held to ensure that those practicing in the field (their supervisees) carry out the codes of ethics and interact with clients, colleagues, and the community in an ethical and competent manner (Miller & Koerin, 2001). In other words, they believe that a key task of their role as supervisor involves watching the gate that separates non-professional actions from professional practice and is intended to help supervisees understand the

distinction between the two. Common agreement amongst participants shows that they attempt to carry out this task through various forms of teaching and mentoring and through the use of monitoring and analyzing supervisees' work (and in all but one case, the countertransference of supervisees as well, discussed in a subsequent section). Ultimately, as the literature proposes, participants strive to "promote in the supervisee the development of an internal supervisor" to help guide each ethically in his or her own practice (Wheeler, 2007, p. 254; Casement, 1985).

Limits, however, often tied to practice setting (private versus agency-based) were discussed for the ability to consistently carry out these supervisory responsibilities. While none of the 12 participants cited what the National Association of Social Workers (NASW) would consider "gross" ethical misconduct throughout their supervision (involving for example, either sexual or substance abuse related misconduct), they did share instances when they struggle to interfere and influence what in the field might still be considered incompetence, inexperience, or potentially less than ethical conduct. A shortness of reach, however, sometimes got in the way of supervisors' ability to take, as stated in a section of the *NASW Code of Ethics*, "appropriate remedial action" against the supervisee when needed, and/or suggest that the supervisee seek "professional help, mak[e] adjustments in workload, terminat[e] practice, or tak[e] other steps necessary to protect the clients and others" (NASW, 1994, p. 3).

Findings revealed this difficulty – that is, to influence and/or help make adjustment to supervisee practice particularly within the more private sectors. For example, nine of the 12 participants worked in the private sector (at least in part at the time of study) supervising personal caseloads of practitioners who sought supervisory services outside of an agency or employment setting. As a result, in the more private supervisory setting, respondents stated that they feel frequently less able to analyze and critique the work of supervisees as much as they

would like because in essence, the supervisee is an employer (that is, pays the person for supervision). If a supervisee, for example, disagrees or feels defensive of the supervisor's suggestions, the supervisee has the choice and flexibility to seek supervisory services elsewhere. That is, the practitioner can choose not only to work with another supervisor but also to stand before a different "gate," avoiding altogether both the supervisor and the standards s/he makes an effort to uphold for proper clinical practice. As illustrated in Chapter II, practitioners who supervise other practitioners watch the "gate" that separates professional from non-professional practice and in doing so, they attempt (by deciding who to let through or not) to hold the standards for ethical practice in the field.

This ability of a supervisee within the private sector to end supervisory practice because of disagreement, for example, over the evaluation of work points to loopholes and inherent weaknesses in the gatekeeping system as it is currently set up in the private social work sector. This presents an issue, which brings back into focus an unanswered and important question raised earlier in the literature review (see Chapter II): If supervision is not mandated in private practice, how does the profession ensure that practice is properly monitored and that ethical practice continues? For that matter, even with the mandated supervision in graduate/training programs and agencies/places of employment, what standards are in place for the way supervision is carried out? What standards help to ensure that supervision itself is conducted properly and effectively? Throughout the interviews, participants in this study were left pointing toward vague and informal supervisory standards in the field, relying instead, they said, predominately on informal support of other colleagues and their own practice experience and wisdom.

There was an expectation amongst many of the participants for past gatekeepers of their current supervisees to have done their gatekeeping job effectively. That is to say, at the point at which a participant supervised a supervisee, there was hope that previous supervision would have picked up an issue and perhaps taken remedial action, preventing at the very least a practitioner from simply carrying on "as is" (as usual) in the field. In short, the hope for respondents was that significant issues would have already been weeded out, perhaps providing justification as well for why they had not yet seen any "gross" (e.g., sexual and substance related misbehavior) and blaring ethical misconduct. However, while practitioners in supervision with sample members may not have presented "gross" misconduct of practice, several were still cited as being potentially harmful in their practice. They might not have set off any alarms for "gross" misconduct (thus, getting through previous gates more easily), but they still engaged in what these respondents indicated were questionable practice methods and violations of professional boundaries.

Two participants in particular spoke specifically to this far-too-easy pass through the gates that monitor professional and ethical conduct in the field and to the possible failure of previous gatekeepers to have done their jobs effectively. One participant conducts her work almost exclusively with MSW graduate students, and the other works predominantly with recent graduates from social work programs. Both of these participants stated that they find the early gatekeeping practices in graduate programs (the ones that the participants seemed to rely on) as far too relaxed. Unless a graduate student shows "gross" misconduct as defined by NASW, they declared, programs seem to have a difficult time preventing students who display incompetence and lack of effectiveness from graduating.

One must ask, then, if gatekeeping practices are not monitored and rather “relaxed” standards seem to remain unaddressed, might not these gatekeeping practices, such as they are, result in the possibility for even greater issues of ethics? This is a particularly important question, considering the large subset of the clinical population that goes on to practice either privately or within a clinical context where supervision is not mandated (decreasing even further the likelihood for the ethics of one’s practice to receive proper monitoring down the line).

Woundedness and **the** ***Wounded Healer Paradigm*****; the** ***Use of Self*** **Concept, and the Clinical Notion of Countertransference**

To help them to understand the purpose and context of this study and to define the concept of the *wounded healer* as utilized for this study, participants were presented with selected research excerpts from the professional literature and studies, which suggest that a high percentage of people are drawn toward helping professions such as social work because of personal life struggle and pain (Barnett, 2007; Lackie, 1982; Marsh, 1988; Vincent, 1996). The issue for practice is, however, according to the literature, that the concept of the *wounded healer* --and thus, *woundedness* -- plays an important role in not only motivation to enter clinical social work but can be significant as well in its ability to help patients to heal and allow for deep understanding of and empathy for someone else’s wounds (Miller & Baldwin, 2008; Wheeler, 2007). The question remains, however, how a practitioner knows that he or she has healed sufficiently from his or her own wounds such that those wounds enhance practice rather than impair it. Thus, the overarching impetus for this research was as follows: How do clinicians who supervise other clinicians know if the wounds of the supervisee have healed enough so that they do not interfere with that practitioner’s ability to maintain ethical practice?

The literature states that a supervising practitioner can begin to uncover answers to these questions by developing an understanding of what brings people to the field in the first place, important, because "if the motivation for choosing this work remains split off in the unconscious there is a very real danger that clients may be used in some way by therapists, rather than helped by them" (Barnett, 2007, p. 259).

In this study, participants were in common agreement that motivation toward the field is not explicitly needed at the outset of the supervisory relationship. In time, however, such motivations do ultimately reveal themselves through the work and countertransference, all but one participant believe, and are, in fact, useful to gain insight into how practitioners use their *self* (including their *woundedness*) as a tool in treatment. For example, one respondent found a particular supervisee's motivations rather narcissistic and thus attempted to help the supervisee to not only recognize and become aware of her needs but also to educate her on how -- when they are left out of her awareness --her needs have the potential to interfere in her work, taking the therapeutic focus off her clients.

Basically, it is clear from the interviews that if and when supervisors understand such motivations for entering into clinical social work, they feel that they have a clearer window of insight into how practitioners carry out their work and what aspects of it might cause difficulty. With that knowledge, they believe, they (supervisors) are better able to help to prevent impaired or unethical practice. Therefore, in line with the current literature as presented in Chapter II, understanding a clinician's personal triggers (reflecting material of a personal nature) can assist supervisors to teach practitioners how to meld the "professional self of what one knows (training, knowledge, technique), with the personal self of who one is (personality traits, belief systems,

and life experience)," moving toward what Dewane (2006) calls the "hallmark of skilled practice" (p. 543).

Analogous to the literature that provided the framework for this study, all participants but one acknowledged that a clinician's *self* and its use in treatment serves as a main therapeutic tool so that the evaluation of that *self* and the teaching of its use in treatment stands as an important aspect of supervision (Ahn & Wampold, 2001; Hayes, 2002; May, 1939/1989). As is the case with motivation, however, supervisors need not know about a practitioner's *woundedness* from the beginning, but such histories inevitably become exposed, it would seem, through evaluation and analysis of the work. In fact, 11 of the 12 believe that when surrounded by awareness and reflexivity, *woundedness* has much to contribute to therapeutic practice. Clearly, however, a clinician's capacity for self-awareness and how his or her *wounds* affect the work is crucial, as the literature indicates (see Chapter II) and when left out of awareness can even take the focus off the client and instead, place it onto the unresolved issues of the clinician himself or herself (Barnett, 2007).

The one participant who does not seem to feel that a history of *woundedness* (or even the discussion of it) belongs at any point in the supervisory relationship still did agree that her role does include ensuring that clinicians practice ethically. However, her approach to this obligation does not involve the exploration to any extent of the supervisee's *woundedness* or personal material of any kind that relates to or becomes triggered by the supervisee's clients. Instead, she spoke a bit about her evaluation process in the following way:

> [H]opefully, I won't know that much about their past, so that their work with their client [what I'm looking at] is just how well and not well they're doing… And I can either help

> them make corrections or keep cheering them on so that … I can just address whatever they're doing.

Her statement seems to deny the fact, however, that supervisees “paint” the clinical picture and the presentation of their work for their supervisors and that their self-image acts as a filter through which all clinical material gets shared. It seems inevitable, therefore, that even as a supervisor evaluates just “how well and not well” a practitioner is doing, the “personal” self is brought into supervision, whether intentional or not. With that must come past experience, for can we really separate experience from the here and now, ultimately?

Interestingly enough, this participant expressed frustration during the interview with 13 of her 14 supervisees, claiming that they all have “high drama” in their personal lives that frequently spills over into their professional work and affects performance. In fact, she spoke at length about the times when personal material was brought into supervision and how she immediately and repeatedly encourages them to take those issues into personal therapy. Most of her supervisees, she stated, are not in therapy, and she feels confounded by how to encourage them to get beyond their own issues and “focus” on their clients, making it clear that supervision is not intended to be therapy for practitioners, a distinction stressed by other participants and that concurs with the literature. Much research and several studies exist that advocates for personal therapy for a host of reasons (Barnett, 2007; Macran, Stiles & Smith, 1999; Norcross et al., 1988; Woods & Hollis, 1999).

When all is said and done, however, the distinct difference between this respondent and the other 11 seems to simply be one of timing -- the point at which a supervisee should bring his or her *woundedness* and countertransference *toward* therapy and thus *away from* supervision. This respondent advocates doing so at the very moment something personal comes up, while the

other 11 suggest it only after it becomes clear that personal material is moving the practitioner into his or her personal pathology and thus, away from direct relevance to the needs of the client.

It is also important to note here that unlike the other 11 participants, this respondent had not had, at least at the time of study, direct exposure to psychodynamic theory or psychoanalytic practice, while her 11 counterparts seem to employ contemporary psychodynamic relational and inter-subjective theories in supervisory practice (Atwood & Storlow, 1993; Mitchell, 1988).

Further, this participant does not seem to ascribe -- as do the other 11 -- to the *use-of-self* concept, which directs a clinician to use all parts of himself or herself to inform and guide treatment (Arnd-Caddigan & Pozzuto, 2007; Dewane, 2006; McTighe, 2010) by acknowledging and using one's feelings (countertransference) toward insight, empathy, and projective identification, all of which can inform and advance the work.

In summation, and accordance with the psychodynamic literature presented in this document's review (see Chapter II), a vast majority (11 of 12) of clinical social workers who supervise other practitioners believe that when it is acknowledged and discussed in supervision, the concepts of *woundedness* and *wounded healer* can play a role in helping practitioners to understand how to use themselves in practice and through that awareness, enhance their ability to help others who are wounded in their own ways.

Implications for Social Work Practice

The findings of this study suggest that ethics need further attention in and by clinical social work and that ethical misconduct and professional impairment in clinical practice extends beyond the commonly accepted scope of "gross" misconduct (e.g., sexual and substance related misbehavior). The findings further suggest that if results from previous studies are in fact accurate and histories of *woundedness* do in fact play a significant role in people's move toward

helping and caring professions like social work, more attention needs to be paid toward this concept given its capacity to harm rather than help practice. However, the findings also seem to confirm what much current psychodynamic theory and thinking already supports, i.e., that *woundedness* can be in fact harnessed and used to the benefit of practice.

In spite of this potential, in this era when there is a perpetual push for evidence-based practice (Bellamy, Bledsoe & Traube, 2006) (due in no small part to the rise of managed care) (Butterfield, Rocha & Butterfield, 2010), psychodynamic theory and its perceived value in clinical practice (perhaps because of its difficulty to measure) continues to be threatened not only in training (resulting in ever fewer practitioners acquainted with such concepts) but results in just a few practitioners who can and do apply it in actual practice. While budgetary constraints are nothing new to social welfare, the managed care seems to have had a great effect on service distribution, threatening in various new ways the ability of social workers to provide the care they see as most fitting the needs of their clients. Not only do such constraints threaten the support of clinicians to their vulnerable and *wounded* clients but clearly affect the nature and degree of support that practitioners who supervise others are able to offer as well.

The need for this study developed from an understanding that supervision is not required for clinicians to practice outside agency settings or beyond initial training for graduate school and licensure and that therefore, many practitioners work without having their practice ethics officially monitored. Unfortunately, the findings from this study reveal that at least in some cases, mandated gatekeeping practices and standards of early professional training are quite lax, presenting the obvious problem of letting people into the field who are, in fact, not prepared for professional practice. Clearly, this poses a potential danger to not just the well-being of the vulnerable people that the field aims to serve, of course, but additionally (although not the

primary concern here) to the unaware clinician, who may be unable to use his or her *woundedness* in the service of good practice. The problem is, as illustrated by some of the expectations identified by these respondents, that later supervision (theirs) may become a bit too relaxed as well, relying on the fact that (assuming that) earlier supervision did, in fact, catch and address the issues (or worse yet, that someone else will catch them in some other venue, such as therapy, or a future supervisor). In the end, then, where does ultimate responsibility lie? If the gatekeepers are lazy, who is "minding" (taking caring of) the profession?

Clearly, there is a greater need in general for not only more rigorous supervisory training but for tighter standards of social work practice as well. The field needs clearer and stronger guidelines to help clinical supervisors to understand how personal vulnerabilities (*woundedness*) can hinder or help practice, and it must give more help to those who supervise so that they can more fully consider the impact of the psychological and emotional well-being of those they supervise. Not only will that benefit people we call clients, whose well-being the field has a responsibility to help ensure and improve, but it will help those who supposedly keep the gates to the profession open or closed offer better support to clinicians who take on the task of helping the most vulnerable in our society.

Recommendations for Future Research

This section discusses the limitations and biases found with this study and makes additional suggestions for future research and investigations around this topic of gatekeeping practice and professional social work ethics. The section is divided into the following subsections: 1) limitations and biases and 2) future studies.

Limitations and Biases of Study

Several limitations exist with the data and interpretations presented for this study. The first, and perhaps most important relates to the sample of participants. While the study sought to include a diverse group of supervisors as participants not only in terms of demographics but also practice settings and theoretical orientations, time limits, budgetary constraints, recruitment methods, and ultimately a small sample size resulted in a relatively homogenous sample demographically and of course, given its nature and size, ungeneralizable.

There was an even split of male-identified participants and female-identified participants, with most of the participants identifying as white or Caucasian (10), and two declining to racially identify. Based on labor force statistics, the Bureau of Labor Statistics from 2015 show that there are approximately 765,000 social workers in the US; 83.8% of who identify as women; 62.5% of who identify as white/non-Hispanic; 22% as African American; 12.5% as Hispanic/Latino and 3% as Asian (Retrieved from http://www.bls.gov/cps/cpsaat11.htm). While there are no statistics specifically for the demographics of clinical social work supervisors, all those who participated in the study were licensed at the time and when compared with the labor statistics just stated, not nearly representative in terms of either race or gender.

Another limitation of this study, again around lack of diversity and generalizability, pertains to supervisory settings and theoretical orientations, also a result of time and budgetary constraints, with both convenience and snowball sampling employed for recruitment. In fact, nine of the 12 participants in the study were practicing supervision, at the time of study, mostly within the private sector, with 11 of the 12 with greatest experience and routine use of psychodynamic orientations clearly not reflecting the vast array of other orientations in the field

or the many influences of setting on practice, on gatekeeping, or on familiarity with the concepts of *woundedness* and *wounded healer*.

At some point during their supervisory careers, most participants had in fact practiced in the public sectors or had supervised in agencies. However, at the time of study only four of them supervised agency employees or MSW interns. Thus, they were the only participants able to offer a peek into the current state of that sector of the field and into mandated supervisory practice. While these four participants brought an important voice to the research, the sample might have been more representative of the overall population had more agency-based supervisors and theoretical perspectives been a part of the sample.

The demographic section of the interview instrument (see Appendix E) includes a question that sought to better understand the theoretical orientation of participants and the variance of their training. While five noted extensive training in one or more practice modalities, 11 of the 12 ultimately addressed the research question from a psychodynamic stance. The one participant who appeared to not predominately ascribe to psychodynamic thinking brought a vastly different perspective on supervisory practice, as noted above, and it is likely that many supervisory perspectives, including those that relate to the concepts of *use of self* and *woundedness*, remain unrepresented by this study. Finally, the literature reviewed for the study is predominately psychodynamic in orientation, as is the concept of the *wounded healer*, which served as a basis for this study. It may well be that those who did not feel well versed in this kind of thinking and/or unfamiliar with the concept or who do not believe in its centrality to social work practice, perhaps, felt unwilling to participate.

The final aspect of this study that requires consideration is reliability of measurement and validity. The interview questions were designed by the researcher and therefore subject to bias

in their formulation and perhaps their analysis as well. Given that the researcher was training at a psychoanalytic institute at the time of study and a student at a graduate social work program with psychodynamic orientation, her personal beliefs, which align with the theoretical orientations espoused by the majority of respondents, probably biased both the manner in which the need for this study was framed and, as noted above, the interpretation of findings.

Future Studies

Hopefully, future studies can have more time and resources, allowing for a larger and more generalizable sample size, which would begin to address some of the limitations of this study as noted above. Additionally, historically speaking, psychodynamic thinking has been conceptualized and conducted mostly by white, affluent males and has been, therefore, more representative of the dominant heteronormative culture and perspective, leaving out many other potential perspectives. Therefore, future studies should give consideration to culture, class, and race as it crosses with and is influenced by (or not) with psychodynamic thinking.

Also, widening the study to include *wounded healers* themselves and their own experience of being *wounded*, both in the field and in the supervisory relationship, could give further insight into how wounded experiences impact the therapeutic process. Such insights could inform standardization of social work supervision toward more effective support for ethical practice. Of course, people who come to social work clinicians for help are and need to remain at the heart of the therapeutic work, but the well-being of the clinician is not incidental to this dynamic. Relatedly, therefore, studies on the potential for stigma surrounding the *woundedness* of a practitioner and creating strategies to reduce its potential for harm will greatly benefit the profession as well.

Concluding Remarks

Its limitations as noted above notwithstanding, this small study helps to expand the professional thinking about the importance of supervision, particularly as it crosses paths with the concept of the *wounded healer*. Because clinical supervisors hold the important position of gatekeeping in the profession, helping to maintain and preserve the conduct of ethical practice, the findings of this study suggest that clinical supervisors and their gatekeeping practices in that role could benefit from an expansion of knowledge around the *wounded healer* concept.

While the experiences, knowledge, expertise, and special abilities of clinicians despite (or because of) their inevitable human *woundedness* can be assets to professional practice, people who supervise that practice can play an important role in helping *wounded healers* pull from their life experiences to help others in meaningful and intentional ways. They need an understanding of and a broad range of skills related to the concept of the *wounded healer* that allows them to venture, even within the supervisory relationship, into the sometimes personal territory of a supervisee's life, one that lets them attend to the psychological and emotional well-being of not just the supervisee's client but to the supervisee as well. As Sue Wheeler (2008) writes, "while the supervisor cannot be the therapist, the personal life of the therapist cannot be ignored"(p. 255). It is widely accepted, at least in social work, that a clinician's life and sense of self affect the treatment relationship, which means that supervising practitioners must recognize and address the healer in his or her totality, wounds and all. Ignoring or not acknowledging that aspect of our humanity risks adding to the harm of the very people who clinicians aim to help and by doing that, breaches the most basic ethical tenet of the profession.

References

Ahn, H., & Wampold, B. E. (2001). Where oh where are the specific ingredients? A meta-analysis of component studies in counseling and psychotherapy. *Journal Of Counseling Psychology*, *48*(3), 251-257.

Arnd-Caddigan, M., & Pozzuto, R (2008). Use of Self in Relational Clinical Social Work. *Clinical Social Work Journal. 36(3), 235-243.*

Aron, L. (1991). The patient's experience of the analysts's subjectivity. *Psychoanalytic Dialogues.* 1(1), 29.

Atwood & , G.E., & Stolorow, R.D. (1993). *Faces in a cloud. Northvale, NJ: Jason Aronson.*

Barnett, M. (2007). What brings you here? An exploration of the unconscious motivations of those who choose to train and work as psychotherapists and counsellors. *Psychodynamic Practice*, *13*(3), 257-274.

Baldwin, M., & Satir, V. (1987). *The use of self in therapy*, New Yor: Haworth Press.

Bellamy, J. L., Bledsoe, S. E., & Traube, D. E. (2006). The Current State of Evidence-Based Practice in Social Work: A Review of the Literature and Qualitative Analysis of Expert Interviews. *Journal of Evidence-Based Social Work*, *3*(1), 23–48. http://doi.org/10.1300/J394v03n01_02

Briere. J. (1992). *Child abuse trauma: Theory and treatment lasting effects.* Newbury Park, CA: Sage.

Butterfield, A.K, Rocha, C. & Butterfield, W.H. (2010). The dynamics of family policy: Analysis and advocacy. Chicago: Lyceum Books.

Bureau of Labor Statistics. (2015). *Household data annual averages* [Data file]. Retrieved from http://www.bls.gov/cps/cpsaat11.htm

Cain, N.R. (2000). Psychotherapists with personal histories of psychiatric hospitalization: Countertransference in wounded healers. *Psychiatric Rehabilitation Journal*, 24, 22-28.

Dewane, C. (2006). Use of self: A primer revisited. *Clinical Social Work Journal*. 34(4), 543-558.

Elson, M. (1986). Self psychology in clinical social work, New York: WW Norton & Co. 1986.

Engel, R.J. & Schutt, R.K. (2013). The practice of research in social work. Thousand Oaks, CA: Sage Publications, Inc.

Freud, S. (1959). Future prospects of psychoanalytic psychotherapy. In J. Strachey (Ed.), *Standard edition of the complete psychological works of Sigmund Freud* (Vol. 20, pp. 87-172). London: Hogarth Press. (Original work published 1910).

Garfield, S. L., & Kurtz, R. (1976). Personal therapy for psychotherapist: Some findings and issues. *Psychotherapy: Theory, research and Practice*, 13, 188-192.

Gelso, C.J., & Hayes, J.A. (2007). *Countertransference and the therapist's inner experience: Perils and possabilities*. Mahwah, NJ: Erlbaum.

Gil, E. (1998). *Treatment of adult survivors of childhood abuse.* Walnut Creek, CA: Launch.

Glaser, B.G and Strauss, A.L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine de Gruyter.

Guggenbuhl-Craig, A. (1999). *Power in the helping professions*. Putnam, CT: Spring Publications.

Guy, J., Stark, M.J., & Polestra, P.L. (1988). Personal therapy for psychotherapists before and after entering professional practice. *Professional Psychology: Research and Practice*, 19, 474-476.

Hayes, J. A. (2002). Playing With Fire: Countertransference and Clinical Epistemology. *Journal Of Contemporary Psychotherapy*, *32*(1), 93.

Hayes, J.A., McKracken, J.M., McClanahan, M.K., Hill, C.E., Harp, J.S., & Carozzoni, P. (1998). Therapist perspectives on countertransference: Qualitative data in search of a theory. *Journal of Counseling Psychology*, 45, 468-482.

Jung, C.G. (1951). *Fundamental Questions of Psychotherpay.* In H. Read, M. Fordham, G. Adler, & W Mcguire (Eds.), *The collected works of C.G. Jung*, vol 16. Princeton: Princeton University Press.

Lackie, B. (1982). *Family correlates of career achievement in social work / by Bruce Lackie*. 1982.

Macaskill, N.D., & Macaskill, A. (1992). Psychotherapists-in-training evaluate their personal therapy: Results of a UK survey. *British Journal of Psychotherapy*, 9, 133-138.

Macran, S., Stiles, W.B., & Smith, J.A. (1999). How does personal therapy affect therapists' practice? *Journal of Counseling Psychology.* 46(4), 419-431.

McLaughlin, J.T. (1981). Transference, psychic reality, and countertransference. Psychoanalytic Quarterly, 50:639-664.

Marsh, S.R. (1988). Antecedents to choice of a helping career: Social work vs. business majors. Smith College Studies in Social Work (Haworth). 58(2), 85. 1988 pg 11

May, R. (1939). *The art of counseling / by Rollo May ; introduction by Harry Bone*. New York : Abingdon Press, c1939.

McHenry, S.S. (1994). When the therapist needs therapy: Characterological countertransference issues and failures in the treatment of the borderline personality disorder. *Psychotherapy: Theory, Research, Practice, Training,* 31(4), 557-570.

McTighe, J. (2011). Teaching the use of self through the process of clinical supervision. *Clinical Social Work Journal,* 39(3), 301-307.

Miller, G. D., & Baldwin Jr., D. C. (1987). Implications of the Wounded-Healer Paradigm for the Use of the Self in Therapy. *Journal Of Psychotherapy & The Family*, *3*(1), 139.

Miller, J., & Koerin, B.B. (2002). Gatekeeping in the Practicum: What Field Instructors Need to Know. *Clinical Supervisor,* 20(2), 1.

Mitchell, S. (1988). *Relational concepts in psychoanalysis: An integration.* Cambridge, MA: Harvard University Press.

National Association of Social Workers. (2008). *Code of Ethics National Association of Social Workers.* Retrieved from https://www.socialworkers.org/pubs/code/code.asp

National Association of Social Workers, W.D. (1994). *Code of Ethics National Association of Social Workers.*

Norcross, J. C., Strausser-Kirtland, D., & Missar, C. D. (1988). The processes and outcomes of psychotherapists' personal treatment experiences. *Psychotherapy: Theory, Research, Practice, Training*, *25*(1), 36-43.

Norcorss, J., Dryden, W., & DeMichele, J.T. (1992). British clinical psychologists and personal therapy III: What's good for the goose? *Clinical Psychology Forum, 29-33.*

Orange, D.M., Atwood, G.E., & Stolorow, R.D. (1997). Working intersubjectively: Contextualism in psychoanalytic practice. Hillsdale, NJ: Analytic Press.

Park, J. (1992). *Shrinks: The Analysts Analyzed*, London: Bloomsbury.

Steinberg, D.M. (2004). *The social work student's research handbook.* New York: The Haworth Press, Inc.

Stolorow, R.D., Atwod, G.E. (1996). The intersubjective perspective. *Psychoanalytic Review*, 83 (2), 181-195.

Sussman, M.B. (1992). *A curious calling: Unconcious motivations for practicing psychotherapy*. NY: Jason Aronson.

Sussman, M.B. (1995). *A perilous calling: The hazards of psychotherapy practice.* New York: Wiley.

Telepak, L. (2010). *Therapists as Wounded Healers: The Impact of Personal Psychological Struggles on Work with Clients.* (Electronic Thesis or Dissertation).

Vincent, J. (1996). Why ever do we do it? Unconscious motivation in choosing social work as a career. *Journal Of Social Work Practice*, *10*(1), 63.

Wheeler, S. (2002). Nature or nurture: are therapists born or trained?. *Psychodynamic Practice*, *8*(4), 427-441.

Wheeler, S. (2007). What shall we do with the wounded healer? The supervisor's dilemma. *Psychodynamic Practice*, *13*(3), 245-256.

Woods, M.E., & Hollis, F. (1990). *Casework, a psychosocial therapy*. New York: McGraw-Hill, [1990].

Wolstein, B. (1983). The pluralism of perspective on countertransference. Contemporary Psychoanalysis, 19:506-521.

Zerubavel, N., & Wright, M. O. (2012). The dilemma of the wounded healer. *Psychotherapy*, *49*(4), 482-491.

APPENDIX A

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (###) ###-#### F (###) ###-####

February 3, 2016

Cristina Bloom

Dear Cristina,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Dominique Steinberg, Research Advisor

APPENDIX B

Recruitment Letter

Dear Colleagues,

I am writing to let you know about a study I am conducting as part of my Masters thesis for the Smith College School for Social Work. It is oriented around professional social work ethics and supervisory gatekeeping practice. Guided by the concept of the *wounded healer*, this study seeks to explore with clinical social work supervisors the continuum of 'woundedness' in supervisees and how, for the sake of ethical practice, they respond to this phenomenon in their role.

I will conduct interviews with licensed clinical social workers who have at least five years of experience in the role of supervisor. I intend to better understand through the shared experiences of supervisors how well prepared or supported they feel to perform and carry out their gatekeeping responsibilities, particularly as it relates to woundedness in their supervisees, and more specifically, how such wounding may interfere with professional ethical practice.

Through my findings I hope to provide further knowledge about how to best support *wounded healers* in the field and additionally, to support the supervisors who aspire to promote more ethical practice in their service of support and teaching as well.

I am looking for participants who meet the following criteria:

(1) be a licensed clinical social worker;

(2) have been performing in the role of a clinical social work supervisor for at least five years;

(3) currently practicing at time of recruitment within the role of clinical social work supervisor.

If you qualify or know of anyone who would be eligible and willing to participate, I would appreciate your passing this information along or asking that person to contact me.

Each interview will last 45-60 minutes and can be in person in the New York City area or over the telephone or through a video chat if distance requires.

I would be happy to discuss the project further and can be reached at [name]@smith.edu or by phone at (###) ###-####.

Thank you so much for your time and help!
Cristina Bloom, MSW Candidate
Smith College School for Social Work
Northampton, Massachusetts

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC)

APPENDIX C

C1: Letter of Informed Consent

2015-2016
Consent to Participate in a Research Study
Smith College School for Social Work ● Northampton, MA
…………………………………………………………………………………….

Dear Research Participant,

My name is Cristina Bloom and I am a graduate student at Smith College School for Social Work. I am conducting a research project oriented around professional social work ethics and supervisory gatekeeping practice. Guided by the concept of the *wounded healer*, this study seeks to examine with clinical social work supervisors the continuum of 'woundedness' in supervisees. I am conducting this research for my MSW thesis, for professional presentation, and for possible future publication.

You have been asked to participate in this study because you are a licensed clinical social worker and a practicing clinical supervisor with at least five years of experience as supervisor. If you agree to participate you will be asked a number of questions in an individual interview that will last from 45 to 60 minutes. You will also be asked for some basic demographic data. Your participation will be completely voluntary, and any identifying information gathered in the data collected will be changed to protect your confidentiality.

My aim with this study is to better understand the experiences of supervisors -- how prepared you feel to perform and carry out your gatekeeping responsibilities, particularly as it relates to dealing with personal wounds in the lives of supervisees and even more specifically, the effects of such wounding on ethical practice.

I will conduct the interview and may take a few notes during the process. With your permission and where possible, I will audio record and video record the interview, transcribing your responses at a later point. In order to conduct the interview, we will either agree on a location in the New York City area that is both private and quiet, as well as convenient to you, or set up a time for a private telephone conversation or video chat if you are willing.

There will be no monetary compensation for participating in this study, but I hope that through your participation you will develop an even deeper understanding of the importance of support for supervisees and enjoy the opportunity to share your ideas about effective gatekeeping responsibilities. Your contributions will provide important information to help educate social

workers and may, as well, have an impact on making sure we maintain strong ethics in social work practice.

Your identity will be protected in a number of ways. Your information will be identified by a pseudonym, and any quotes from your interview that appear in the report will be represented by this pseudonym that has no connection to your actual name. I will be the primary handler of all data collected. Any person assisting in transcription will be required to sign a confidentiality agreement. I will keep the audio record, the transcripts, consent forms and other data separately in a locked and secure environment for three years following the completion of the research, consistent with Federal regulations. After that time, all material will remain locked and secured if still being used or destroyed if no longer needed.

Should this study be presented or published at any time, all identifying information, such as schools attended or agencies worked for, will be disguised and a pseudonym will be used.
This study is completely voluntary. Choosing not to participate will not affect the participant's relationship with the researcher or Smith College. You are free to refuse to answer specific questions and/or to withdraw from this study up until two weeks after our interview. After that time, the interview will be integrated into the written report. If you decide to withdraw, all recordings and data describing you and your experiences will immediately be destroyed.

If you have any questions or would like to withdraw from the study, please contact Cristina Bloom at (###) ### -#### or by e-mail at [name]@smith.edu. Please keep a copy of this consent form for your records. If you have any concerns about your rights or any aspect of the study, you may contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (###) ###-####.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

______________________________ _________________ **Signature of Participant Date**

______________________________ _________________ **Signature of Researcher Date**

Thank you for your participation in this study. Please keep a copy of this consent form for your files. If you should need to contact me for any reason, I can be reached by phone at (###) ### - #### or by e-mail at [name]@smith.edu.

APPENDIX C

C2: Letter of Informed Consent to Audio/Video Record

…………………………………………………………………………
[if using audio or video recording, use next section for signatures:]

1. I agree to be [audio or video] taped for this interview:
Name of Participant (print):
____

Signature of Participant: _________________________________ Date: _____________

Signature of Researcher(s): _______________________________ Date: _____________

2. I agree to be interviewed, but I do not want the interview to be taped:
Name of Participant (print):
____

Signature of Participant: _________________________________ Date: _____________

Signature of Researcher(s): ______________________________

Thank you for your participation in this study. Please keep a copy of this consent form for your files. If you should need to contact me for any reason, I can be reached by phone at (###) ### - #### or by e-mail at [name]@smith.edu.

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC)

APPENDIX D

Non Disclosure Agreement (NDA)

I, ______________________________ transcriptionist, agree to maintain full confidentiality in regards to any and all audiotapes and documentations received from (Cristina Bloom) related to his/her research study on the researcher study titled (*The continuum of woundedness in 'wounded healers:' Positive and negative implications for clinical social work practice as seen through the lens of clinical supervisors*). Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents.
2. To not make copies of any audiotapes or computerized titles of the transcribed interviews texts, unless specifically requested to do so by the researcher, (Cristina Bloom).
3. To store all study-related audiotapes and materials in a safe, secure location as long as they are in my possession.
4. To return all audiotapes and study-related materials to (Cristina Bloom) in a complete and timely manner.
5. To delete all electronic files containing study-related documents from my computer hard drive and any back-up devices.

I am aware that I can be held legally responsible for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes and/or files to which I will have access.

Transcriber's name (printed) ____

Transcriber's signature ____

Date ____

APPENDIX E

Interview Guide

Demographic Questions

1. What is your gender?
2. What is your age?
3. How do you identify racially?
4. How do you identify ethnically?
5. Where did you obtain your MSW degree? What year?
6. How many years have you been performing the role of clinical supervisor?
7. In what kind/s of setting/s have you done most of your supervision?
8. What kind of social work training, if any, do you have beyond the MSW?

Substantive Questions

1. What inspired/motivated you to become a clinical social work supervisor?
2. What responsibilities do you include in your role as a clinical social work supervisor?
3. Do you have support to carry out your supervision responsibilities? If so, from where?
4. How do you describe the supervisory environment you seek to create?
5. Is it important to know about the factors that motivated your supervisees to become clinical social workers? If so, why? If not, why not?
6. Do you address personal material that supervisees reveal to you? If so, how? If not, why not?
7. Do you believe psychological well-being, personal difficulties, or organizational conflicts of your supervisee should be discussed in supervision? If so, why? If not, why not?
8. Do you distinguish between supervisory and therapeutic material in supervision? If so, what do you do if something appears to be personal (therapeutic) rather than professional (supervisory)?
9. Research and other professional literature suggest that many people who are drawn to helping professions like social work go through a journey that involves pain and suffering (Barnett, 2007). If this is the case, do you think a supervisor can know whether a practitioner calls on that experience such that it enhances rather than interferes with his/her clinical work with patients? If so, how so? If not, why not?

10. Would you be able to differentiate between personal distress and professional impairment in a supervisee? If so, how? If not, why not?
11. What would (or do) you do if you believe(d) that the personal 'wounds' of your supervisee are/were inhibiting his or her ability to conduct effective therapy?
12. The NASW Code of Ethics states that supervision has a role in preventing "personal problems, psychosocial distress, substance abuse, or mental health difficulties" from interfering with "professional judgment and performance or jeopardize the best interests of those for whom the social worker has a professional responsibility?" Can you give some examples of how you (attempt to) carry out this role?