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Childhood Trauma History and Vicarious Traumatization In Early Career Mental Health Professionals: The Roles of Supervisory Working Alliance and Shame

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CHILDHOOD TRAUMA HISTORY AND VICARIOUS TRAUMATIZATION IN EARLY CAREER MENTAL HEALTH PROFESSIONALS: THE ROLES OF SUPERVISORY WORKING ALLIANCE AND SHAME

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ABSTRACT

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Vicarious traumatization (VT) in the context of early career mental health professionals (MHPs) with personal trauma histories has been examined in the literature on a limited basis, particularly regarding the role that supervisory working alliance and shame could contribute to the effects of VT. Research questions asked: (a) Among early career MHPs who have a personal childhood trauma history, does shame mediate the relationship between personal childhood trauma history and VT? and (b) Among early career MHPs who have a personal childhood trauma history, does supervisory working alliance moderate the relationship between personal childhood trauma history and VT? These questions were answered using a sample of early career MHPs who were within 10 years of their graduation from a counseling masters or doctoral program. Participants completed the Adverse Childhood Experiences Questionnaire as an initial screening measure assessing for the presence of childhood trauma. Fifty-nine (59) participants completed the Early Trauma Inventory Self Report-Short Form (ETI-SR-SF), the Trauma and Attachment Belief Scale (TABS), the External and Internal Shame Scale (EISS), the Supervisory Working Alliance Inventory-Supervisee Form (SWAI-SF), and the demographics questionnaire. Multiple linear regression was used to analyze the data and both moderation and mediation analyses were conducted using PROCESS Macro. Results showed that early career MHPs who had increased severity of personal childhood trauma were also experiencing increased levels of VT.

Results showed that shame was significant as a mediator between personal childhood trauma and VT. The supervisory working alliance did not appear significant as a moderator between personal childhood trauma and VT. This study aimed to understand the antecedents that impacted the severity and presence of VT symptoms and experiences in early career MHPs.

Keywords: vicarious trauma, shame, childhood trauma history, supervisory working alliance, early career mental health professional

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INTRODUCTION

Mental health professionals help individuals with their physical, emotional, and mental health issues to improve clients' sense of well-being, alleviate feelings of distress, and resolve crises (American Psychological Association [APA], 2022). Researchers have identified potential consequences that mental health professionals may face when working with clients from traumatic backgrounds. One of these consequences is known as vicarious traumatization (VT; S. A. Adams & Riggs, 2008; Brady et al., 1999; Kadambi & Truscott, 2003; Williams et al., 2012). According to McCann and Pearlman (1990), VT refers to the negative changes in a mental health professional's view of themselves, others, and the world resulting from repeated empathic engagement with their clients' trauma-related stories, memories, thoughts, and emotions. Throughout this study, *mental health professionals (MHPs)* was used to denote any worker within a mental health related field (e.g., clinicians, counselors, psychologists, social workers, and therapists).

Across the mental health field as a whole, the rate and severity of VT can exponentially increase when MHPs are working with large caseloads of clients that come from backgrounds with high exposure to trauma or when MHPs have limited experience in working with trauma (Butler et al., 2018; Williams et al., 2012). Early career professionals newly finished with their training working with trauma survivors are potentially more vulnerable to experiencing VT. This could be attributed to performance anxiety and fear, gaps in understanding between theory and practice, lack of experience and supervision, unrealistic expectations about client progress, and

ethical and legal confusion (Can, 2018; Merriman, 2015; Roach & Young, 2007; Skovholt & Trotter-Mathison, 2016; Smith et al., 2008). Some of the impacts associated with VT and early career mental health professionals include a higher report of somatic symptoms and intrusive ideation, disruptions in self-trust (i.e., the belief that one can trust one's own judgment and perceptions), disruptions in self-intimacy (i.e., the belief that one can feel connected to oneself), and disruptions in self-esteem (i.e., the belief that one is valuable; Pearlman & Mac Ian, 1995). As a result, there is a great need to better understand the contributing factors in developing or buffering VT as it has significant impacts on early career mental health professionals.

Definition and Prevalence of Vicarious Traumatization

McCann and Pearlman (1990) defined the term *VT* as the transformation in the internal experience and psychological well-being of a mental health professional that comes about as a result of empathy engagement with a client's trauma material that is presented in the therapy room. Vicarious trauma encompasses the negative impact of trauma work on the professional's psychological functioning and includes changes perhaps in their worldview, identity, values, philosophy of life, and sense of the world as a result of prolonged exposure to clients' experiences of trauma. Changes to cognitive schemas are central to the development of VT as schemas relate to psychological needs, disruptions, and memory (Hernandez-Wolfe et al., 2015; Pearlman & Saakvitne, 1995; Way et al., 2007).

Vicarious trauma is associated with disruptions to one's schema in five possible areas (McCann & Pearlman, 1992). These are safety, trust, esteem, intimacy, and control, each representing a psychological need. Each schema is experienced in relation to oneself, other people, and the world. According to Pearlman and Saakvitne (1995), important signs of disrupted schema include an increased sense of personal vulnerability or capacity to do harm (i.e., safety),

a decreased sense of trust in one's perceptions or judgments or in others (i.e., trust), a devaluing of oneself or others (i.e., esteem), an increased need for control or decreased sense of control over self or others (i.e., control), and a decreased sense of connection with self or others (i.e., intimacy)" (Pearlman & Saakvitne, 1995). Mental health professionals' schema changes included an array of symptoms including loss of energy, difficulty in maintaining interpersonal relationships, cynicism, nightmares, feelings of hopelessness and despair, a disrupted frame of reference (i.e., change in worldview), disrupted psychological functioning, increased emotionality, emotional numbness, and even dissociation and depersonalization (Etherington, 2007; Pearlman & Saakvitne, 1995; Pistorius et al., 2008; Satkunanayagam et al., 2010; Shamai & Ron, 2009; Splevins et al., 2010).

Several studies have been conducted to determine the prevalence of VT among various types of mental health professionals (e.g., therapists, psychologists, social workers, and child welfare workers). The prevalence of VT in mental health professionals has revealed a wide array of professionals reporting symptoms extending from as low as 15% (Aafjes-van Doorn et al., 2020; Michalopoulos & Aparicio, 2012) to 100% reporting symptoms (Barrington & Shakespeare-Finch, 2013). Mathieu (2012) predicted that 40%-85% of helping professionals in mental health and non-related fields (e.g., counselors, child protection workers, child welfare workers, nurses, and law enforcement officers) will develop VT and high rates of traumatic symptoms.

Long-Term Effects of Vicarious Traumatization

Vicarious trauma can result in both intra- and interpersonal difficulties (Butler et al., 2017; Jordan, 2010; McCann & Pearlman, 1990; McCormack & Adams, 2016; Trippany et al., 2004). Impacts include frequent job turnover (Middleton & Potter, 2015), increased alcohol and

other substance use (Palm et al., 2004; Rich, 1997; Way et al., 2004), and decreased intimacy and sexual desire (Branson et al., 2014; Vrklevski & Franklin, 2008). Furthermore, researchers suggest that mental health professionals who experienced higher levels of VT were more likely to possess lower self-efficacy related to their ability to be effective in their professional responsibilities (Sartor, 2016). Due to VT including a negative shift in an MHP's personhood and worldview, it can have major impacts on the therapeutic process including long-term significant negative effects on the MHP's ability to provide effective counseling services (Bell & Robinson, 2013; Goldblatt et al., 2009; McCormack & Adams, 2016; Pack, 2014; Tosone et al., 2012). It can also lead to compromised therapeutic boundaries, misdiagnosis, diminished ability to attend to client needs, loss of energy, and decreased levels of hope and optimism (Baker, 2012; Lonn & Haiyasoso, 2016; Newell & MacNeil, 2010; Sexton, 1999; Trippany et al., 2004; Wilson & Thomas, 2004). On the other hand, additional studies have indicated that VT may also be associated with some positive outcomes within MHPs' such as vicarious resilience (Hernández et al., 2010), vicarious posttraumatic growth (Cosden et al., 2016), and compassion satisfaction (Baugerud et al., 2018; Conrad & Kellar-Guenther, 2006).

Factors Impacting the Development of Vicarious Traumatization

According to the Office for Victims of Crime (2017), any individual working with survivors of trauma and violence is at risk of being negatively impacted by the varied effects of VT. Factors that may lead such MHPs to become more vulnerable to this occupational risk include personal factors such as social isolation; a tendency to avoid one's feelings; a tendency to withdraw, or assign blame to others in stressful situations; having either fearful-avoidant or preoccupied attachment styles; difficulty expressing emotions and feelings; and lack of self-care and employment of coping strategies post-empathetic engagement with traumatic material

(Harrison & Westwood, 2009; Himelstein et al., 2012; Jordan, 2010; Lee, 2017; Marmaras, 2000; Moulden & Firestone, 2007; Way et al., 2007; Williams et al., 2012). Organizational factors found to impact VT include having a lack of preparation, orientation, training, and supervision in their professions; being newer employees with less experience at their jobs; type or content of the traumatic material; percentage of trauma clients on one's caseload; constant and intense exposure to trauma with little or no variation in work tasks; and a lack of an effective and supportive process for discussing traumatic content of the work (Cunningham, 2003; Dunkley & Whelan, 2006; Fama, 2003; Moulden & Firestone, 2007; Voss Horrell et al., 2011; Williams et al., 2012). Among all of the factors that may impact the development of VT, perhaps a more salient one may be the previous traumatic life experiences and exposures had by MHPs (S. A. Adams & Riggs, 2008; Baird & Kracen, 2006; Dunkley & Whelan, 2006; Moosman, 2002; Sansbury et al., 2015; Sartor, 2016). Some long-term and potentially chronic challenges following exposures to trauma include emotional consequences such as sadness, anger, and fear; somatic reactions including numbness, nausea, and tiredness; detachment; and decreased personal and professional functioning (S. A. Adams & Riggs, 2008; Berger & Quiros, 2014; Feiring & Taska, 2005; Howlett & Collins, 2014). For MHPs who have previous trauma histories, these challenges can have devastating consequences that can interfere with not only the well-being of the MHP but could impact an MHP's work with clients. New trauma material exposure such as a client discussing their personal trauma in a therapy session also has the potential to trigger past memories of an MHP's own personal trauma experience (Elwood et al., 2011). There is a glaring need at present for further research to better understand the exact nature of the relationship between an MHP's personal childhood trauma history and VT.

Prevalence of Childhood Trauma History in Mental Health Professionals

The presence of childhood trauma history is not a fringe issue for our collective field. A growing body of research indicates that a significant percentage of helping professionals including, therapists, social workers, psychologists, counselors, judges, coaches, doctors, and nurses, have experienced childhood maltreatment (Jaffe et al., 2003; Michalopoulos & Aparicio, 2012; Nikčević et al., 2007; VanDeusen & Way, 2006). For example, childhood trauma histories have been found in 15-100% of professionals with more extensive and intensive exposure to trauma (S. A. Adams & Riggs, 2008; Makadia et al., 2017; Michalopoulos & Aparicio, 2012; Pearlman & Mac Ian, 1995; VanDeusen & Way, 2006). Shannon et al. (2014) conducted research with graduate students studying social work and discovered that 47% of participants reported significant childhood trauma histories. Furthermore, many MHPs describe entering the field with the hope of helping others to resolve certain issues of personal childhood trauma (Manson, 2019). Given the apparent prevalence of personal childhood trauma histories among MHPs, it is of particular importance to better understand how having such a personal childhood trauma history can contribute to the development of VT, especially given that MHPs are exposed to significant traumatic material by hearing their clients' personal stories (Conchar & Repper, 2014; Michalopoulos & Aparicio, 2012).

Mental Health Professionals' Personal Trauma Histories and Vicarious Traumatization

Research studies regarding MHPs' personal trauma history and the relationship to the development of VT are important simply due to the prevalence of personal trauma histories among MHPs. A risk factor that concerns mental health professionals is their own history of personal trauma and a propensity for VT development. Some studies have found pervasive

connections between MHPs with personal trauma histories and an increased risk for the development of VT (S. A. Adams & Riggs, 2008; Camerlengo, 2002; Dickes, 2001; Pearlman & Mac Ian, 1995; Radey & Figley, 2007; Schauben & Frazier, 1995; Shannon et al., 2014; Trippany et al., 2004; Young & Ahmad, 1999). Williams et al. (2012) tested whether having a history of childhood trauma affects the development of VT among MHPs. Mental health professionals in their study who reported increased experiences of past childhood trauma were more likely to also experience symptoms of VT later on as MHPs. These results, which aligned with constructivist self-development theory (CSDT), indicated that MHPs who reported a history of childhood trauma also reported more cognitive distortions associated with VT (e.g., diminished sense of self-competency and self-worth; Pearlman & Mac Ian, 1995; Way et al., 2007). Shannon et al. (2014) found that graduate students who were at the greatest risk of experiencing adverse reactions to traumatic material were those who had their own histories of trauma. Their sample had an unusually high percentage of graduate students with trauma exposure in their backgrounds (47%) as compared to previous literature indicating that approximately one-third of clinical students report trauma histories (S. A. Adams & Riggs, 2008; Sellers & Hunter, 2005). Consistent with previous research (Elwood et al., 2011), Shannon et al. (2014) found that graduate students who have histories of trauma exposure have unique and sometimes more difficult reactions to hearing or reading about another person's traumatic experiences including re-experiencing symptoms of posttraumatic stress (e.g., heightened fear, nightmares, flashbacks, avoidance behaviors, and hyperarousal).

Supervisory Working Alliance

Clinical supervision in psychology serves as a collaborative relationship between supervisor and supervisee that has both a facilitative and an evaluative component. The goals of

supervision include: (a) enhancing the professional competence and science-informed practice of the supervisee, (b) monitoring the quality of services provided, (c) protecting the public, and (d) providing a gatekeeping function for entry into the counseling profession (APA, 2014). Research has established clinical supervision to be an active process for preventing or lessening the effects of VT for MHPs (Abassary & Goodrich, 2014; Bell et al., 2003; Bohnenstiehl, 2019; Knight, 2013; Lonn & Haiyasoso, 2016; Sommer, 2008). Herman (1992) noted, "Just as no survivor can recover alone, no therapist can work with trauma alone" (p. 141). Mental health professionals need safe environments and support from supervisors to explore the host of feelings and thoughts that can arise in response to trauma work (Etherington, 2009; Schauben & Frazier, 1995; Trippany et al., 2004). McCann and Pearlman (1990) suggested that clinical supervision could affect the relationship between an MHP's childhood trauma history and VT as it aids to help MHPs to normalize their reactions to trauma work, avoid professional isolation, and promote greater self-awareness in their reactions to what is discussed in the therapy room (Sommer, 2008).

One method of measuring the quality of the supervision relationship is through the supervisory working alliance (Bordin, 1983). The supervisory working alliance is a collaborative alliance between supervisor and supervisee consisting of (a) establishing a mutual understanding of goals (e.g., mastery of counseling skills), (b) establishing a mutual understanding of tasks (e.g., observing sessions), and (c) developing a strong emotional bond (e.g., mutual care, respect, and trust). Bernard and Goodyear (2019) proposed that the supervisory working alliance has been demonstrated to be one of the most important variables in supervision due to its high influence on supervision-related outcomes, therapy-related outcomes, and impacts on the supervisee. The supervisory working alliance is positively related to supervision effectiveness,

supervisee development and well-being, the effectiveness of problem-solving, supervision outcomes, supervisee feelings of safety and comfort, and satisfaction with supervision (Ladany et al., 1999). It has also been associated with various supervision outcomes for supervisees such as lower levels of burnout, higher satisfaction with supervision, and higher levels of self-efficacy (Livni et al., 2012; Watkins, 2014). Patton and Kivlighan (1997) first documented the important connection between supervision and supervisee clinical work and reported a significant impact of the supervisory working alliance on the therapeutic alliance. This impact included supervisees taking the knowledge they gained during supervision about building and maintaining relationships and applying it to the relationship with their client. A strong supervisory working alliance provides professional and psychological support to supervisees, with research documenting that as supervisees' perceptions of the quality of the supervisory working alliance increase, their perceptions of work-related distress decrease (Sterner, 2009). Furthermore, associations with the supervisory working alliance also exist with VT among MHPs (Williams et al., 2012), phone counselors (Dunkley & Whelan, 2006; Taylor & Furlonger, 2011), and psychology supervisees (Fama, 2003).

On one hand, strong supervisory working alliances appear to encourage supervisees to discuss and reflect on important issues such as VT that can arise within the counseling relationship with their clients. But on the other hand, weak supervisory alliances have contributed to ethical concerns including supervisees not feeling comfortable or safe enough to discuss professional issues within the supervision relationship (Pakdaman et al., 2015). Fama (2003) was able to determine that the quality of the relationship supervisees had with their clinical supervisors was inversely related to levels of vicarious trauma. Dunkley and Whelan (2006) found that phone counselors who perceived themselves as having a strong supervisory

working alliance with their agency supervisors experienced fewer disruptions in cognitive beliefs, indicating lower levels of VT. Williams et al. (2012) proposed a model with the supervisory working alliance acting as a mediator between MHPs' personal childhood trauma and VT because it helps therapists to avoid professional isolation, promotes self-awareness, and normalizes a therapist's reactions to trauma work. They found that although the supervisory working alliance did not partially mediate the effect of childhood trauma on VT, negative correlations of supervisory working alliance and VT and childhood trauma and supervisory working alliance and VT were statistically significant. In addition, a statistically significant positive correlation between childhood trauma and VT was found indicating a possible relationship between the constructs for which their model did not account.

Regarding the supervisory working alliance including discussion on personal childhood trauma, there needs to be a professional boundary between providing supervision and providing individual therapy to a supervisee (Berger & Quiros, 2014; Levy, 2018; Quiros et al., 2013). Although it is beyond the role of the clinical supervisor to explore and help a supervisee address their personal traumatic experiences, there still may need to be some references to these experiences in supervision when it pertains to the supervisee's work with their clients (Berger & Quiros, 2014). The type of traumatic events that mental health professionals have encountered and how they address them may affect how they approach their work with clients who present with trauma material. For example, a supervisee who shares or resonates with a client's traumatic experience may try to avoid discussing the experience because that client's issues trigger painful memories and reactivate the professional's own trauma reactions (Bicknell-Hentges & Lynch, 2009; Otgaar et al., 2018; Sexton, 1999; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014; Trippany et al., 2004). This strategy may compromise the

mental health professional's ability to help the client. In another example, a mental health professional might also assume that the coping skills that helped them to heal and recover from their prior trauma may be equally appropriate for the client. For each of these examples, the goals within supervision would be (a) to provide requisite emotional safety for the supervisee so that the work that needs to be done with the client will not be compromised, and (b) for a supervisor to continually emphasize self-reflective practice (Berger & Quiros, 2014). Addressing countertransference and transference issues in an emotionally safe manner allows for both personal and professional growth within the supervisor-supervisee relationship (Berger & Quiros, 2014).

Given that there is support in the literature to address some personal childhood trauma history in the supervisory relationship as it pertains to client work and the potential for strong supervisory relationships to help assist countertransference issues that occur as a result of hearing trauma material (Hernandez-Wolfe et al., 2015; Shafranske & Falender, 2008), this study aimed to examine if the supervisory working alliance could serve as a moderator between personal childhood trauma and VT. It was hypothesized that developing a strong supervisory working alliance may help to decrease the strength of the direct relationship between personal childhood trauma and VT among MHPs.

Shame

Shame is seen as a part of self-conscious emotions, which are more elaborate emotional reactions that are closely associated with complex sociocognitive processes such as self-awareness and self-evaluation (Dyer et al., 2017). Gilbert (1998) has suggested that the self-conscious affect of shame should be distinguished into both internal and external shame. External shame is associated with one's belief that others look down on them and see them as

inferior, inadequate, weak, or disgusting in some way. By contrast, internal shame relates to the experiences of oneself as devalued in their own eyes to a degree that is damaging to their self-identity (Lee et al., 2001). The notions of external and internal shame have connections to how an individual understands their trauma experiences. Lee et al. (2001) posits that schematic representations of the self as shameful or others as shaming may be activated via attributional processes in the aftermath of exposure to trauma. Furthermore, shame appears to be linked to the development and maintenance of posttraumatic stress symptoms (PTSS) following exposure to trauma (Badour et al., 2020; Beck et al., 2011; Ginzburg et al., 2009; Leskela et al., 2002; Pineles et al., 2006; Street & Arias, 2001) and has been described as a particularly painful and potentially maladaptive emotion (Badour et al., 2020).

Schema theory (Young et al., 2003) offers a useful framework to understand shame and its connections with the complex and adverse outcomes associated with interpersonal trauma. According to Schema theory, early maladaptive schemas are defined as "a broad, pervasive theme or pattern, comprised of memories, emotions, cognitions, and bodily sensations, regarding oneself and one's relationships with others, developed during childhood or adolescence, elaborated throughout one's lifetime and dysfunctional to a significant degree" (Young et al., 2003, p. 7). Given that shame involves a pervasive pattern of "hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others" (Young et al., 2003, p. 14), it is conceptualized as one of the most powerful and dangerous early maladaptive schemas as the result of traumatic experiences in childhood (Young et al., 2003).

Personal Childhood Trauma, Shame, and Vicarious Trauma

Both schema theory (Young et al., 2003) and constructivist self-development theory (CSDT; McCann & Pearlman, 1992) emphasize the tremendously important role of schemas in

understanding the unique inner experiences of trauma survivors. According to CSDT, individuals develop schemas through their life experiences that aid them to organize information and shift future experiences (McCann & Pearlman, 1992). Schemas originate in one's experiences from early childhood or adolescence and become increasingly stable over time, come to be associated with specific emotions or feeling states, and can determine how one perceives others, the self, and their relations with others.

Pertaining to MHPs in particular, engaging in empathic listening by an MHP to repeated stories of human suffering challenges and activates that MHP's deeply held beliefs, assumptions, and expectations from their own previous experiences (Evces, 2015). These then can manifest as intrusive thoughts and images associated with intensive emotions. For those MHPs with personal childhood trauma histories, pervasive feelings of shame may also be activated as a result. The development of a healthy sense of self begins in early childhood and is reinforced by significant attachment figures. If a child experiences abuse at a young age, this could elicit feelings that they deserved it or that they were somehow to blame for the abuse (Su & Stone, 2020). It is not unusual for survivors of trauma to continue carrying pervasive feelings of shame despite being valued and respected (Su & Stone, 2020). MHPs working with clients who share stories of traumatic material are in danger of having interference and shifts in their feelings, cognitive schemas and worldview, memories, and sense of safety (Hernandez-Wolfe et al., 2015; Pearlman & Saakvitne, 1995). These changes and shifts are central to the development of VT (Hernandez-Wolfe et al., 2015; Pearlman & Saakvitne, 1995; Way et al., 2007).

According to CSDT, shame develops as a result of traumatic experiences in childhood and has the potential to play a role in the development of VT. No known studies have empirically tested this hypothesis. In the following sections, empirical evidence on the relationship between

personal childhood trauma history and shame as well as the relationship between shame and vicarious trauma will be presented as additional support in establishing the rationale to examine shame as a mediator of the relationship between personal childhood trauma history and vicarious trauma for MHPs in the current study.

Personal Childhood Trauma and Shame

Shame connected to trauma elicits aversive emotions and can function as a reminder of trauma memories (Ehlers & Clark, 2000). Research examining shame as a risk factor for psychological difficulties centers on trauma populations. Reasonably, traumatic experiences, particularly those that involve profound threats to self-appraisals and self-concept (e.g., childhood abuse, physical assault, and sexual assault), have been found to evoke acute shame responses (Dorahy & Clearwater, 2012; Dyer et al., 2017; Srinivas et al., 2015). Within studies examining shame in conjunction with exposure to childhood trauma, the embodiment of shame was manifested in feelings of being a failure, being defective, being unworthy, being valueless, lacking a sense of self-esteem and self-efficacy, feelings of inferiority, being unacceptable, feeling insignificant, and feeling unlovable (Beck et al., 2011; Dorahy & Clearwater, 2012; Ross et al., 2019).

Shame is a common and central reaction to sexual childhood abuse (Feiring & Taska, 2005; Finkelhor & Browne, 1985). The emotional experience of shame and its relation to poorer adjustment in adulthood has also been connected to other forms of maltreatment including physical abuse (Milligan & Andrews, 2005), emotional abuse (Stuewig & McCloskey, 2005), and neglect (Bennett et al., 2010). According to Brown (2006), shame is an epidemic and affects the ways people work, look at themselves, and look at each other. This has the potential to have a

profound impact on how MHPs process their own trauma histories as well as working with those who discuss trauma material.

Shame and Vicarious Trauma

Empirical support in the investigation of shame and VT is lacking; however, increasing literature has supported the relationship between shame and posttraumatic stress symptoms (PTSS; Dunmore et al., 2001; Feiring & Taska, 2005; López-Castro et al., 2019; Schumm et al., 2006; Taylor, 2015). The latter of which has been linked to the presence of VT. The crossover of symptoms between PTSS and VT include suspiciousness, hypervigilance or increased anxiety, depression/sadness, somatic symptoms, intrusive thoughts and feelings, avoidance, emotional numbing and flooding, a decrease in empathy, and increased feelings of personal vulnerability (S. A. Adams & Riggs, 2008; Howlett & Collins, 2014; Michalopoulos & Aparicio, 2012; Nelson, 2016; Neumann & Gamble, 1995; Pearlman & Mac Ian, 1995; Steed & Downing, 1998). The newest edition of the *Diagnostic and statistical manual of mental disorders* (DSM-5-TR) even expanded the scope of the diagnostic criteria for posttraumatic stress disorder (PTSD) to include a criterion that is evidenced by the presence of trauma-related shame, guilt, or anger (American Psychiatric Association, 2022a). Shame has been proposed to be a main factor leading to poor adjustment in adulthood (Feiring et al., 1996). Shame is considered to be a persistent emotion linked to the experiences of abuse and may contribute to the maintenance of PTSS (Feiring & Taska, 2005). In a meta-analytic study completed by López-Castro et al. (2019) examining the association between shame and PTSS after trauma exposure, they found a moderate and reliable association between self-reported shame and PTSS. These researchers further suggested that shame is likely linked to PTSS through a variety of biopsychosocial mechanisms. This mechanism highlights that during and after exposures to trauma, negative self-

appraisals fuel persistent negative beliefs and perceptions of the self as defective (Dunmore et al., 2001). When unchecked, shame motivates social withdrawal and avoidance, isolating the trauma survivor from the potentially buffering and reparative force of social connection (Schumm et al., 2006). Taylor (2015) addressed the underlying dynamics of shame and proposed that it might function as a unifying and core component in the exacerbation, maintenance, and delayed presentation of PTSS. They proposed that the identification of the extent of shame's presence can best be accomplished through three domains: (a) intrapersonal shame (i.e., any changes in self-concept), (b) interpersonal shame at the intimate level (i.e., any changes in personal relationships), and (c) interpersonal shame at an occupational and societal level (i.e., issues of loss, isolation, and exclusion).

Given the increasing evidence to support shame's role in PTSS as well as regarding the connections between PTSS and VT, another goal of this study was to explore how shame more directly influences VT among MHPs. Empirical support for the relationships between childhood trauma history and shame and between shame and VT have been provided, leading to a conclusion that the mediation relationship is possible; however, no known study has researched those relationships. The current study attempted to test the mediational role of shame between childhood trauma and vicarious trauma in a sample of early career mental health professionals. It was hoped that the findings of this study would provide a further understanding of the role that shame has in developing and maintaining trauma symptomatology. With this understanding, researchers can better provide mental health professionals and educators with information about how to develop interventions that best support early career mental health professionals with personal trauma histories.

Study Rationale

Increasing evidence suggests that the rate and severity of VT experienced among MHPs can exponentially increase when they not only are working with clients who come from traumatic backgrounds but when they have also been exposed to personal trauma (Butler et al., 2018; Williams et al., 2012). According to the National Council for Behavioral Health (2022), "70% of adults in the U.S. have experienced some type of traumatic event at least once in their lives" (p. 1). Additionally, "in public behavioral health, over 90% of clients have experienced trauma" (p. 1). Due to the rate of traumatic exposures being on the rise across age groups, mental health professionals are increasingly likely to be more exposed to client trauma narratives (Lanier & Carney, 2019; Sommer, 2008; Trippany et al., 2004). When MHPs are continuously exposed to trauma material, they are in danger of occupational hazards including burnout, compassion fatigue, secondary traumatic stress, and VT (Branson, 2019; Butler et al., 2017; Iqbal, 2015; Jordan, 2010; Lawson, 2007; Maslach et al., 2001; Merriman, 2015; Newell & MacNeil, 2010).

VT in particular has been linked to long-term consequences for MHPs who extensively listen to trauma material including cognitive, emotional, mental, neurologic, physical, sexual, and spiritual changes (Aparicio et al., 2013; Branson et al., 2014; Dombo & Gray, 2013; L. C. L. Hayes, 2013; Măirean & Turliuc, 2011; Sansbury et al., 2015; Shepard, 2013; Tyler, 2012). Early career MHPs may be additionally susceptible to developing VT difficulties (Gibson, 2022; Pearlman & Mac Ian, 1995). Another potential risk factor for an MHP developing VT is when they have their own personal childhood trauma history although there is disagreement on its effects within the literature. For example, some studies have found significant correlations between an MHP's personal childhood trauma history and VT (S. A. Adams & Riggs, 2008;

Bride, 2004; Camerlengo, 2002; Dickes, 2001; Gibson, 2022; Pearlman & Mac Ian, 1995; Radey & Figley, 2007; Schauben & Frazier, 1995; Shannon et al., 2014; Trippany et al., 2004; Young & Ahmad, 1999), while others have not (R. E. Adams et al., 2008; Dunkley & Whelan, 2006; Schauben & Frazier, 1995). Additionally, there is much less clarity in the literature on the exact nature of these relationships and how these factors may interact. Some studies present competing models with different relationships between personal childhood trauma history and VT including additional variables of personal traits, workplace supports, environmental factors, personal care, and density of trauma exposure (S. A. Adams & Riggs, 2008; Benatar, 2000; Gibson, 2022; Gonzalez et al., 2019; Lerias & Byrne, 2003; Newell & MacNeil, 2010; Sansbury et al., 2015; Williams et al., 2012). Few studies have directly examined the relationship between an MHP's personal childhood trauma history and VT. One study explored a moderation model (S. A. Adams & Riggs, 2008), and the others a mediation model (Benatar, 2000; Lerias & Byrne, 2003; Williams et al., 2012). There was an evident need for further research to better understand the exact nature of the relationship between an MHP's personal childhood trauma history and VT.

To better understand the relationship between an MHP's personal childhood trauma history and VT, the two variables of interest explored in this study included shame and supervisory working alliance. This study utilized a mediation model looking specifically at shame in relation to an MHP's personal childhood trauma history and VT. No known empirical studies have explored this connection. Researchers have made connections between childhood trauma and shame (Beck et al., 2011; Dorahy & Clearwater, 2012; Ross et al., 2019) in addition to shame and posttraumatic stress (Dunmore et al., 2001; Feiring & Taska, 2005; López-Castro et al., 2019; Schumm et al., 2006; Taylor, 2015). Further research was needed to examine the relationship between an MHP's personal childhood trauma history, shame, and VT so that

mental health professionals could better understand how their personal childhood trauma histories were still impacting them today both inside and outside of the therapy room.

This study utilized a moderation model looking specifically at the supervisory working alliance between supervisee and supervisor in relation to an MHP's personal childhood trauma history and VT. Although supervision is not therapy, there could be some reparative effects for supervisees gained from supervision including adaptive emotion regulation skill development, improving coping skills in response to trauma reactions, recognizing strength and resilience, fostering understanding of posttraumatic growth, assisting in the development of self-care strategies, and developing empathy skills in the context of maintaining personal and professional boundaries (DelTosta et al., 2019). Further research is needed to examine the relationship between an MHP's personal childhood trauma history, supervisory working alliance, and VT so that MHPs may better be able to respond to their own trauma reactions, learn how to manage clients who discuss trauma, and learn strategies to buffer symptoms of VT.

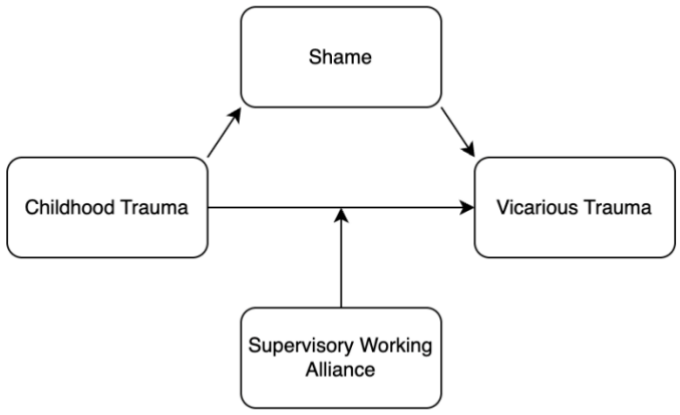
Statement of Purpose

The purpose of this study was to explore the relationships between an MHP's personal childhood trauma history, shame, supervisory working alliance, and VT among a sample of early career MHPs. Specifically, the researcher explored how the supervisory working alliance moderated the impact that an MHP's personal childhood trauma history had on VT. Additionally, the researcher explored how shame mediated the influence that an MHP's personal childhood trauma history had on VT. A visual representation of this model is presented in Figure 1. In doing so, this study aimed to add to the literature on VT, MHPs' personal childhood trauma histories, shame, and supervisory working alliance to discover implications for early career MHPs, supervisors, educators, and therapeutic outcomes.

One of the anticipated benefits of this study was to help early career MHPs gain a better understanding of how VT develops and how to approach having caseloads with clients who discuss trauma. Additionally, the researcher hoped to increase awareness of the prevalence of MHPs who have their own personal childhood trauma histories and how these histories may have ongoing impacts on an MHP's professional and personal life. It was hoped that this study would encourage MHPs to utilize supervision as a safe space to process trauma reactions as it pertains to clinical work, to learn skills in coping with ongoing exposures to trauma material, and to apply what is gained in supervision in their work with clients to improve the therapeutic relationship and client outcomes. By improving the experiences of early career MHPs, it was hoped that this would reduce levels of distress in MHPs, increase satisfaction in the workplace, reduce the number of MHPs who leave the field, and improve the care that clients receive. An additional benefit was implications for graduate training programs to better prepare their students as they enter into the professional field, help supervisors improve supervision methods and better support supervisees, and to bring earlier awareness to VT for improved early intervention.

Figure 1

Predicted Relationships Between Childhood Trauma History and Vicarious Trauma, with Shame as a Mediator and the Supervisory Working Alliance as a Moderator.



Research Questions and Hypotheses

Q1 Among MHPs who have a personal childhood trauma history, does shame help to explain the relationship between personal childhood trauma history and VT?

H1 For those MHPs who have a personal childhood trauma history, shame (as measured by the EISS) will significantly mediate the relationship between personal childhood trauma history (as measured by the ETI-SR-SF) and vicarious traumatization (as measured by the TABS).

Q2 Among those MHPs who have a personal childhood trauma history, how does the supervisory working alliance impact the relationship between personal childhood trauma history and VT?

H2 For those MHPs who have a personal trauma history, supervisory working alliance (as measured by the SWAI) will significantly moderate the relationship between personal childhood trauma history (as measured by the ETI-SR-SF) and vicarious traumatization (as measured by the TABS). It is hypothesized that as supervisory working alliance increases, the impacts of childhood trauma on vicarious traumatization will decrease.

Limitations

This study had several potential limitations. A limitation of this study and any current study of VT is the lack of consensus in the field on the definition of VT and the differentiation in symptoms of neighboring constructs (e.g., STS, compassion fatigue, and burnout). The generalization of the results of the current study may be limited by some important factors. First, the sample included a convenience sample of early career MHPs that may not be diverse regarding the inclusion of racial/ethnic minorities, urbanicity and access to support resources, demographics of the client population served, type of agency worked for, and the novice of MHPs so generalizing the findings to populations outside of this type of sample would need to be done cautiously. Second, the sample may include MHPs who may have not had sufficient exposure to working with clients with trauma, therefore impacting their potential severity of VT, and limiting the number of participants with professional activities relevant to this analysis. Third, all data were collected through the administration of self-report measures via Qualtrics,

which increased the potential for inaccurate and/or biased information to be obtained. In an effort to account for the effect of social desirability regarding participants reporting their trauma, shame, and relationship with supervisors, no identifying information was collected. Lastly, another limitation of collecting data through Qualtrics was that participants might not completely answer the survey items or might stop filling out the survey before completing it in its entirety. In an effort to address this, as discussed subsequently, the current study incorporated the shortest measures available with solid psychometrics that accurately measured this study's variables.

Definitions of Terms

Childhood Trauma. According to Peterson (2018), children (aged 0 to 18) who suffer from childhood traumatic stress are those who have been exposed to one or more traumas throughout their lives and develop reactions that persist and affect their daily lives after the events have ended. Traumatic reactions can include a variety of responses, such as intense and ongoing emotional upset, depressive symptoms or anxiety, behavioral changes, difficulties with self-regulation, problems relating to others or forming attachments, regression or loss of previously acquired skills, attention and academic difficulties, nightmares, difficulty sleeping and eating, and physical symptoms, such as aches and pains. Older children may use drugs or alcohol, engage in unhealthy sexual activity, or behave in other risky ways. A traumatic event is a frightening, dangerous, or violent event that poses a threat to a child's life or bodily integrity. Witnessing a traumatic event that threatens the life or physical security of a loved one can also be traumatic. This danger can come from outside of the family (such as a natural disaster, car accident, school shooting, or community violence) or from within the family, such as domestic violence, physical or sexual abuse, or the unexpected death of a loved one.

Early Career Mental Health Professionals. "Counseling Psychology Professionals who completed their final degree (master's degree or doctorate) within the last 10 years" (Society of Counseling Psychology, 2022, p. 1).

Early Maladaptive Schemas (EMS). "A broad, pervasive theme or pattern, comprised of memories, emotions, cognitions, and bodily sensations, regarding oneself and one's relationships with others, developed during childhood or adolescence, elaborated throughout one's lifetime and dysfunctional to a significant degree" (Young et al., 2003, p. 7).

Shame. The intensely painful feeling or experience of believing that we are flawed and therefore unworthy of love and belonging--something we've experienced, done, or failed to do that makes us unworthy of connection (Brown, 2006).

Supervisory Working Alliance. The supervisory working alliance is the interpersonal process between both supervisor and supervisee (Bordin, 1983). According to Bordin, this relational bond develops between supervisor and supervisee when they work together to achieve mutual goals through clearly identified tasks. The supervisory working alliance is the predominant means by which the supervisee becomes engaged in supervision and the goals of supervision are accomplished (Holloway, 1997).

Vicarious Traumatization (VT). The transformation in the internal experience and psychological well-being of a mental health professional that comes about as a result of empathy engagement with a client's trauma material presented in the therapy room. It encompasses the negative impact of trauma work on the therapist's psychological functioning and describes changes in worldview, identity, values, philosophy of life, and

sense of the world as a result of prolonged exposure to clients' experiences of trauma (McCann & Pearlman, 1990).

Summary

Vicarious trauma in the context of early career MHPs with personal trauma histories has been examined in the literature on a limited basis, particularly regarding the role that supervisory working alliance and shame could contribute in its effects. It remains unclear if mental health professionals with personal trauma backgrounds experience more symptoms of VT compared to mental health professionals without personal trauma histories. The current study aids in developing a better understanding of childhood trauma and the potential effects it has on shame and the experiences of VT among MHPs. The current study also aids in examining the effects that the supervisory working alliance has on the relationship between childhood trauma and VT. By examining the interrelationships of childhood trauma, shame, the supervisory working alliance, and VT, this study aims to better understand the antecedents that impact the severity and presence of VT symptoms and experiences in early career mental health professionals.

CHAPTER II

REVIEW OF LITERATURE

Introduction

Trauma is a significant and ever-growing public health concern due to its steady and severe impact (Paige et al., 2017). Approximately 80% of clients seen by mental health professionals have experienced at least one incident of trauma during their lifetime (Jones & Cureton, 2014). Some of the most frequently reported traumatic events in clinical practice include physical or sexual assault in both childhood and adulthood, natural disasters, domestic violence, and school and work-related violence (James & Gilliland, 2013; Paige et al., 2017). Given the prevalence of traumatic events, it is likely that mental health professionals will encounter clients who have experienced trauma (Layne et al., 2014; Paige et al., 2017; Sommer, 2008; Webber et al., 2017). Given the rise of trauma's presence not only in society but also in the therapy room, VT is a real potential consequence that can occur due to repeated empathic engagement with a client's trauma-related stories, memories, thoughts, and emotions.

This chapter reviews the empirical and theoretical foundations for the current study's major concepts including vicarious trauma (VT), mental health professional personal childhood trauma history, shame, and supervisory working alliance (SWA). Trauma prevalence will be reviewed first. Secondly, VT will be discussed with a brief discussion on often confused variables followed by shame and mental health professional personal childhood trauma history. Then, the literature on SWA will be explored. The following review of literature will be closed with a summary, including rationale and potential implications for the current study.

Trauma Prevalence in the United States

Currently, there are numerous research publications on the ways adverse childhood experiences and childhood maltreatment impact individuals across their lifespans. These impacts are related to mental and physical health, victimization/perpetration, risky behaviors, and occurrences in special populations. Adverse childhood experiences include, but are not limited to exposure to childhood maltreatment, divorce, incarcerated family members, substance abuse, mental illness, domestic violence, and bullying. Childhood maltreatment can be defined as any type of abuse and neglect (e.g., physical, sexual, and emotional) to a child under the age of 18 years old by a parent or other individual in a custodial role (Centers for Disease Control and Prevention (CDC, 2022a). Child Protective Services (CPS) reports of child maltreatment may underestimate the true occurrence of individuals who experience some form of abuse before the age of 18 due to underreporting because of fear, shame, embarrassment, and other negative consequences (CDC, 2022a; Schreiber et al., 2013). A non-CPS study estimates that one in four U.S. children experience some form of child maltreatment in their lifetimes (Finkelhor et al., 2013).

According to the most recent National Crime Victimization Survey (NCVS) conducted in 2018, in three years from 2015-2018, the portion of U.S. residents aged 12 or older who self-reported that they were victims of violent crime rose from 0.98% to 1.18% (up 20%; Morgan & Oudekerk, 2019). The NCVS also notes that the total number of reported violent victimizations rose from 5.0 million in 2015 to 6.4 million in 2018, while the reported rate of violent victimization rose from 18.6 to 23.2 victimizations per 1,000 persons aged 12 or older (Morgan & Oudekerk, 2019). In addition to crime victimization, the National Child Abuse and Neglect Data System (NCANDS) is a federally sponsored effort that collects and analyzes annual data on

child abuse and neglect. In 2017, child abuse reports involved 7.1 million children in addition to 3.9 million child maltreatment referral reports being received (U.S. Department of Health & Human Services, 2022).

The Substance Abuse and Mental Health Services Administration (SAMHSA) in conjunction with the Health Resources and Services Administration (HRSA) reports that "in the United States, 61% of men and 51% of women report exposure to at least one lifetime traumatic event" and "90% of clients in public behavioral health care settings have experienced trauma" (National Council for Behavioral Health, 2022, p. 1; Substance Abuse and Mental Health Services Administration, 2014, p. 8). With the incidence of trauma in the United States continuing to be on the rise, mental health professionals inevitably are being exposed to more distressing stories of abuse, trauma, and disempowerment. Most therapists will therefore work with trauma survivors at some point (Bride, 2004; Trippany et al., 2004).

Vicarious Trauma

Vicarious trauma is a specific term used to describe the unique, negative, and accumulative changes that can occur to mental health professionals who engage in an empathetic relationship with trauma survivors (McCann & Pearlman, 1990). Furthermore, McCann and Pearlman (1990) discuss the lasting alterations in their cognitive schemas, having a significant impact on the mental health professional's feelings, relationships, and life. Authors posit that VT can become destructive not only to the mental health professional but also to the therapeutic process (Branson, 2019; Iqbal, 2015; Jordan, 2010). Some of the specific changes that can occur in a mental health professional as a result of VT include cognitive changes (Aparicio et al., 2013), emotional changes (Sansbury et al., 2015), mental changes (Măirean & Turliuc, 2011),

neurological changes (Shepard, 2013; Tyler, 2012), physical changes (L. C. L. Hayes, 2013), sexual changes (Branson et al., 2014), and spiritual changes (Dombo & Gray, 2013).

Neighboring Constructs of Vicarious Traumatization (VT)

There is increasing evidence that distinct differences and distinct outcomes exist between VT and burnout, compassion fatigue, countertransference, posttraumatic stress, and secondary traumatic stress (Branson, 2019). The rate and severity of these consequences can exponentially increase when individuals are working with clients who come from traumatic backgrounds and experiences. Vicarious trauma is more complicated than some of its counterparts (i.e., secondary traumatic stress and compassion fatigue) in that vicarious trauma focuses on the theory of what is occurring within the context of trauma counseling (Tosone et al., 2012). Mental health professionals who continue to work with trauma clients are at increased risk for experiencing the effects of vicarious trauma as a result of the constant, taxing emotional engagement and continuous exposure to clients' trauma material, experiences, and stories.

Burnout

Maslach et al. (2001) present burnout as prolonged exposure to long-term emotional and interpersonal stressors on the job. These researchers separate burnout into three key dimensions: overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment. The risk of burnout is increased significantly for helping professionals with large caseloads, limited professional support/supervision, lower levels of experience, and challenging client/patient populations (Butler et al., 2017; Maslach et al., 2001; Newell & MacNeil, 2010). Other consequences of burnout include negative impacts on physical health and health risk behaviors (Butler et al., 2017; McEwen, 2012).

Compassion Fatigue

The term *compassion fatigue* is often connected to secondary traumatic stress and is viewed as the individual's response to interacting specifically with trauma clients due to the conditions and experiences associated with providing care (Bride et al., 2007). In a recent study conducted by Hansen et al. (2018), the researchers define compassion fatigue as the negative cognitive and emotional consequences for those who utilize empathy in various healthcare professions. Consequences of compassion fatigue include but are not limited to the empathizer feeling sad, inadequate, and exhausted. Merriman (2015) stated that ongoing compassion fatigue negatively impacts counselors' health as well as their relationships with others including clients, a lack of empathy toward clients, a decrease in motivation, and a performance drop in effectiveness. When compassion fatigue occurs, counselors can project their anger on others, develop trust issues, and experience feelings of loneliness (Harr, 2013). Therefore, the demands of the counseling profession can affect many counselors' wellness and could hurt the quality of client care provided (Lawson, 2007; Merriman, 2015). Further, counselors experiencing compassion fatigue might have difficulties making effective clinical decisions and potentially be at risk for harming clients (Eastwood & Ecklund, 2008). Consequently, scholars appear to agree that compassion fatigue is an occupational hazard that mental health care professionals need to address (Figley, 2002; Merriman, 2015).

Countertransference

Three conceptions of countertransference have emerged as the most prominent over the years: the classical (e.g., countertransference is the therapist's unconscious reaction to a client's transference), totalistic (e.g., countertransference refers to all of the therapist's reactions to a client), and complementary (e.g., a client exhibits certain pulls on the therapist; J. A. Hayes et al.,

2018). Hayes et al. (2011) conceptualize countertransference as a reaction to all clinically relevant material, including a client's transference, personality style, the actual content that a client is presenting, and a client's appearance. As an internal emotional state, countertransference may be reflected in therapist anxiety, anger, boredom, despair, arousal, and disgust. Differences between countertransference and VT are not always distinct although both have some differentiations in their conceptualizations (Trippany et al., 2004). Some of the differences include countertransference referring to a therapist's emotional reaction to a client as a result of that therapist's past life experiences whereas VT is not a reaction as a result of past life experiences (Trippany et al., 2004). Another difference is that countertransference is specific to a therapist's experiences during or around therapy sessions, whereas the effects of VT extend beyond the therapy session and can affect multiple areas of a therapist's life (Trippany et al., 2004).

Posttraumatic Stress Disorder (PTSD)

Posttraumatic Stress Disorder (PTSD) is a *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev., American Psychiatric Association, 2022a) diagnosis involving characteristic symptoms resulting from exposure to threat via first-hand victimization, being a witness to threat, or indirect exposure to trauma through a loved one's trauma. PTSD and VT have a great deal of overlap with a major exception being that VT does not meet the requirements of precipitating events. Mental health professionals are neither experiencing first-hand victimization nor witnessing a trauma unfold in real time. Additionally, mental health professionals are not bearing witness to the traumatic details of trauma from loved ones as their discipline-specific professional boundaries and ethics dictate that loved ones are to be referred to other mental health professionals for services (Iqbal, 2015).

Secondary Traumatic Stress

Secondary traumatic stress can impact any individual including mental health professionals. It can, and sometimes does, affect those who merely have close contact with a trauma survivor and a desire to help (Bride, 2007). Canfield (2005) presents secondary traumatic stress as the direct result of listening to emotionally taxing material presented by clients with traumatic backgrounds. It has been argued that secondary traumatic stress is a normal reaction to traumatic material -- if symptoms subside in less than a month (O'Halloran & Linton, 2000). One of the primary differences between secondary traumatic stress and posttraumatic stress is that the stress is endured from listening to traumatic material rather than physically experiencing it. Symptoms of secondary traumatic stress often mirror those of post-traumatic stress disorder as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev., American Psychiatric Association, 2022a). The effects of secondary traumatic stress can occur suddenly after hearing only one isolated account of the trauma experience and is not a cumulative response to professional stress (Bell et al., 2003; Tosone et al., 2012).

Theories of Vicarious Traumatization (VT)

McCann and Pearlman can be credited with the creation of the constructivist self-development theory (CSDT). This theory blends object relations, self-psychology, and social cognition theories. Constructivist self-development theory was also founded upon a constructivist view of trauma and how individuals use their personal histories to shape and adapt to their exposures to trauma. This theory originated to provide a conceptual framework for assessing and treating traumatized college students (McCann & Pearlman, 1992). Other researchers have utilized CSDT to gain a better understanding of the unique inner experiences of trauma survivors that accounts for individual differences, their responses, and their recovery

from trauma (Branson et al., 2014; Havlin, 2015; Izzo & Miller, 2010; Michalopoulos & Aparicio, 2012; Middleton & Potter, 2015; Moeller, 2011; Pack, 2014; Pearlman, 2003; Turliuc et al., 2015).

Constructivist self-development theory (CSDT) holds that individuals actively create and construe their realities and representational models of the world to assign meaning to new experiences (McCann & Pearlman, 1992). Trauma such as assault, crime, and combat are not events where individuals carry predetermined and predictable responses to the trauma, and these events can only be understood through the survivor's meaning system. Major constructs within CSDT include the concepts of schemas. McCann and Pearlman describe schemas as the beliefs, expectations, and assumptions about oneself, other people, and the world. Individuals develop these schemas through their life experiences, which aid them to organize information and shift future experiences. Over time, schemas can come to be associated with specific emotions or feeling states. Another concept within CSDT is the principle of self-capacities: "the ability to tolerate strong affect and regulate self-esteem; cognitive schemas, or beliefs and expectations about self and others in the areas of frame of reference (or identity and world view), safety, trust, esteem, intimacy, power, and independence; and intrusive trauma memories and related distressing affect" (McCann & Pearlman, 1992).

Pearlman and Saakvitne (1995) utilized the CSDT framework to describe how counselors working with clients with traumatic histories shift their worldviews, internal belief systems, and perceptions based upon their frames of reference in conjunction with client stories of trauma. Branson and fellow researchers utilized the CSDT framework to better understand how behavioral health clinicians develop vicarious trauma through their exposure to client disclosures of trauma as well as the development of negative effects in other areas of a clinician's persona,

such as cognitions concerning sexuality. These researchers also reported findings that reinforced the underpinnings of CSDT because of the reported symptoms of intrusive imagery and the negative changes to cognitive schemas, psychological needs, frame of reference, and creating damaging influences on memory encoding (Branson et al., 2014). In a study conducted by Moeller (2011), this research examined the long-term effects of multiple acts of childhood maltreatment and poly-victimization through the framework of CSDT. This researcher found a significant relationship between impairment in self-capacities and a history of poly-victimization as compared to their non-poly-victim counterparts, which provided preliminary support for CSDT as a possible explanation for the development of psychological distress in individuals with a history of poly-victimization. The effects of exposures to trauma, whether it be singular events or multiple exposures across the lifetime, can have a profound impact on an individual's inter- and intra-personal functioning.

Empirical Studies of Vicarioius Traumatization (VT)

Similar to symptoms of personal trauma, symptoms of VT are diverse and can impact a mental health professional's work life and personal life. VT symptomology breaks down into four categories including intrusive imagery, arousal, avoidance behaviors, and negative changes to cognitions (Aparicio et al., 2013; Mishori et al., 2014). A partial list of symptoms includes intrusive thoughts, nightmares and sleep disturbances, increased absenteeism from work, frequent job turnover and removing oneself from the mental health field, social isolation and avoidance, avoidance of client traumatic disclosures, hyperarousal to personal safety and safety of loved ones, avoidance of physical intimacy, increasing cynicism and pessimistic views of the world, distance from spiritual beliefs, and stress-induced medical conditions (Aparicio et al., 2013; Baird & Jenkins, 2003; Barrington & Shakespeare-Finch, 2013; Branson et al., 2014;

Bride, 2007; Butler et al., 2017; Cohen & Collens, 2013; Ilesanmi & Eboiyehi, 2012; Măirean & Turliuc, 2011; McCann & Pearlman, 1990; Michalopoulos & Aparicio, 2012; Mishori et al., 2014; Osofsky et al., 2008; Possick et al., 2015; Pryce et al., 2007; Sansbury et al., 2015; Wies & Coy, 2013).

In a recent study of mental health professionals working during the COVID-19 pandemic, researchers found that nearly a quarter of their sample reported experiencing moderate to high levels of VT (Aafjes-van Doorn et al., 2020). Additionally, younger therapists as well as those with less clinical experience reported higher levels of VT ($p < .05$). Mental health professionals who reported higher levels of VT felt more tired, less confident, less competent, less emotionally connected to clients, and reported a weaker therapeutic relationship (Aafjes-van Doorn et al., 2020). Researchers suggest future research to explore individual differences associated with susceptibility to the development of VT (Aafjes-van Doorn et al., 2020; Barros et al., 2020; Foreman et al., 2020; Long, 2020).

Measures of Vicarious Traumatization (VT)

Secondary Traumatic Stress Scale (STSS)

The STSS **(**Bride et al., 2004**)** is a self-report inventory designed to assess the frequency of STS symptoms in professional caregivers. Respondents rate using a 5-point Likert scale (1 = *never* to 5 = *very often*) how often they experience each of the 17 STS symptoms during the last week. The wording of the instruction refers explicitly to client exposure as the traumatic stressor. The STSS is organized into three subscales: intrusion, avoidance, and arousal. The subscales were derived to maintain congruence with the *Diagnostic and statistical manual of mental disorders* (DSM-IV) separate criteria for PTSD (Bride et al., 2004). The STSS total score

is calculated by summing up the item scores, with a higher score indicating a higher frequency of symptoms. A total score below 28 corresponds to "little or no STS," a score between 28 and 37 means "mild STS," between 38 and 43 "moderate STS," between 44 and 48 "high STS," and beyond 49 "severe STS" (Bride et al., 2007, p. 68). Psychometric data for the original STSS indicated very good internal consistency reliability with coefficient alpha levels of .93 for the total STSS scale, .80 for the Intrusion subscale, .87 for the Avoidance subscale, and .83 for the Arousal subscale (Bride et al., 2004). The original study demonstrated evidence for convergent and discriminant validity (Bride et al., 2004). In another study, internal consistency reliability for the total STSS was high with an alpha of .94 and was moderately high for the Intrusion subscale ($\alpha = .79$), the Avoidance subscale ($\alpha = .85$), and the Arousal subscale ($\alpha = .87$; Ting et al., 2005).

Traumatic Stress Institute Belief Scale-Revision L (TSI-BSL)

The TSI-BSL (Traumatic Stress Institute, 1994) is an 80-item questionnaire measuring levels of disruption among five separate domains of safety, trust, control, esteem, and intimacy (Jenkins & Baird, 2002). Constructed to tap cognitive schema, the scale emphasizes "inner experiences" (Pearlman & Mac Ian, 1995) rather than a full range of potential effects of traumatic stress. Pearlman reported overall internal consistency reliability (Cronbach's alpha) of .98 (Pearlman, 1996), with subscale reliabilities ranging from .77 (other-control) to .91 (self-esteem). Schauben and Frazier's study (1995) reported internal consistency reliabilities of five selected subscales ranging from .68 to .84 in a sample of psychologists and counselors working with sexual violence survivors (Schauben & Frazier, 1995). Jenkins and Baird's study (2002) internal consistency was high with a Cronbach's alpha of .95 for the total score; subscale alphas varied from .62 to .83. Furthermore, results showed evidence of good concurrent validity for the Compassion Fatigue Self-Test (CFST; Figley, 1995) and the TSI-BSL as well as appropriate

associations with general psychological distress for the CFST, TSI-BSL, and the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981).

Trauma and Attachment Belief Scale (TABS)

The TABS (Pearlman, 2003) is an 84-item self-report questionnaire that measures an individual's beliefs about self and others related to the five psychological needs (safety, intimacy, trust, control, and esteem) that are commonly altered by exposure to trauma (Pearlman, 2003). Participants answer items on a 6-point Likert-type scale ranging from 1 (*disagree strongly*) to 6 (*agree strongly*). The TABS consists of 10 subscales. Subscales represent disruptions in beliefs about self and others related to the five psychological needs, including self-safety ("I believe I am safe"); other-safety ("I can't stop worrying about others' safety"); self-trust ("I don't trust my instincts"); other-trust ("trusting people is not smart"); self-esteem ('Tm not worth much"); other-esteem (I often think the worst of others"); self-intimacy ("I feel hollow inside when I am alone"); other-intimacy ("I don't feel much love from anyone"); self-control ("I feel like I can't control myself); and other-control ("I often feel people are trying to control me"). Higher subscale and total scores indicate a greater disruption in beliefs about safety, trust, esteem, intimacy, and control and are therefore associated with high levels of VT. The measure has been normed with adults aged 17 and older (Pearlman, 2003). Regarding reliability, a Cronbach alpha of .79 was found for the subscales. The TABS total scale revealed a Cronbach alpha of .96. The TABS demonstrated test-retest reliability of .75 with subscales test-retest liability ranging from .60 to .79. Construct validity of the TABS was supported through measurement of concurrent validity between the TABS and the Trauma Symptom Inventory (TSI), in which all TABS subscales were significantly correlated with TSI trauma symptom scales. Strong correlations were specifically found between the TABS self-oriented subscales

and the TSI Impaired Self-Reference scale, with correlations ranging from .57 to .72 (Pearlman, 2003).

Vicarious Trauma Scale (VTS)

The VTS (Vrklevski & Franklin, 2008) is a brief measure consisting of eight items each assessed on a 7-point Likert scale (1 = *strongly disagree* to 7 = *strongly agree*). The VTS was designed to assess distress resulting from such exposure and has the potential as a screening tool for VT in practice and educational settings. The VTS was originally validated using a sample of criminal lawyers but has demonstrated utility as a brief screening tool for VT in social workers (Aparicio et al., 2013). In Vrklevski and Franklin's original study (2008), the VTS demonstrated good internal consistency with a Cronbach's alpha of .88 in a sample of criminal lawyers. Despite its potential utility, the research on the VTS scale is limited. To date, only two known studies have evaluated the psychometric properties and viability of using the VTS to evaluate vicarious trauma (Aparicio et al., 2013; Benuto et al., 2018). The VTS demonstrated good internal consistency with a Cronbach's alpha of .77 in a sample of social workers (Aparicio et al., 2013) and a Cronbach's alpha of .83 in a sample of victim advocates (Benuto et al., 2018). This measure was found to not have solid construct validity and further studies exploring its other psychometric properties are warranted (Benuto et al., 2018).

The TABS will be used in the current study as it is the only measure with the most literature support demonstrating reliability and validity in its ability to measure disruptions in cognitive schemas related to the five needs areas of control, safety, intimacy, esteem, and trust. Additionally, the TABS is unique in identifying disruptions in cognitions in oneself and relation to interactions with others (Briere & Spinazzola, 2005). According to Pearlman (2003), a measure like the TABS is important due to the link between trauma exposures and relational

difficulties. The TABS is a valuable tool in assessing MHPs with VT in addition to being brief, easy to read, and highly sensitive to the specific effects of traumatic experiences (WPS, 2022).

Childhood Trauma

There are several definitions related to adverse and traumatic experiences that can occur before an individual turns 18. According to the National Child Traumatic Stress Network (2021), childhood traumatic stress is a result of children being exposed to one or more traumatic experiences that are frightening, dangerous, or violent and that pose a threat to a child's life or bodily integrity. Furthermore, they include numerous experiences that may be considered traumatic including physical, psychological, and sexual abuse and neglect with the inclusion of trafficking, family or community violence, sudden or violent loss of a loved one, personal or familial substance use, refugee and war experiences, serious accidents, life-threatening illness, military family-related stressors, and natural and technological disasters (National Child Traumatic Stress Network, 2021).

Adverse childhood experiences have been coined as another term that has been associated with early exposure to adversities in childhood including physical, verbal, and sexual abuse and neglect, incarcerated parents, family members with severe mental illness, the disappearance of a parent through death, divorce, or abandonment, parents with substance abuse challenges, and a mother who is a victim of domestic violence (Felitti et al., 1998). A study conducted by Kaiser Permanente and the Centers for Disease Control and Prevention (CDC) from 1995 to 1997 has received considerable attention as it has been one of the largest investigations into childhood abuse and neglect and other household challenges and its impact on later-life and well-being (CDC, 2022b). Since the original study, researchers have attempted to identify additional adversities that can impact an individual well into their adulthood including peer rejection, peer

victimization, community violence exposure, school performance, and socioeconomic status although there is no fully agreed upon list of adverse childhood experiences (Finkelhor, 2020; Finkelhor et al., 2013). ACEs have also been conceptualized as a subset of childhood conditions that have been consistently associated with many long-term negative effects, both behavioral problems such as substance abuse and depression and physical health problems such as heart disease, obesity, and asthma (Felitti et al., 1998; Nurius et al., 2015, 2019; Petruccelli et al., 2019; Schilling et al., 2007; Shonkoff et al., 2012).

Mental Health Professional Personal Trauma History

The prevalence of mental health professionals who have experienced personal trauma is roughly that of the general population approximately 30% in samples of their peers (S. A. Adams & Riggs, 2008; Makadia et al., 2017; Michalopoulos & Aparicio, 2012). In an examination of mental health professionals working with survivors of trauma, this rate drastically increases to roughly 80% (Pearlman & Mac Ian, 1995; VanDeusen & Way, 2006). Elliott and Guy (1993) found the presence of childhood trauma alone was a significant factor in individuals' career choices in the therapeutic arena and was not attributed to education in trauma or having engaged in personal therapy (Elliott & Guy, 1993). In addition, psychology undergraduates who wanted to work within clinical settings were found to have higher rates of abuse than other psychology counterparts (Nikčević et al., 2007). Conchar and Repper (2014) found that personal experience and exposure to mental illness were found to be among the most predominant reasons contributing to an individual's passion to work as a mental health professional. Other researchers have found that exposure to maladaptive patterns stemming from parent-child or caregiver/child relationships in therapists compared to the general population has been reported as a leading reason for individuals to seek a therapeutic type of career. Individuals who experience childhood

trauma may have higher levels of sensitivity to the emotional pain of others, empathy, positive regard, and putting others' needs first (Halewood & Tribe, 2003). Another reason why individuals may seek this type of profession is to give others a life to which they may have not been privy and to assist others to avoid the pain and triumph they may have had to endure, causing a large desire to help others (Ivey & Partington, 2014). Huynh and Rhodes (2011) suggest that students are inspired by the desire to resolve personal psychological distress, a wish to fulfill unmet childhood needs for intimacy, and the need to maintain caretaking roles adopted in the family of origin.

Theories of Childhood Trauma

At present time, there is an emerging theory on the relationship between child maltreatment and its effect on function and structure in stress susceptible brain regions. In Van der Kolk's (2015), *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*, the author has contributed a better understanding of traumatic stress, revealing how trauma impacts brain wiring specifically areas dedicated to pleasure, engagement, control, and trust. In a review, Teicher and Samson (2016) synthesized neuroimaging findings in children with a history of physical, sexual, and emotional abuse and neglect. The researchers attempted to answer questions regarding the importance of the extent of exposure to child maltreatment, timing, gender differences, and the relationship between brain changes and psychopathology. The results from their review present that parental emotional and sexual abuse in addition to children witnessing domestic violence appear to target specific brain regions of the auditory, somatosensory, and visual cortex in addition to the pathways that process aversive experience. Child maltreatment is shown to also be associated with structural alterations in the prefrontal and

orbitofrontal cortex, corpus callosum, and hippocampus, and produces an increased amygdala response to emotional faces (Teicher & Samson, 2016).

There is a large debate regarding the initial state of the complex systems used to assist children in emotion regulation, perception, and recognition of what other individuals are feeling. One proposed hypothesis is that facial expressions and emotional recognition is obtained very early in life (Haviland & Lelwica, 1987). The contrasting hypothesis is that the recognition of emotion is learned through experience and based on the gradual refinement of children's production and recognition of emotional cues (Fogel et al., 1992). Children who demonstrate attention bias to threat may respond differently when exposed to facial stimuli of fear and anger as compared to those without a history of child-directed violence. Bar-Haim et al. (2007) suggested that attention bias stems from the tendency to dedicate more attention in an unbalanced manner towards less extreme threats such as images of anger (Bar-Haim et al., 2007). Burns et al. (2010) examined the relationship between multiple subtypes of child maltreatment, post-traumatic stress disorder, and emotion regulation. Participants were presented with measures that assessed child maltreatment history, emotion regulation difficulties, and posttraumatic symptomology. Results from the self-report measures revealed that women who reported a history of child maltreatment exhibited greater emotion regulation difficulties compared to the control group. The findings suggest that emotional abuse was the strongest predictor for emotion dysregulation and that emotion dysregulation partially explained the relationship between post-traumatic stress disorder and physical and emotional abuse (Burns et al., 2010). In a study completed by Masten et al. (2008), the researchers wanted to examine how children who exhibit high rates of post-traumatic stress disorder (PTSD) process facial emotions. The study included 29 maltreated and 17 non-maltreated children who were assessed for

diagnoses of PTSD and other disorders as determined through a combination of self-reports from the child, parents, and teachers. The children were presented with a morphed facial emotion identification task with eight different models with ten variants of emotional expression of happy, neutral, and fearful faces with varying intensity. Maltreated children displayed overall faster reaction times than their control counterparts when labeling emotional facial expressions. Maltreated children diagnosed with and without PTSD also showed enhanced response times when identifying fearful faces. There were no group differences in the labeling of emotions when identifying happy and neutral faces (Masten et al., 2008).

Empirical Studies of Childhood Trauma

Increasing amounts of evidence suggest that children with a history of child maltreatment are at an increased risk for internalizing and externalizing issues. The detrimental effects of child maltreatment also put individuals at risk for greater psychological problems throughout their lifetime such as major depression (Heim et al., 2008; Humphreys et al., 2020; Mandelli et al., 2015; Spatz Widom et al., 2007; Wiersma et al., 2009; Wu et al., 2021), anxiety (Huh et al., 2017; Kascakova et al., 2020; Maughan & Cicchetti, 2002; van Nierop et al., 2018), post-traumatic stress disorder (De Bellis & Thomas, 2003; Malarbi et al., 2017; Torjesen, 2019), alcohol and drug abuse (Garami et al., 2019; Mergler et al., 2018; Moustafa et al., 2021; Wells, 2009), personality disorders (Cattane et al., 2017; Johnson et al., 1999; Neumann, 2017; Rosenstein et al., 2018; Velikonja et al., 2019; Voestermans et al., 2021), and poor academic outcomes (Welsh et al., 2017). Furthermore, in addition to increased rates of adjustment challenges, individuals with a history of child maltreatment exhibit greater struggles in regulating and differentiating affective experiences than their non-maltreated counterparts (Cicchetti et al., 1991).

It is important to understand the long-term consequences that exposure to childhood trauma can have on an individual's health, well-being, and quality of life. The CDC-Kaiser ACE Study (Felitti et al., 1998) proposed a mechanism by which adverse childhood experiences influence a person's life. Researchers argue that childhood trauma can lead to disrupted neurodevelopment; social, emotional, and cognitive impairment; adoption of health-risk behaviors; and disease, disability, and social problems, which can ultimately lead to early death (Felitti et al., 1998). Despite the increasing knowledge to better understand childhood trauma, adverse childhood experiences are one of the greatest public health threats facing our nation today (Bryant et al., 2020; Dube, 2018; Lambert et al., 2017).

Measures of Childhood Trauma

Multiple self-report measures exist to assess the prevalence of childhood trauma histories in adults. There are also several measures to collect information on a broader topic, such as general mental health or substance abuse, that include a subsection on childhood trauma. Some of the potential limitations to self-report measures of childhood trauma are underestimation, memory biases (i.e., the tendency to selectively remember trauma-relevant or negative information), sociocultural factors contributing to denial and minimization, issues of confidentiality, mandated reporting, and trust (McKinney et al., 2009; Newbury et al., 2018). These limitations can influence responses to questionnaires by making some individuals less inclined to reveal personal histories of abuse or neglect (McKinney et al., 2009).

Early Trauma Inventory Self Report-Short Form (ETI-SR-SF)

The ETI (Bremner et al., 2007) was designed to assess the domains of physical, emotional, and sexual abuse, as well as a domain of general traumatic experience (Bremner et al., 2007). The ETI includes three separate versions: a clinical version, a self-report form, and a self-report short

form. The 56-item semi-structured interview was designed to assess the frequency of abuse/trauma by developmental stage, onset and termination of abuse/trauma, and the perpetrator/cause of the abuse/trauma. The semi-structured interview of this questionnaire will not be used in this study as it does not match the method of this study. The longer 62-item self-report form was designed to assess the four domains of trauma and includes questions regarding the frequency, perpetrator, and age of onset (age 0-5, 6-12, 13-18) of each trauma. The longer ETI-SR will not be used in this study as it goes beyond the purpose and needs of this study. The ETI-SR-SF (Bremner et al., 2007) is a retrospective self-report measure of childhood trauma before the age of 18. It was designed to assess the domains of physical abuse (i.e., physical contact, constraint or confinement, with intent to hurt or injure emotional), emotional abuse (i.e., verbal communication with the intention of humiliating or degrading the victim), sexual abuse (i.e., unwanted sexual contact performed solely for the gratification of the perpetrator or to dominate or degrade the victim), and general traumatic experience (i.e., a range of stressful and traumatic events which can be mostly secondary to chance events). The ETI-SR-SF consists of 27 items with five physical abuse items, five emotional abuse items, six sexual abuse items, and eleven general trauma items. For each item, participants are asked to respond with “yes” or “no” regarding the specific trauma listed. Higher scores on this scale indicate higher severity of traumas. A global score is obtained by summing the total number of items endorsed out of 27. A domain score is obtained by summing the items endorsed within each respective domain of physical abuse, emotional abuse, sexual abuse, and general trauma. The ETI-SR-SF can be interpreted with a maximum of two missing items; if more than two items are missing, the total score cannot be interpreted. According to Bremner et al. (2007), cut-off scores for the division of abused versus non-abused individuals are as follows: physical abuse (≥ 3), emotional abuse (≥ 3), sexual abuse (≥ 1), general trauma (≥ 4), and the total ETI-SR-SF score (≥ 7).

In a study examining the psychometric properties of the ETI-SR-SF (Bremner et al., 2007), authors show that the ET-SR-SF is a valid instrument for the measurement of childhood physical, emotional, sexual abuse, and general traumas. In their sample of 288 adults, domain scores for the shortlist correlated highly with the original list for general trauma ($r = 0.91$), physical ($r = 0.94$), emotional ($r = 0.97$), and sexual abuse ($r = 0.97$). Each domain for the short form demonstrated high internal consistency with Cronbach's alphas for general trauma ($\alpha = 0.70$), physical ($\alpha = 0.75$), emotional ($\alpha = 0.86$), and sexual abuse ($\alpha = 0.87$) trauma domains. The ET-SR-SF was able to discriminate patients with known associations with trauma from comparison subjects. In a sample of 304 adults, the ETI-SR-SF demonstrated a good level of internal consistency with a Cronbach's alpha of 0.806 (Jeon et al., 2012). It also demonstrated good convergent validity with the Childhood Trauma Questionnaire-Short Form (CTQ; Bernstein & Fink, 1998; $r = 0.691$) and divergent validity with the Beck Depression Inventory (BDI; Beck et al., 1961; $r = 0.424$) and the Beck Anxiety Inventory (BAI; Beck et al., 1988; $r = 0.397$; Jeon et al., 2012). In a sample of 86 adolescents, the ETI-SR-SF demonstrated a good level of internal consistency with a Cronbach's alpha of 0.803 (Park, 2018). For this study, the ETI-SR-SF will be used as a measure of childhood trauma among MHPs.

Trauma and Distress Scale (TADS)

The TADS (Patterson et al., 2002) is a retrospective self-report measure of childhood adversities and traumatic experiences (Salokangas et al., 2016). It consists of 43 items and focuses on five core domains of emotional neglect, emotional abuse, physical neglect, physical abuse, and sexual abuse. Other items assess for other traumatic experiences including loss, discrimination, bullying, and guilt. Two items represent a lie scale for validity. For each item, participants were asked to report the frequency of a behavioral occurrence on a 5-point scale (0 =

never to 4 = *almost always)*. Scoring results in two separate scores with a TADS total trauma score which is the sum of all five domain scores and a TADS total score which is the sum of all 43 items. The total TADS sum score of all 43 items demonstrated strong internal consistency with a Cronbach's alpha of 0.94. The total TADS sum trauma score of all items in the five core domains demonstrated strong internal consistency with a Cronbach's alpha of 0.92.

Childhood Trauma Questionnaire-Short Form (CTQ-SF)

The CTQ-SF (Bernstein & Fink, 1998) is a retrospective self-report measure of childhood and adolescent abuse and neglect experiences. It consists of 28 items and yields five subscales: three scales assess different forms of abuse (Emotional, Physical, and Sexual) and two assess neglect (Emotional and Physical). Three additional items compose the Minimization/Denial subscale for detecting socially desirable responses or false-negative trauma reports. For each item, participants were asked to report the frequency of a behavioral occurrence on a 5-point scale (1 = *never true* to 5 = *very often true*). Scoring results in the classification of the level of maltreatment with higher scores reflecting increasing severity (i.e., None, Low, Moderate, and Severe) for each of the five domains with scores ranging from 5 to 25. Three additional items compose the Minimization/Denial subscale for detecting socially desirable responses or false-negative trauma reports. Across psychometric studies assessing the reliability and validity of the CTQ-SF, scores can be compared to data from more than 2,200 males and females from seven different clinical and community samples, representing a broad range of ages, socioeconomic statuses, and different racial/ethnic groups (Pearson, 2018). The initial study of the CTQ-SF demonstrated a Cronbach's alpha of .95 for the total scale (Bernstein et al., 1994). Other studies have demonstrated a Cronbach's alpha ranging from .65 to .92 (Forde et al., 2012; VanDeusen & Way, 2006). The CTQ-SF also demonstrated good test-retest reliability for an adolescent

subgroup (N = 40) over a 2- to 8-month interval, with an intraclass correlation for the total scale of .88. The CTQ-SF subscale scores have test-retest reliability coefficients ranging from. 79 to. 86, and internal consistency coefficients ranging from. 66 to. 92 across initial validation samples (Bernstein et al., 2003; Scher et al., 2001; Thombs et al., 2009). Factor analysis tests on the five-factor CTQ-SF model showed structural invariance which demonstrated good validity (Bernstein & Fink, 1998). Convergent validity of the CTQ-SF was determined by assessing the association of CTQ-SF scales with analogous Childhood Trauma Interview (CTI), scales by Spearman's rank order correlation coefficients (Spinhoven et al., 2014). Other studies have demonstrated convergent validity between the CTQ-SF and other measures of childhood trauma including the Interview for Traumatic Events in Childhood (ITEC), and Computer-Assisted Maltreatment Inventory (CAMI) with moderately high associations (DiLillo et al., 2010; Spinhoven et al., 2014; Thombs et al., 2009). Discriminant validity was supported as the CTQ-SF factors and total score were unrelated to measures of verbal intelligence and social desirability (Bernstein & Fink, 1998).

Parental Acceptance and Rejection Questionnaire (PARQ)

The PARQ (Rohner, 1990) is a brief self-report questionnaire designed to assess individuals' perceptions of their childhood experiences of love and love withdrawal in relation specific to their mothers and fathers. The PARQ elicits information concerning affection, hostility, neglect, and undifferentiated rejection. Khaleque and Rohner (2002) summarized the reliability of the Child, Adult, and Parent versions of the PARQ in a meta-analysis of 51 studies worldwide. The results suggest that this measure is reliable for research, clinical, and applied purposes with an overall alpha coefficient of .89 aggregated across all three versions of the

PARQ. Evidence supporting the convergent, discriminant, and construct validity of the PARQ is provided in Rohner (2004).

Childhood Maltreatment Questionnaire (CMQ)

The CMQ (Demaré, 1993) assesses the frequency of maltreatment on or before the age of 17. The 110-item CMQ has three component questionnaires: the Psychological Maltreatment Questionnaire (PMQ; 72 items), the Physical Abuse Questionnaire (PAQ; 16 items), and the Sexual Abuse Questionnaire (SAQ; 22 items). Each subscale was found to be a significant predictor of measures of psychological functioning for both genders. Correlations with the Parental Acceptance and Rejection Questionnaire (PARQ; Rohner, 1990) were used to confirm the convergent validity of the measure. Evidence of discriminant validity was confirmed due to the correlations between the PMQ and the PARQ being significantly higher than those observed between the PMQ and the measures of the divergent forms of maltreatment represented by the PAQ and the SAQ (Demaré, 1993).

Adverse Childhood Experiences Questionnaire (ACES)

The ACES (Felitti et al., 1998) measure is a 10-item self-report questionnaire used to measure ten different types of childhood trauma. Five are personal: physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect. Five are related to other family members: a parent who's an alcoholic, specifically, a mother who is a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the disappearance of a parent through divorce, death, or abandonment. The ACES Questionnaire has demonstrated good concurrent validity with the Hopkins Symptom Checklist (HSCL; Parloff et al., 1954), the Perceived Stress Scale (PSS; Cohen, 1994), and the 36-Item Short Form Health Survey

questionnaire (SF-36; Karatekin & Hill, 2019; McHorney et al., 1994). Convergent validity was assessed with the Childhood Trauma Questionnaire-Short Form (CTQ-SF) and the Stressful Life Events Screening Questionnaire-Revised (SLESQ; Green et al., 2006). Internal consistency coefficients ranged from .71 to .74 (Karatekin & Hill, 2019).

Despite the vast list of traumatic experiences to which an individual could be exposed, for this study, the focus will be on childhood trauma that stems from specifically physical, sexual, and emotional abuse and neglect because many assessments of childhood maltreatment and adverse childhood experiences have a serious lack of standardization (Hulme, 2004; Roy & Perry, 2004; Spinhoven et al., 2014). Furthermore, the CTQ-SF is simple to administer, is brief, and has demonstrated adequate psychometric properties, including a good fit to the five-factor structure in clinical and nonclinical samples, internal consistency, and test-retest reliability (Spinhoven et al., 2014).

Supervisory Working Alliance

Bordin (1983) generalized the therapeutic working alliance to the supervisory relationship. The supervisory working alliance is comprised of the same three components as the therapeutic working alliance (i.e., goals, tasks, and bonds). One significant difference is that the alliance is formed between supervisor and supervisee instead of counselor and client. Bordin asserted that stronger supervisory working alliances are conducive to supervision outcomes, just as strong therapeutic alliances have been related to improved counseling outcomes (Horvath & Symonds, 1991). Bernard and Goodyear (2019) propose that the supervisory working alliance has been demonstrated as one of the most important variables in supervision.

Theories of Supervisory Working Alliance

Working alliance theory as a theory of counseling and psychotherapy was initially developed by Edward Bordin and is the conceptual foundation of the Supervisory Working Alliance Model (Bernard & Goodyear, 2019; Bordin, 1979, 1983; Dykeman, 1995; Horvath & Greenberg, 1994; Ladany & Bradley, 2001; Wood, 2005). Bordin's working alliance theory explores the nature of the therapeutic alliance in the counseling relationship consisting of three major components of the working alliance: goals, tasks, and bond. Having a strong working alliance involves mutual agreement and understanding regarding the goals sought in the change process and the tasks of both the mental health professional and the client. In addition, it involves the development of a strong emotional bond between both parties. According to Bordin (1994), his theory is founded upon psychoanalytic terminology. Bordin endorsed that his theory was built from Greenson's (1967) concepts of the real relationship and the alliance along with the work of Carl Rogers (1951) and Otto Rank (1945). The work of Rogers and Rank influenced the key component of the working alliance with the view that the person seeking change takes an active position in the change process (Bordin, 1994).

The Supervisory Working Alliance Model (Bordin, 1983) applies the working alliance theory and the goal, task, and bond constructs to the parallel process between supervisor and supervisee (Wood, 2005). Shulman (2006) discussed that the parallel process between supervisor and supervisee has "striking parallels in the dynamics and skills" seen in counseling between counselor and client despite serving different functions. Bordin (1983) transformed the terms of the therapeutic alliance into those of the supervisory alliance. Furthermore, he identified a list of supervisory goals including (a) mastery of skills, (b) enlarging one's understanding of clients, (c) enlarging one's awareness of process issues, (d) increasing awareness of self and impact on

process, (e) overcoming personal and intellectual obstacles toward learning and mastery, (f) deepening one's understanding of concepts and theory, (g) provide a stimulus to research, and (h) maintenance of standards of service (Bordin, 1983).

Regarding tasks of supervision, Bordin highlights that depending on the goals being sought, the supervisor might be engaged in discussion with a focus on the supervisee's feelings or understanding the client's feelings. Another important task identified within this theory is that of participation in objective observation. Bordin (1983) argues that without direct observation, a supervisor will be handicapped in their task of contributing to goals. Lastly, Bordin discusses the role that supervisees play within the working alliance including taking an active stance in advocating for certain problems and issues to be discussed within supervision. The supervisor then must be able to judge how these topics address the goals of supervision and connect process issues to them.

Bordin (1983) identified that an important bonding problem is created by the evaluative element in supervision given that supervisors act as gatekeepers designed to protect the public and the profession. Furthermore, he argued that trust is necessary for confronting one's innermost experiences.

Empirical Studies of Supervisory Working Alliance

Various studies have focused on the relationship between the supervisory working alliance and self-disclosure (Cheun & Yoo, 2010; Ju et al., 2014; Schweitzer & Witham, 2018), the relationship between the supervisor and the supervisee (Desai, 2016; Efstation et al., 1990; Ganske et al., 2015; White, 1999; White & Queener, 2003), and the parallel relationships between supervisor and supervisee and counselor and client (Bell et al., 2016; DePue et al., 2016; Ganske et al., 2015; Gnilka et al., 2012, 2016).

According to Watkins and Scaturo (2013), the supervisory working alliance forms the foundation of the supervision process. Holloway (2016) found that a supervisor's ability to build strong relationships with their supervisees, relationships built on trust, safety, and empathy, formed a foundational approach to supervision and to dealing with supervisee shame. Supervisors promote a positive and secure supervisory working alliance when they recognize supervisee strengths (Ellis et al., 2014). A misalignment of supervisory styles and supervisee developmental level can hurt the supervisory working alliance and lead to ruptures in the supervisory relationship (Farnan et al., 2009). Some other challenges that can hurt the supervisory working alliance are unclear or unconstructive feedback (Gray et al., 2001). A poor supervisory working alliance can lead to poor supervisee (Ladany et al., 1999) and client outcomes (Patton & Kivlighan, 1997).

Measures of Supervisory Working Alliance

Supervisory Working Alliance Inventory-Supervisee Form (SWAI-SF)

The SWAI (Efstation et al., 1990) was designed to measure the quality of the counseling supervision relationship. The SWAI includes two separate forms: a supervisor form and a supervisee form. The 23-item supervisor form of this questionnaire is designed to measure the supervisor's perception of the quality of the supervisory relationship. The supervisor form of this questionnaire will not be used in this study as it goes beyond the purpose of this study. It would require the need to collect personally identifying information to be able to link supervisor and trainee responses as well as potentially limiting responses due to needing both parts of the SWAI completed.

The 19-item supervisee form of this questionnaire is designed to measure the trainee's perception of the quality of the supervisory relationship. A factor analysis of the supervisee form identified two subscales, rapport, and client focus. Rapport refers to the trainee's perception of support from the supervisor. Client focus refers to the trainee's perception of the emphasis the supervisor placed on promoting the trainee's understanding of the client (Efstation et al., 1990). To demonstrate the internal consistency of the scale, Efstation et al. (1990) reported a Cronbach's alpha coefficient of .90 for the rapport subscale and a Cronbach's alpha coefficient of .82 for the client focus subscale. In a follow-up study, a Cronbach's alpha coefficient of .91 for the rapport subscale and a Cronbach's alpha coefficient of .72 for the client focus subscale was calculated (Patton et al., 1992).

Compared to other established measures, the SWAI-SF form demonstrated convergent and divergent validity. Adequate concurrent, convergent, and discriminant validity evidence was obtained from correlations of SWAI scales with scales of the Supervisory Styles Inventory (SSI; Friedlander & Ward, 1984) and the Personal Reactions Scale Revised (PRS-R; Efstation et al., 1990; Holloway & Wampold, 1984; Patton et al., 1992). The trainee version of the Rapport and Client Focus scales of the SWAI are significantly correlated with the Self-Efficacy Inventory (SEI; Friedlander & Snyder, 1983) at .22 and .15, respectively (Efstation et al., 1990). Correlations of the trainee scales of the SWAI with the supervisee version of the Personal Reactions Scale Revised (PRS-R: Holloway & Wampold, 1984) were: rapport ($r = .85$, $p < .001$), and client focus, ($r = .52$, $p < .001$) (Patton et al., 1992).

Working Alliance Inventory (WAI)

The WAI (Felitti et al., 1998) is a 36-item measure comprised of three subscales: goals, tasks, and bonds. The WAI was later revised into a Working Alliance Inventory-Short Form

(WAI-S; Tracey & Kokotovic, 1989). The WAI-S, a 12-item inventory, measures the same three components of the working alliance between a counselor and a client as does the WAI. Some examples of items are “My client and I both feel confident about the usefulness of our current activity in therapy” and “We are working toward mutually agreed upon goals.” Horvath and Greenberg (1986) demonstrated adequate reliability for the WAI. Internal consistency estimates of Cronbach’s alpha were .93 for the overall client score with subscale alphas of .85 to .88 and .87 for the overall therapist score with subscale alphas of .68 to.87 (Horvath & Greenberg, 1986). The WAI found good concurrent validity with two other measures of counselor-client relationship including the Counselor Rating Form (CRF; LaCrosse & Barak, 1976) and the Empathy scale of the Relationship Inventory (RI; Barrett-Lennard, 1962; Horvath & Greenberg, 1986). Strong associations demonstrating good convergent validity between the WAI and other inventories designed to measure similar traits were also found (Horvath & Greenberg, 1986).

The Supervisory Working Alliance Inventory (SWAI) was designed to measure the working alliance in supervision from both a supervisor and supervisee perspective. Higher scores are indicative of more effective alliances. The SWAI can be used as an ongoing repeated measure of the supervisory working alliance (Efstation et al., 1990). The SWAI was selected for this study as it contains a specific trainee response form (SWAI-SF) and has been used frequently in supervision research (Bernard & Goodyear, 2014) with evidence of meaningful correlations with trainee-supervisor attachment, trainee disclosure, and ratings of supervisor competence and supervision effectiveness (Gonsalvez et al., 2017; Gunn & Pistole, 2012).

Shame

Shame is seen as a part of self-conscious emotions, which are more elaborate emotional reactions that are closely associated with complex sociocognitive processes such as self-

awareness and self-evaluation (Dyer et al., 2017). Gilbert (1998) has suggested that the self-conscious affect of shame should be distinguished into both internal and external shame. External shame is associated with beliefs that others look down on the self and see the self as inferior, inadequate, weak, or disgusting in some way whereas internal shame relates to the experiences of self as devalued in one's own eyes, which is damaging to self-identity (Lee et al., 2001). Additional consequences can include feelings of blame, hopelessness, guilt, and fear (Wood & Irons, 2017). The notions of external and internal shame have a connection to how an individual perceives their trauma experiences. Lee et al. (2001) posit that schematic representations of the self as shameful or others as shaming may be activated via attributional processes in the aftermath of exposure to trauma. Furthermore, shame appears to be linked to the development and maintenance of posttraumatic stress symptoms (PTSS) following exposure to trauma (Badour et al., 2020; Beck et al., 2011; Ginzburg et al., 2009; Leskela et al., 2002; Pineles et al., 2006; Street & Arias, 2001) and has been described as a painful and potentially maladaptive emotion (Badour et al., 2020).

Neighboring Construct of Shame

The term *guilt* is often associated with shame given that both have a great deal in common including both being self-conscious emotions, implying self-reflection and self-evaluation, involving feelings of distress elicited by one's perceived failures or transgressions, and strongly correlating with one another (Miceli & Castelfranchi, 2018). These researchers posit that shame implies a perceived lack of power to meet the standards of one's ideal self and is likely to motivate either withdrawal or increased efforts in building one's aspired-to identity. Guilt on the other hand implies a perceived power and willingness to be harmful and is likely to motivate either reparative or self-punitive behavior (Miceli & Castelfranchi, 2018).

Theories of Shame

Shame is a painful emotional experience because one's core sense of self is in jeopardy (Tangney et al., 2007) and is typically accompanied by an overwhelming sense of worthlessness, incompetence, and inferiority (Bastin et al., 2016; Tangney et al., 2011). People experiencing shame usually attempt to deny, hide, and withdraw physically and/or psychologically from the situation eliciting the feeling of shame (Tangney et al., 2007; Tignor & Colvin, 2019). Several theoretical models have depicted the relations of shame to PTSS. The contemporary cognitive model posits that two key processes, excessively negative appraisals of traumatic events and/or their consequences and disorganized autobiographical memory, produce a sense of serious current threat, which leads to persistent PTSS (Ehlers & Clark, 2000). Evaluations concerning the violation of individuals' important internal standards may elicit a threat to the self and then shame (Lawrence & Taft, 2013). Shame may also arise from the congruence of the traumatic event' meaning with underlying shame schemas that have deeper implications for the self and/or others, or from the breakdown of a positive self-identity (Lee et al., 2001). PTSS may emerge from the impacts of the dysregulation of emotions (e.g., shame) on social cognition and interpersonal functions (Budden, 2009; Sharp et al., 2012).

According to Brown (2006), shame is a silent epidemic, and the more we keep it secret, the firmer its hold on us. Shame is associated with a host of issues including addiction, violence, and depression (Bilevicius et al., 2018; Weingarden et al., 2016). Brown defines shame as the intense and painful feeling or experience of believing that something is wrong with us; therefore, we are unworthy of connection and belonging. Brown has conceptualized shame as a daily human emotion that one cannot escape; however, one can develop resilience to shame. Shame resilience theory (Brown, 2006) teaches that shame resilience can be cultivated by recognizing

and accepting personal vulnerability, raising critical awareness regarding social/cultural expectations, forming mutually empathetic relationships that facilitate reaching out to others, and possessing the language and emotional competence to discuss and deconstruct shame.

Shame Resilience Theory (SRT) proposes that the great majority of the emotions, thoughts, and behaviors demonstrated by individuals experiencing shame are efforts to develop shame resilience by decreasing the feelings of being trapped, powerless, and isolated and increasing the opportunities to experience empathy by increasing connection, power, and freedom from the shame web. Brown (2006) conceptualizes the shame web as the experienced shame is a "web of layered, conflicting, and competing expectations that are, at the core, products of rigid socio-cultural expectations" (Brown, 2006, p. 46) SRT proposes that shame resilience is best understood on a continuum that represents, on one end, feelings of being trapped, powerless, and isolated. On the opposite end of the continuum are the components of shame resilience: empathy, connection, power, and freedom. The complicated weaving of these concepts makes shame so powerful, complex, detrimental, and often difficult to overcome (Kiffin-Petersen, 2018).

The central premise of SRT is to understand the cause of shame and to examine the strategies that can be used to avoid feeling trapped, powerless, or isolated (Hernandez & Mendoza, 2011). These feelings can lead to a wide array of negative consequences including a lack of sense of self, becoming silent, and being avoidant (Brown, 2006; Hahn, 2000; Hauser, 2016; Rizvi et al., 2011). However, if an individual manages to have a better understanding of shame and its causes, then they develop shame resilience (Dayal et al., 2015; Hernandez & Mendoza, 2011).

Empirical Studies of Shame

Shame has been linked to depression, suicidal behavior, and posttraumatic stress disorder (Bilevicius et al., 2018; Weingarden et al., 2016). There is also research to suggest that shame can be linked to personal trauma histories due to gender-stereotyped beliefs (e.g., preconceptions about attributes or characteristics, or the roles that are or ought to be possessed by specific genders; Bomyea & Allard, 2017; Bruggman & Ortiz-Hartman, 2017; Dorahy & Clearwater, 2012; Manson, 2019) and altered cognitions and negative underlying assumptions (Platt & Freyd, 2012; Wilson et al., 2006). Negative effects of shame impact individuals who are more prone to shame as well as individuals who only experience it at certain moments of their lives (De Rubeis & Hollenstein, 2009; Turner, 2014). Shame-proneness is the characteristic of being particularly susceptible to shame over a wide range of situations and times and has been referred to as a personality trait (De Rubeis & Hollenstein, 2009). Multiple studies have shown shame-proneness to correlate with maladjustment including social phobias, adjustment disorders, anxiety, and obsessive-compulsive disorder (Andrews et al., 2002; Fergus et al., 2010; Lewis, 1995; Rüsch et al., 2007; Schoenleber & Berenbaum, 2010; Tanaka et al., 2015; Tangney, 1995; Van Vliet, 2008; Wright et al., 2009). Shame-proneness has been linked to decreased performance in outcomes across professions (Hofseth et al., 2015; Turner, 2014). Additionally, researchers are increasingly recognizing the predictive role of shame in social and behavioral problems (Bennett et al., 2005; Lynch et al., 2012). Some of these social and behavioral problems include restricted interpersonal problem-solving (e.g., a lack of ability to generate effective solutions to interpersonal problems and one's ability to implement those solutions), substance abuse, eating disorders, violent behavior, social withdrawal, and reduced empathy (Brown, 2004; Covert et al., 2003; Dearing et al., 2005; Dost & Yagmurlu, 2008; Gambin &

Sharp, 2018; Goss & Allan, 2009; Lee et al., 2001; Nechita et al., 2021; Owen & Fox, 2011; Rahim & Patton, 2015; Swan & Andrews, 2003; Van Vliet, 2008; Wells et al., 1999; Wiechelt, 2007)

Measures of Shame

External and Internal Shame Scale (EISS)

The EISS (Ferreira et al., 2020) is an 8-item measure designed to assess the global shame experience in a single measure that evaluates the propensity to experience external and internal shame. The EISS has two subscales: external and internal shame. External shame is focused on the experience of the self as seen in a judgmental way by others, whereas internal shame is conceptualized as self-focused negative evaluations and feelings about the self. Participants answer items on a 5-point Likert-type scale ranging from 0 (*never*) to 4 (*always*). Results from the EISS presented good psychometric properties. Regarding reliability, Cronbach's alphas of .80 and .82 were found for the external shame subscale and the internal shame subscale, respectively. The EISS total scale revealed a Cronbach alpha of .89. In a cross-national study included 1405 participants recruited in community samples of adults from Portuguese, French, Australian, Singaporean, and Japanese populations, who completed the EISS in four different languages, Cronbach alphas ranged from .81 to .91 (Matos et al., 2021). Item-total correlations were all moderate to high, ranging from .55 to .75. Concurrent validity was assessed by calculating the zero-order and partial correlation coefficients between each of the two EISS subscales and the Other as Shamer Scale-2 (OAS-2; Matos et al., 2015), Forms of Self-Criticizing/Attacking and Self-Reassuring Scale (FSCRS; Gilbert et al., 2004) and the Depression, Anxiety and Stress Scale-21 Items (DASS-21; Lovibond & Lovibond, 1995). The depression score was strongly correlated with the EISS global score and both subscales. When

testing the partial correlations for each subscale, the partial correlations remained significant. Moreover, the ES and IS subscales showed to be positively and significantly correlated (r =.76; p < .001). The association between EISS global score, the ES and IS subscales, and the SR-FSCRS (self-reassurance) was calculated to address discriminant validity. Results on the partial correlation between the IS and the Self-Criticizing subscale of the FSCRS while controlling for the ES were strong and highly significant (r = .56; p < .001). Partial correlations between the IS and the Self-Reassuring subscale of the FSCRS while controlling for the ES were moderate and highly significant (r = −.45; p < .001).

Test of Self-Conscious Affect-3 (TOSCA-3)

The TOSCA-3 (Tangney et al., 2000) is a 16-item scenario-based measure that is used to assess guilt and shame. The TOCSA-3 is composed of 11 negative and 5 positive scenarios yielding indices of Shame-Proneness, Guilt-Proneness, Externalization, Detachment/Unconcern, Alpha Pride (i.e., the pride in the entire self), and Beta Pride (i.e., the pride associated with a specific behavior). For each scenario, participants rate their shame and guilt response items on a 5-point Likert scale (1 = *very unlike me* to 5 = *very like me*) to indicate their likelihood of responding in the manner depicted yielding sum-scores for shame-proneness and guilt-proneness between 16 and 80. The Cronbach's alpha coefficients for the Shame and Guilt scales were .76 and .66, respectively (Tangney et al., 2000). In a recent study, short versions of the TOSCA-3 Shame and Guilt scales correlated .94 and .93, respectively with their corresponding full-length versions (Watson et al., 2016).

Personal Feelings Questionnaire-2 (PFQ-2)

The PFQ-2 (Harder & Zalma, 1990) is a 16-item measure designed to assess guilt and shame proneness. Respondents indicate the frequency of their experiences consistent with guilt and shame-related affective descriptors on a Likert-type scale. The PFQ-2 includes six items assessing guilt-proneness (e.g., remorse) and ten items assessing shame-proneness (e.g., feeling disgusting to others). Cronbach's alpha scores for the PFQ-2 Shame subscale = .78; and PFQ-2 Guilt subscale = .72. Test-retest reliability was established over a two-week period with alphas for the PFQ-2 Shame subscale =.91; and for PFQ-2 Guilt subscale =.85. Construct validity was examined by comparing the PFQ-2 scale to the Hoblitzelle Adapted Shame and Guilt Scale (ASGS; Hoblitzelle, 1988). The PFQ-2 showed the ability to correlate successfully with public self-consciousness and social desirability, whereas the ASGS demonstrated the predicted ability to correlate with shyness, narcissism, and more convincingly with social anxiety (Harder & Zalma, 1990).

Experience of Shame Scale (ESS)

The ESS (Andrews et al., 2002) is a 25-item questionnaire that assesses four areas of characterological shame: the shame of personal habits, manner with others, sort of person you are, and personal ability; three areas of behavioral shame: shame about doing something wrong, saying something stupid, and failure in competitive situations; and bodily shame: feeling ashamed of one's body or any part of it. The total scale showed a high internal consistency with an alpha of .90. The internal consistency for the subscales ranged with Cronbach's alphas of .86 to .90. The test-retest reliability over 11 weeks was equal to an alpha of .83. The test-retest reliabilities for the subscales over 11 weeks ranged from alphas of .74 to .82. Confirmatory

factor analysis suggested a 3-factor model: Characterological shame, behavioral shame, and bodily shame (Andrews et al., 2002).

Attitudes Towards Mental Health Problems Scale (ATMHP)

The ATMHP (Gilbert et al., 2007) is a 35-item self-report scale aimed at the assessment of attitudes toward mental health that involve several factors relating to attitudes and shame (internal, external, and reflected shame) when facing mental health problems. Participants rate each item on a 4-point (0 = *do not agree at all* to 3 = *completely agree*). Higher scores on this scale indicate more negative attitudes toward mental health problems. Preliminary analysis showed that all subscales presented good internal consistency, with Cronbach's alpha ranging from .85 to .97 (Gilbert et al., 2007).

Other as Shamer Scale (OAS)

The OAS (Goss et al., 1994) is an 18-item self-report instrument measuring external shame. Respondents are asked to indicate the frequency on a 5-point scale of their feelings and experiences to items such as, "I feel other people see me as not quite good enough." Higher scores indicate higher levels of external shame. The original and the Portuguese version of the scale presented good internal consistency (Cronbach's alpha .92 and .91, respectively; Goss et al., 1994; Matos et al., 2015). In a more recent sample, internal consistency was .96 (Master et al., 2016).

Internalized Shame Scale (ISS)

The ISS (Cook, 1987) is a 24-item self-report inventory measure of internal shame consisting of negatively worded items assessing the frequency in which people experience feelings of shame; and a 6-item scale consisting of positively worded items assessing self-esteem. The ISS Technical Manual (Cook, 2001) reports test-retest reliability correlations across

a 7-week interval of .84 and .69 for the shame and self-esteem subscales, respectively. Regarding internal consistency, the manual reports shame subscale alpha coefficients of .95 and .96 for non-clinical and clinical samples, respectively in addition to self-esteem subscale alpha coefficients of .90 and .87, respectively. Rybak and Brown (1996) reported similar alpha coefficients of .97 and .90 for shame and self-esteem subscales based on a mixed, non-clinical, and clinical sample.

The assessment of shame using self-report questionnaires can help to understand the role shame has in various mental health challenges. However, shame measures have predominantly been tested among healthy subjects that show consistently lower levels of shame; therefore, little is known about the comparative validity of different shame questionnaires (Rüsch et al., 2007). Another challenge that exists within shame measures is that several measure different facets of shame including shame proneness, momentary shame reactions, and the interest of this study looking at external and internal shame. Although a relatively new measure, the External and Internal Shame Scale (EISS; Ferreira et al., 2020) was selected for this study because it addresses specific dimensions of external and internal shame as well as a global sense of shame experience, additionally to preliminary findings support it as a short, robust, and reliable measure (Ferreira et al., 2020).

Summary

A theoretical and empirical basis and rationale for the current study were established through a comprehensive review of the literature. While the completed literature review has potential limitations (e.g., approach to the search, search terms used, and errors integrating available sources), it has attempted to present and synthesize relevant literature related to trauma prevalence in the U.S., VT, mental health professional personal trauma histories, childhood trauma, supervisory working alliance, and shame.

What has not been addressed in the empirical literature is the possible effect shame may have on childhood trauma history and its relationship to the later development of VT. The research has shown that there is a connection between personal childhood trauma history and VT (S. A. Adams & Riggs, 2008; Camerlengo, 2002; Dickes, 2001; Pearlman & Mac Ian, 1995; Radey & Figley, 2007; Schauben & Frazier, 1995; Shannon et al., 2014; Trippany et al., 2004; Young & Ahmad, 1999). Additionally, both quantitative and qualitative research has shown a link between personal childhood trauma history and shame (Dorahy & Clearwater, 2012; Dyer et al., 2017; Srinivas et al., 2015) as well as shame and the development of PTSS (Dunmore et al., 2001; Feiring & Taska, 2005; López-Castro et al., 2019; Taylor, 2015). However, no known quantitative research has looked specifically at how shame and supervisory working alliance may mediate or moderate the relationship between personal childhood trauma history and VT. There is a clear gap in the literature and need to fill it. In the next chapter, the methodology for this study will be presented along with specific research questions and statistical analyses.

CHAPTER III

METHODOLOGY

In this chapter, the research methods of this study are discussed. This study examined if the supervisory working alliance moderates the relationship between childhood trauma and vicarious traumatization among early career MHPs. Additionally, the current study examined the mediational role of shame between personal childhood trauma history and its impact on the susceptibility of developing vicarious traumatization among this group. By examining the interrelationships of childhood trauma, shame, supervisory working alliance, and vicarious traumatization, this study aimed to understand the antecedents that impact the severity and presence of vicarious traumatization symptoms and experiences in early career mental health professionals (McCann & Pearlman, 1992). To address the study's research questions, a non-experimental, cross-sectional survey research design using convenience sampling was used. In this chapter, the following is described: the present study's (a) procedures, (b) participants, (c) instrumentation, (d) hypotheses, and (e) data analyses.

Procedures

Before participant recruitment and data collection, approval was received by this researcher's university's Institutional Review Board (IRB; Appendix A). All data were collected online using Qualtrics, an online service specializing in the collection of research data through online surveys.

Participant Recruitment

Participants were recruited through convenience sampling. Recruitment included posting a recruitment letter (see Appendix B) and survey link to two American Psychological Association Division 17 listservs accessed by counseling psychology professionals across the nation. Permission was also obtained to post the recruitment letter on The Testing Psychologist Community Facebook page which is a group of over 10,000 mental health clinicians across the United States, the American College Counseling Association (ACCA) Facebook page, and a licensed mental health counselors group page. Additionally, permission was obtained to send the recruitment letter to counseling psychologists at a regional children's hospital. Other recruitment methods included posting a recruitment letter and survey link to Facebook including the primary researcher's personal Facebook page as well as a request for colleagues to share to their personal Facebook pages.

As the data were gathered through Qualtrics, the participant was prompted by an initial page to confirm that they met the inclusion criteria to participate in this study (Appendix C). This page asked participants to acknowledge that they met the following criteria: (a) were at least 18 years of age and living in the United States, (b) pursued a master's or doctoral level counseling program, (c) were post-graduation and within 10 years of their degree completion, (c) were actively receiving clinical supervision at least once a month, and (d) worked with clients who discussed trauma. If participants met the inclusion criteria for this study and confirmed that they met the criteria by selecting each statement, participants were then prompted to review the informed consent form (Appendix D).

Informed Consent Process

The informed consent form provided the individual with the contact information for the primary researcher, her Research Advisor, and the researcher's university's Institutional Review Board. Additionally, it included an explanation of the study's potential risks and benefits, a statement that confidentiality could not be guaranteed with data collected online, and an acknowledgment that participants could decline or stop participation at any point in the survey without repercussion. All participants were also informed that their completion of the survey would qualify them to enter into a drawing for one of five Visa gift cards worth $20 each. To indicate their consent for participation, participants chose an option stating, "I consent to participate in this study." Those participants who did not consent by selecting, "I do not consent to participate in this study" were directed to a page thanking them for their time. Participants were notified that there would be an initial screening measure to assess for the presence of childhood trauma exposure that they experienced before the age of 18. The participants who consented by selecting "I consent to participate in this study" were instructed to complete the ACES Questionnaire (Felitti et al., 1998; Appendix E) as an inclusion benchmark in this study.

Participant Screening

Participants who provided informed consent by electing to continue with the survey were presented with the ACES Questionnaire (Felitti et al., 1998). This 10-item inventory was used to screen out participants who did not report at least one type of exposure to childhood trauma. Using the survey flow features through Qualtrics, participants who scored one or above were directed to the remaining measures. Participants who scored zero were considered excluded from this current study and directed to a debriefing statement with the researcher's contact information, an explanation of the study, and a list of national support resources.

Survey Procedure

If participants endorsed one or more of the 10 items listed in the ACES Questionnaire (Appendix E), they were then instructed to complete the Early Trauma Inventory-Self Report Short Form (ETI-SR-SF; Appendix F), the External and Internal Shame Scale (EISS; Appendix G), the Supervisory Working Alliance Inventory-Supervisee Form (SWAI-SF; Appendix H), the Trauma and Attachment Belief Scale (TABS; Appendix I), and a demographics questionnaire (Appendix J). Inventories were presented to the participant in randomized order to control for order effects. The last instrument to be completed was the demographic questionnaire.

Due to the potentially triggering and emotional material of childhood trauma and vicarious trauma, participants were directed to a short debriefing statement (Appendix K) with the researcher's contact information, an explanation of the study, and a list of national support resources at the end of the study. After the debriefing statement, participants were directed to a separate voluntary survey not connected with their original survey responses to provide their contact information if they wished to enter the drawing for one of the five Visa gift cards. These participants were informed that their email addresses would be stored in a separate database from the research data and that their email addresses could not be connected back to their survey responses.

Data Storage

All of the data and identifying information were thoroughly secured to ensure participant confidentiality. All data from the survey responses were stored on the Qualtrics secure server. Following the completion of the data collection process, the data were downloaded and imported into a statistical software package, IBM Statistical Product and Service Solutions (SPSS) version 29.0 on the researcher's password-protected computer. The data stored on the Qualtrics server

were password-protected and only accessible by the primary researcher. The data will be destroyed after three years.

Participants

Twenty participants (n = 20) were screened out of the study. An additional 10 (n = 10) participants were removed during the data cleaning process. A total of 59 participants remained in the final data analysis. The average age of the final sample of participants (N = 59) was 30.83 years with an average of 2.78 years of experience in the mental health field since completion of their graduate degree (see Table 1).

Table 1

Workplace Demographic Variables

	M	*SD*	Min.	Max.
Age	30.83	5.90	23	51
Years in Field	2.78	2.11	1	8

Note. N = 59

Additionally, the majority of participants in this study identified as female (n = 50, 84.7%), Caucasian, European American, European (n = 45, 76.3%), who completed a master's degree in counseling (n = 38, 64.4%), and are currently receiving their own outpatient counseling (n = 40, 67.8%). Approximately half of the participants reported that they have received prior trauma treatment (n = 30, 50.8%). The highest frequencies for participants included those who worked in private practice (n = 27, 45.8%), reported practicing in the Western United States (n = 21, 35.6%), and received weekly supervision (n = 45, 76.3%). The highest frequencies for the percentage of trauma caseload were participants who reported that 50% (n = 11, 18.6%) or 70%

of their caseloads included clients who discuss trauma (n = 11, 18.6%). Participant demographics including gender, race, graduate program level, previous trauma treatment, current engagement in outpatient counseling, type of workplace agency, region of practice, frequency of clinical supervision, and percentage of trauma caseload are presented in Table 2.

An a priori power analysis was conducted using G*Power version 3.1.9.6 (Faul et al., 2007) to determine the minimum sample size required to test the study's first hypothesis. Results indicated that the required sample size to achieve a power of .80 for detecting a medium effect of $f2$ = .15, at a significance criterion of α = .05, was N = 55 for linear multiple regression (fixed model, single regression coefficient). Thus, the obtained sample size of N = 55 is adequate to test the study's first hypothesis. A second power analysis using the same pre-specified levels with one tested predictor and three total predictors was conducted using G*Power version 3.1.9.6 (Faul et al., 2007) to determine the minimum sample size required to test the study's second hypothesis. Results indicated that the required sample size to achieve a power of .80 for detecting a medium effect, at a significance criterion of α = .05, was N = 55 for linear multiple regression (fixed model, R^2 increase). Following Cohen's (1988) standards, this power analysis was based on pre-specific levels of significance, power, and effect size. This study used a medium effect size of $f2$ = .15 (Cohen, 1992), a power of .80, and an α level of .05, which is a standard α level for behavioral research (Tabachnick & Fidell, 2007).

Table 2

Demographic Variables

	Frequency	Percent
Gender		
Female	50	84.7
Male	7	11.9
Genderqueer/Genderfluid	2	3.4
Race		
African American, Black	1	1.7
Caucasian, European American, European	45	76.3
Latino/a/x American, Hispanic, Chicano/a/x	6	10.2
Biracial/multiracial	5	8.5
Counseling Program Level		
Master's	38	64.4
Ph.D. or Psy.D.	21	35.6
Previous Trauma Treatment		
Yes	30	50.8
No	29	49.2
Currently Engaged in Outpatient Counseling		
Yes	40	67.8
No	19	32.2

Table 2 (continued)

	Frequency	Percent
Workplace Agency		
College/University	7	11.9
Community Mental Health	18	30.5
Private Practice	27	45.8
Medical Hospital	2	3.4
Psychiatric Hospital	3	5.1
Alcohol and Drug Rehabilitation	1	1.7
Not listed above	1	1.7
Region of Practice		
West	21	35.6
Southwest	8	13.6
Midwest	18	30.5
Northeast	7	11.9
Southeast	3	5.1
Multiple regions	2	3.4
Frequency of Supervision		
Weekly	35	59.3
Bi-weekly	11	18.6
Monthly	13	22.0

Table 2 (continued)

	Frequency	Percent
Percentage of Trauma Caseload		
Less than 10%	2	3.4
10%	3	5.1
20%	2	3.4
30%	5	8.5
40%	8	13.6
50%	11	18.6
60%	1	1.7
70%	11	18.6
80%	8	13.6
90%	5	8.5
100%	3	5.1

Note. $N = 59$

Instrumentation

Prospective participants who met initial inclusion criteria were directed to Qualtrics, a popular online survey software, using a link that contained the electronic informed consent (see Appendix D) and the Adverse Childhood Experiences Questionnaire (ACES; see Appendix E). Scores on the ACES determined further inclusion in this study. Participants who reported at least one childhood exposure to trauma were included in the current study and directed to continue responding to measures of childhood trauma, shame, supervisory working alliance, and VT.

The following measures were selected for each construct in consideration of empirical support and the current study's underlying theoretical framework (McCann & Pearlman, 1992;

Young et al., 2003). The Adverse Childhood Experiences Questionnaire (ACES; Felitti et al., 1998) was used to assess the presence of childhood trauma history (see Appendix E). The Early Trauma Inventory-Self Report Short Form (ETI-SR-SF; Bremner et al., 2007) was used to measure the severity of a mental health professional's personal childhood trauma history before 18 years of age (see Appendix F). The External and Internal Shame Scale (EISS; Ferreira et al., 2020) was utilized to measure the variable of shame (see Appendix G). The Supervisory Working Alliance-Supervisee Form (SWAI-SF; Efstation et al., 1990) was used to measure the variable of supervisory working alliance (see Appendix H). Lastly, the Trauma and Attachment Belief Scale (TABS; Pearlman, 2003) was used to measure the presence of VT among the sample (see Appendix I). Following the measures, participants completed a demographics questionnaire (see Appendix J). Additionally, all participants were presented with a debriefing form consisting of national support resources that are available to them if needed, an explanation of this study, and a page thanking them for their time (see Appendix K).

Measures

Adverse Childhood Experiences Questionnaire (ACES)

The Adverse Childhood Experiences Questionnaire (ACES Questionnaire; Felitti et al., 1998) is a 10-item self-report questionnaire used to assess the historical presence of 10 different types of childhood trauma. Five are personal: physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect. The remaining are in reference to other family members: parental substance dependence, parental domestic violence, parental incarceration, parental mental illness, and parental separation or divorce. For each item, participants are asked to respond with "yes" or "no" regarding the specific trauma listed. Higher scores on this scale

indicate exposure to a higher number of categories of adverse childhood experiences endured before the age of 18 (Felitti et al., 1998).

The ACES Questionnaire has demonstrated good concurrent validity with other measures including the Hopkins Symptom Checklist (HSCL; Parloff et al., 1954), the Perceived Stress Scale (PSS; Cohen, 1994), and the 36-Item Short Form Health Survey questionnaire (SF-36; Karatekin & Hill, 2019; McHorney et al., 1994). Convergent validity of the ACES was assessed with the Childhood Trauma Questionnaire-Short Form (CTQ-SF) and the Stressful Life Events Screening Questionnaire-Revised (SLESQ; Green et al., 2006) with correlations of .47 and .29 respectively. Internal consistency reliability coefficients ranged from. 71 to. 74 demonstrating fair internal consistency (Karatekin & Hill, 2019).

Demographics Questionnaire

The demographics questionnaire was created by the researcher specifically for this study. Demographic information was collected to provide data regarding research participants and was necessary for the determination of whether the individuals in this particular study were a representative sample of the target population for generalization purposes (Dobosh, 2017). This questionnaire asked participants to report their age, gender, ethnicity/race, years of experience in the counseling field, type of graduate-level counseling program, how often the individual is currently receiving supervision, the perceived portion of workload that involves trauma work, type of agency they are working for, previous trauma treatment, and region.

Early Trauma Inventory Self-Report-Short Form

The Early Trauma Inventory Self Report-Short Form (ETI-SR-SF; Bremner et al., 2007) is a retrospective self-report measure of childhood trauma before the age of 18. It was designed to assess the domains of physical abuse (i.e., physical contact, constraint or confinement, with

intent to hurt or injure emotional), emotional abuse (i.e., verbal communication with the intention of humiliating or degrading the victim), sexual abuse (i.e., unwanted sexual contact performed solely for the gratification of the perpetrator or to dominate or degrade the victim), and general traumatic experience (i.e., a range of stressful and traumatic events which can be mostly secondary to chance events). The ETI-SR-SF consists of 27 items with five physical abuse items, five emotional abuse items, six sexual abuse items, and eleven general trauma items. For each item, participants are asked to respond with "yes" or "no" regarding the specific trauma listed. Higher scores on this scale indicate higher severity of traumas. A global score is obtained by summing the total number of items endorsed out of 27. A domain score is obtained by summing the items endorsed within each respective domain of physical abuse, emotional abuse, sexual abuse, and general trauma. The ETI-SR-SF can be interpreted with a maximum of two missing items; if more than two items are missing, the total score cannot be interpreted. According to Bremner et al. (2007), cutoff scores for the division of abused versus non-abused individuals are as follows: physical abuse (≥ 3), emotional abuse (≥ 3), sexual abuse (≥ 1), general trauma (≥ 4), and the total ETI-SR-SF score (≥ 7).

In a study examining the psychometric properties of the ETI-SR-SF (Bremner et al., 2007), authors show that the ETI-SR-SF is a valid instrument for the measurement of childhood physical, emotional, sexual abuse, and general traumas. In their sample of 288 adults, domain scores for the shortlist correlated highly with the original list for general trauma (r = 0.91), physical (r = 0.94), emotional (r = 0.97), and sexual abuse (r = 0.97). Each domain for the short form demonstrated high internal consistency with Cronbach's alphas for general trauma (α = 0.70), physical (α = 0.75), emotional (α = 0.86), and sexual abuse (α = 0.87) trauma domains. The ET-SR-SF was able to discriminate patients with known associations with trauma from

comparison subjects. In a sample of 304 adults, the ETI-SR-SF demonstrated a good level of internal consistency with a Cronbach's alpha of 0.806 (Jeon et al., 2012). It also demonstrated good convergent validity with the Childhood Trauma Questionnaire-Short Form (CTQ; Bernstein & Fink, 1998; $r = 0.691$) and divergent validity with the Beck Depression Inventory (BDI; Beck et al., 1961; $r = 0.424$) and the Beck Anxiety Inventory (BAI; Beck et al., 1988; Jeon et al., 2012; $r = 0.397$). In a sample of 86 adolescents, the ETI-SR-SF demonstrated a good level of internal consistency with a Cronbach's alpha of 0.803 (Park, 2018). For this study, the ETI-SR-SF was used as a measure of childhood trauma among MHPs.

Trauma and Attachment Belief Scale (TABS)

The Trauma and Attachment Belief Scale (TABS; Pearlman, 2003) is an 84-item self-report questionnaire that measures an individual's beliefs about oneself, and others related to the five psychological needs (safety, intimacy, trust, control, and esteem) that are commonly altered by exposure to trauma (Pearlman, 2003). The TABS is the revised version of the Traumatic Stress Institute (TSI) Belief Scale and was designed for use with individuals who have experienced traumatic events. However, it has also been used by researchers to assess the effects of vicarious traumatization (Barros et al., 2020; Raunick et al., 2015; Sartor, 2016; Steiner, 2016; Way et al., 2007; Williams et al., 2012). In this current study, the TABS total score will be used to determine the presence of VT. Participants answer items on a six-point Likert-type scale ranging from 1 (*disagree strongly*) to 6 (*agree strongly*).

The TABS consists of 10 subscales. These subscales represent disruptions in beliefs about oneself and others related to the five psychological needs, including self-safety ("I believe I am safe"); other-safety ("I can't stop worrying about others' safety"); self-trust ("I don't trust my instincts"); other-trust ("trusting people is not smart"); self-esteem ('Tm not worth much");

other-esteem (I often think the worst of others"); self-intimacy ("I feel hollow inside when I am alone"); other-intimacy ("I don't feel much love from anyone"); self-control ("I feel like I can't control myself); and other-control ("I often feel people are trying to control me"). Higher subscale and total scores indicate a greater disruption in beliefs about safety, trust, esteem, intimacy, and control and are therefore associated with high levels of VT.

The TABS has been normed with adults aged 17 and older (Pearlman, 2003). The TABS total scale revealed a Cronbach alpha of .96 demonstrating strong internal consistency. Cronbach's alphas of .79 were found for the subscales. The TABS demonstrated test-retest reliability of .75 with its subscales test-retest liability ranging from .60 to .79. Construct validity of the TABS was supported through measurement of concurrent validity between the TABS and the Trauma Symptom Inventory (TSI; Briere, 1995), in which all TABS subscales were significantly correlated with TSI trauma symptom scales. Strong correlations were specifically found between the TABS self-oriented subscales and the TSI Impaired Self-Reference scale, with correlations ranging from .57 to .72 (Pearlman, 2003). For this study, the TABS was used as a measure of vicarious trauma among MHPs.

External and Internal Shame Scale (EISS)

The External and Internal Shame Scale (EISS; Ferreira et al., 2020) is an eight-item measure designed to assess the global shame experience in a single measure that evaluates the propensity to experience external and internal shame. Higher scores are indicative of higher levels of experienced shame. The EISS has two subscales consisting of four items each: external shame and internal shame. External shame is focused on the experience of the self as seen in a judgmental way by others, whereas internal shame is conceptualized as self-focused negative evaluations and feelings about the self (Ferreira et al., 2020). The EISS items were designed to

assess external and internal shame considering four core domains of shame including inferiority and inadequacy, exclusion, emptiness, and criticism (Ferreira et al., 2020). Participants answer items on a 5-point Likert-type scale ranging from (0 = *never* to 4 = *always*).

The EISS has demonstrated itself to have good psychometric properties. The EISS total scale revealed a Cronbach alpha of .89 demonstrating good internal consistency (Ferreira et al., 2020). Cronbach's alphas of .80 and .82 were found for the external shame subscale and the internal shame subscale, respectively. In a cross-national study included 1405 participants recruited in community samples of adults from Portuguese, French, Australian, Singaporean, and Japanese populations, who completed the EISS in four different languages, Cronbach's alphas ranged from .81 to .91 (Matos et al., 2021). Item-total correlations were all moderate to high, ranging from .55 to .75. Concurrent validity was assessed by calculating the zero-order and partial correlation coefficients between each of the two EISS subscales and the Other as Shamer Scale-2 (OAS-2; Matos et al., 2015), Forms of Self-Criticizing/Attacking and Self-Reassuring Scale (FSCRS; Gilbert et al., 2004) and the Depression, Anxiety and Stress Scale - 21 Items (DASS-21; Lovibond & Lovibond, 1995). The depression score was strongly correlated with the EISS global score and both subscales. When testing the partial correlations for each subscale, the partial correlations remained significant. Moreover, the ES and IS subscales showed to be positively and significantly correlated ($r = .76$; $p < .001$). The association between EISS global score, the ES and IS subscales, and the SR-FSCRS (self-reassurance) was calculated to address discriminant validity. Results on the partial correlation between the IS and the Self-Criticizing subscale of the FSCRS while controlling for the ES were strong and highly significant *(*$r = .56$; $p < .001$). Partial correlations between the IS and the Self-Reassuring subscale of the FSCRS while

controlling for the ES were moderate and highly significant (r = -.45; p < .001). For this study, the EISS was used as a measure of shame among MHPs.

Supervisory Working Alliance Inventory - Supervisee Form (SWAI-SF)

The Supervisory Working Alliance Inventory-Supervisee Form (SWAI; Efstation et al., 1990) is a 19-item questionnaire designed to measure the supervisee's perception of the quality of the supervisory relationship from responses to a seven-point, Likert-type scale ranging from 1 (*almost never*) to 7 (*almost always*). Higher scores on the measure indicate a stronger supervisory working alliance. A factor analysis of the SWAI-SF identified two subscales: (a) rapport and (b) client focus. Rapport refers to the supervisee's perception of support from the supervisor. Client focus refers to the supervisee's perception of the emphasis that their supervisor placed on promoting the supervisee's understanding of the client.

To demonstrate the internal consistency of the scale, Efstation et al. (1990) reported a Cronbach's alpha coefficient of .90 for the Rapport subscale and a Cronbach's alpha coefficient of .82 for the Client Focus subscale. Cronbach's alpha coefficients found in later studies range from .95 to .96 for the full scale indicating strong internal consistency (Ganske et al., 2015; Gunn & Pistole, 2012; McCarthy, 2013; Schultz et al., 2002).

Compared to other established measures of the supervisory working alliance, the SWAI-SF has demonstrated convergent and divergent validity. Adequate concurrent, convergent, and discriminant validity evidence was obtained from significant correlations of SWAI subscales with subscales of the Supervisory Styles Inventory (SSI; Friedlander & Ward, 1984) and the Personal Reactions Scale Revised (PRS-R: Efstation et al., 1990; Holloway & Wampold, 1984; Patton et al., 1992). The supervisee version of the Rapport and Client Focus scales of the SWAI-SF are significantly correlated with the Self-Efficacy Inventory (SEI; Friedlander & Snyder,

1983) at r = .22 and .15, respectively (Efstation et al., 1990). Correlations of the supervisee scales of the SWAI with the supervisee version of the Personal Reactions Scale Revised (PRS-R: Holloway & Wampold, 1984) were: rapport (r = .85, p < .001) and client focus, (r = .52, p < .001; Patton et al., 1992). For this study, the SWAI-SF was used as a measure of supervisory working alliance among MHPs.

Data Analysis Plan

This section presents the detailed analysis plan for preliminary analyses before hypotheses testing including (a) a descriptive analysis, (b) an examination of means and standard deviations, frequencies, and assumption testing, and (c) internal consistency reliability estimations for each measure. Additionally, assumptions were tested before all analyses including corrective action if assumptions are to be violated. The following chapter includes a comprehensive review of the data and analyses actually employed in the study.

Data Cleaning and Preliminary Analyses

Descriptive statistics including frequency tables were run for each measure to assess for errors (Pallant, 2020). If errors were caught, an attempt to correct the error was executed by referring to the original data set. If the information that is necessary to identify the case with the error could not be obtained, the value was then deleted, and SPSS treated it as a missing value.

Next, data cleaning was conducted before any analyses were completed. SPSS Version 29.0 was utilized to clean the data. The first important consideration is the pattern of missingness. This is largely due to the potential for discarding valuable information, losing power, and results of statistical analyses potentially being biased depending on the underlying mechanism that caused the missing data (van Ginkel et al., 2020). The three types of missing

mechanisms include missing completely at random (MCAR), missing at random (MAR), and not missing at random (NMAR).

The determination of the type of missing mechanism is important to influence how to handle the missing data (van Ginkel et al., 2020). A missing value analysis was run to determine the missing mechanism. One statistical advantage of data that are MCAR is that the analysis remains unbiased in the absence of the data (Kang, 2013). If the assumption of MCAR is satisfied, listwise deletion is an optimal method for handling missing data in social sciences research (Cook, 2021; Kang, 2013; Sterner, 2011; van Ginkel et al., 2020). It was determined that the cases with missing data were missing completely at random (MCAR) as determined by Little's MCAR test with significance being determined at the $p < .05$ level (van Ginkel et al., 2020). Missing completely at random (MCAR) can be determined if $p > .05$.

Once the missing data mechanism was determined, an evaluation of the percentage of missing values was conducted. The proportion of missing data has a direct relationship with the quality of statistical inferences (Dong & Peng, 2013). Dong and Peng (2013) also posit that there is no established cutoff regarding an acceptable percentage of missing data in a data set for making valid statistical inferences. However, Bennett (2001) maintained that statistical analysis is likely to be biased when more than 10% of data are missing. If the missing data mechanism is MCAR, listwise deletion involves removing all participant responses that had at least 10% of missing data points from the analyses to reduce bias and allow for valid statistical inferences (Cook, 2021). Participants with missing cases were removed from the total sample, and the resulting leftover sample can be interpreted still as representative of the population as the original sample is and will not give any biased results as a result of the absence of data (Kang, 2013; van Ginkel et al., 2020).

Additional data cleaning steps included analyses to determine if outliers were present within the data as both univariate and multivariate outliers can influence the outcome of statistical analyses. The problem with having outliers is that they can distort the results of data, for example, by altering the mean performance, increasing variability, and/or affecting the regression coefficients (Kwak & Kim, 2017). Therefore, detecting outliers is a growing concern. The planned outlier analyses included the following steps to evaluate cases that differ substantially from the main trend in the data. Box plots were produced to examine potential univariate outliers. If no asterisks appeared on either end of the box plots, this was interpreted as an indication that no univariate outliers are present in the current data set (Field, 2013). Another step in determining the impact that univariate outliers have on the model is by calculating standardized residuals (Field, 2013). Standardized residuals were calculated to identify any unusually high values larger than 3.29. Values exceeding 3.29 create cause for concern as a value this high is unlikely to occur in an average sample (Field, 2013). Additionally, if the sample has less than 96% of cases that have standardized residuals within +/- 2, then the model may be a poor representation of the data. If less than 99% of cases have standardized residuals within +/- 2.5, there is evidence to suggest that the level of error within the model may be unacceptable. If this sample is consistent indicating that this sample conforms to what is expected from a fairly accurate model, it was concluded that the level of error within the model is acceptable (Field, 2013).

Multivariate outliers were examined by calculating the Cook's and Mahalanobis distances before running a regression analysis. Cook's distance is a measure of the overall influence of a case on the model (Field, 2013). Mahalanobis distances were used to measure the distance of individual cases from the means of each predictor variable and the covariance ratio

was identified for each case to determine whether it had a significant influence on the variance of the regression parameters (Field, 2013). If no Cook's distances were greater than 1, it suggested that no cases within this sample have an undue influence on the model (Field, 2013). When examining the Mahalanobis distances, if no values were above 15, it was suggested that no multivariate outliers are present among the current sample.

Research Questions, Hypotheses, and Analyses

The following research questions and hypotheses were created to address these research questions:

Q1 Among MHPs who have a personal childhood trauma history, does shame help to explain the relationship between personal childhood trauma history and VT?

H1 For those MHPs who have a personal childhood trauma history, shame (as measured by the EISS) will significantly mediate the relationship between personal childhood trauma history (as measured by the ETI-SR-SF) and vicarious traumatization (as measured by the TABS).

To test the overall fit of the model, multiple linear regression was used to test for the first hypothesis. The outcome variable of interest was VT as measured by the TABS full scale. The predictor variable of interest was the presence of personal childhood trauma history as measured by the ETI-SR-SF. The mediator variable was shame as measured by the EISS full scale. First, the total effect of personal childhood trauma history was tested on VT. To establish the mediation, the effect of personal childhood trauma history was tested on shame. Then, an analysis was conducted to confirm if shame predicted VT while controlling for personal childhood trauma history.

Multiple linear regression analysis requires five key assumptions: (a) linearity, (b) normality, (c) little to no multicollinearity, (d) homoscedasticity, and (e) independence (Field, 2013). The first assumption of linearity emphasizes that the outcome variable, VT, must be

linearly related to the predictor variables: personal childhood trauma history, shame, and supervisory working alliance. A linear model must be present to interpret the data and draw conclusions. To test the linearity assumption, scatterplots were examined for linearity within these relationships (Field, 2013).

To test for the second assumption of normality, the Kolmogorov-Smirnov (K-S) statistic and the Shapiro-Wilk (S-W) statistic were reviewed for significance. If the statistics showed non-significance, it was concluded that the assumption of normality was met, and the analyses of the Pearson correlations and the statistically testable assumptions were reported within a correlational matrix.

The third assumption of little to no multicollinearity was tested by visually examining scatterplots to ensure that there is no perfect linear relationship between any of the predictor variables (Field, 2013). If this assumption was violated, confidence intervals and significance tests that were produced through analyses would again be invalid and would therefore negatively impact conclusions about the relationships between the variables. To meet this assumption, weighted least squares were used to weight each case for each predictor by its variance (Field, 2013).

The fourth assumption of independence asserts that residual terms for any two observations should be uncorrelated. If this assumption was not met, confidence intervals and significance tests were invalid, making it so conclusions could be drawn from the data. To test this assumption, the Durbin-Watson statistic can be examined which tests for serial correlations between errors (Field, 2013). If this statistic were between one and three, it was determined that the assumption of independence was met.

Lastly, the fifth assumption of homoscedasticity ensures that the residuals at each level of the predictors (childhood trauma, shame, and supervisory working alliance) all have the same variance. If this assumption is violated, confidence intervals and significance tests produced through analyses will again be invalid and will therefore negatively impact conclusions about relationships between the variables. To meet this assumption, weighted least squares were used to weight each case for each predictor by its variance (Field, 2013).

PROCESS macro v.4.2 by A. F. Hayes (2013) was used. PROCESS is an extension available for SPSS and is designed to estimate both indirect and direct effects in single mediation models (A. F. Hayes, 2013). In the PROCESS macro extension, different model templates help the researcher to test the desired mediation relationships (Stride et al., 2015). This macro was used to test the current study's first hypothesis, for those MHPs who have a personal childhood trauma history, shame will significantly mediate the relationship between personal childhood trauma history and VT. Significance was determined at the $p < .05$ level within this model. Given that only one mediator is proposed in this model, Model 4 was used to run a simple mediation analysis along with a bootstrap test to determine the significance of the indirect effect that shame has on this relationship. VT was entered as the outcome (Y) variable, childhood trauma was entered as the predictor (X) variable, and shame was entered as the mediator (M) variable.

Q2 Among those MHPs who have a personal childhood trauma history, how does the supervisory working alliance impact the relationship between personal childhood trauma history and VT?

H2 For those MHPs who have a personal trauma history, the supervisory working alliance (as measured by the SWAI-SF) will significantly moderate the relationship between personal childhood trauma history (as measured by the ETI-SR-SF) and vicarious traumatization (as measured by the TABS). It is hypothesized that as the supervisory working alliance increases, the impacts of childhood trauma on vicarious traumatization will decrease.

To test the overall fit of the model, multiple linear regression was used to test for the second hypothesis. The outcome variable of interest was VT as measured by the TABS. The predictor variable of interest was the severity of personal childhood trauma history as measured by the ETI-SR-SF. The moderator variable was the supervisory working alliance as measured by the SWAI-SF. First, the total effect of personal childhood trauma history was tested on VT. To establish moderation, the effect of personal childhood trauma history was tested on the supervisory working alliance.

PROCESS macro v.4.2 by A. F. Hayes (2013) was used. In the PROCESS macro extension, different model templates help the researcher test the desired moderation relationships (Stride et al., 2015). This macro was used to test the current study's second hypothesis, for those MHPs who have a personal childhood trauma history, the supervisory working alliance will significantly moderate the relationship between personal childhood trauma history and vicarious traumatization. Significance was determined at the $p < .05$ level within this model. Model 1 of the PROCESS macro is used when only one variable is examined as a moderator. Model 1 was used to assess the moderating effect of the supervisory working alliance on the relationship between childhood trauma and vicarious traumatization. VT was entered as the outcome (Y) variable, childhood trauma was entered as the predictor (X) variable, and the supervisory working alliance was entered as the moderator (M) variable.

Summary

This chapter described the methods of this study. To explore the relationships between personal childhood trauma history, shame, the supervisory working alliance, and vicarious traumatization, early career mental health professionals were recruited from across the U.S. Participants completed online measures of childhood trauma, external and internal shame, supervisory working alliance, and VT. Personal childhood trauma history was measured by the

experiences of physical, sexual, emotional abuse, and general trauma before the age of 18 using the ETI-SR-SF (Bremner et al., 2007). The presence of external and internal shame was measured with the EISS (Ferreira et al., 2020). Vicarious traumatization was measured using the TABS (Pearlman, 2003). The supervisory working alliance was measured using the SWAI-SF (Efstation et al., 1990).

This study hypothesized that for those MHPs who have a personal childhood trauma history, shame would mediate the relationship between personal childhood trauma history and VT. Lastly, this study hypothesized that for those MHPs who have a personal trauma history, the supervisory working alliance would moderate the relationship between personal childhood trauma history and VT. These hypotheses were tested with multiple linear regression, and with tests of moderation and mediation. The results for each of these hypotheses are discussed in Chapter IV along with a depiction of participant demographics and a descriptive analysis for each measure used.

CHAPTER IV

RESULTS

This chapter provides the results of statistical analyses performed to address the research questions for the current study and test the hypotheses. The first section of this chapter describes preliminary analyses. The second section provides the descriptive and reliability statistics for each variable. The third section describes the statistical analyses performed to answer each of the research questions.

Preliminary Analyses

Screening Criteria

The ACES Questionnaire (Felitti et al., 1998) was used in the current study as a screening measure for the presence of childhood trauma history in an early career mental health professional's life before the age of 18. A total of 89 participants completed the ACES Questionnaire. After consenting to the study, participants who did not report at least one type of exposure to childhood trauma were screened out of the study and directed to the debriefing statement (Appendix K). Frequencies were calculated to identify the participants who scored a 0 on the ACES Questionnaire (Felitti et al., 1998). These statistics can be found in Table 3. A total of 20 participants were screened out due to their scoring a 0 on the ACES Questionnaire, leaving 69 participants for the remaining analyses.

Table 3

Frequency Analysis for the Adverse Childhood Experiences Questionnaire (ACES)

Total Score	Frequency	Percent
0	20	22.47
1	13	14.61
2	13	14.61
3	12	13.48
4	11	12.36
5	8	8.99
6	8	8.99
7	4	4.49
8	0	0
9	0	0
10	0	0

Note. $N = 89$

Data Cleaning

Data cleaning was conducted among the remaining 69 participants using SPSS Version 29.0. Descriptive statistics were run to assess for errors (Pallant, 2020). No errors were found within the data set. Data cleaning was conducted before any analyses were completed using the 69 participants who remained after removing those screened-out participants. An important consideration is the pattern of missingness. This is largely due to the potential for discarding valuable information, losing power, and results of statistical analyses potentially being biased depending on the underlying mechanism that caused the missing data (van Ginkel et al., 2020).

The three types of missing mechanisms include missing completely at random (MCAR), missing at random (MAR), and not missing at random (NMAR). The determination of the type of missing mechanism is important to influence how to handle the missing data (van Ginkel et al., 2020). A missing value analysis was run to determine the missing mechanism. One statistical advantage of data that are MCAR is that the analysis remains unbiased in the absence of the data (Kang, 2013). If the assumption of MCAR is satisfied, listwise deletion is an optimal method for handling missing data in social sciences research (Cook, 2021; Kang, 2013; Sterner, 2011; van Ginkel et al., 2020). The proportion of missing data has a direct relationship with the quality of statistical inferences (Dong & Peng, 2013). Dong and Peng (2013) also posit that there is no established cutoff regarding an acceptable percentage of missing data in a data set for making valid statistical inferences. However, Bennett (2001) maintained that a statistical analysis is likely to be biased when more than 10% of data are missing.

Six participants were unable to complete the survey and had survey responses with more than 10% of data missing from their responses. The missing data analysis revealed that an additional 11 cases were missing across four participants' responses. Within the Early Trauma Inventory (ETI), one case was missing from the following items: "Did you experience the divorce or separation of your parents?" and "Were you often ignored or made to feel that you didn't count?" Within the External and Internal Shame Scale (EISS), one case was missing from the following item: "Other people are judgmental and critical of me." Within the Supervisory Working Alliance Inventory (SWAI), one case was missing from the following item: "My supervisor's style is to carefully and systematically consider the material I bring to supervision." Within the Trauma and Attachment Belief Scale (TABS), one case was missing from each of the following items: "People are wonderful," "If I need them, people will come through for me," "I

feel like I can't control myself," "I am often in conflicts with other people," "I have problems with self-control," and "I can make good decisions." It was determined that the cases with missing data were missing completely at random (MCAR) as determined by Little's MCAR test ($p > .05$; van Ginkel et al., 2020).

Once the missing data mechanism was determined, an evaluation of the percentage of missing values was conducted. Given the MCAR mechanism, six participants that had more than 10% of missing data points were removed from the analyses to reduce bias and allow for valid statistical inferences ($n = 6$; Cook, 2021). Listwise deletion was used to address item non-responses by removing all data for a case that had one or more missing values ($n = 4$). Complete data without any missing values are needed for many kinds of calculations (e.g., regression and correlation analyses; Nahhas, 2023). This ensures that the descriptive statistics for all variables are based on the same sample as each other and that the same sample is used when fitting the regression model (Nahhas, 2023). As a total of 10 participants were removed from the total sample; the resulting leftover sample ($N = 59$) still could be interpreted as representative of the population as the original sample was and would not give any biased results as a result of the absence of data (Kang, 2013; van Ginkel et al., 2020).

Additional data cleaning steps included analyses to determine if outliers were present within the data as both univariate and multivariate outliers can influence the outcome of statistical analyses. The problem with having outliers is that they can distort the results of data, for example, by altering the mean performance, increasing variability, and/or affecting the regression coefficients (Kwak & Kim, 2017). Therefore, detecting outliers is a growing concern. The outlier analyses included the following steps to evaluate cases that differ substantially from the main trend in the data. Box plots were produced to examine potential univariate outliers. No

asterisks appeared on either end of the box plots therefore this was interpreted as an indication that no univariate outliers were present in the current data set (Field, 2013).

Another step in determining the impact that univariate outliers have on the model is by calculating standardized residuals (Field, 2013). Standardized residuals were calculated to identify any unusually high values larger than 3.29. In a normally distributed sample, 95% of *z*-scores should fall between – 1.96 and + 1.96, Additionally, 99% of *z*-scores should fall between -2.58 and +2.58, and 99.9% of *z*-scores should fall between - 3.29 and + 3.29 (Field, 2013). Values exceeding 3.29 create cause for concern as a value this high is unlikely to occur in an average sample (Field, 2013). Additionally, if the sample has less than 96% of cases that have standardized residuals within +/- 2, then the model may be a poor representation of the data. If less than 99% of cases have standardized residuals within +/- 2.5, there is evidence to suggest that the level of error within the model may be unacceptable. Results of the standardized residual calculations indicated that no values exceeded 3.29. Additionally, 96% of cases had standardized residuals within +/- 2, and 100% of cases had standardized residuals within +/- 2.5. This sample conformed to what was expected from a normally distributed model; thus, it was concluded that the level of error within the model was acceptable (Field, 2013).

Multivariate outliers were examined by calculating the Cook's and Mahalanobis distances before running a regression analysis. Cook's distance is a measure of the overall influence of a case on the model (Field, 2013). Mahalanobis distances were used to measure the distance of individual cases from the means of each predictor variable and the covariance ratio was identified for each case to determine whether it had a significant influence on the variance of the regression parameters (Field, 2013). There were no Cook's distances greater than 1, suggesting that no cases within this sample had an undue influence on the model (Field, 2013).

In examining the Mahalanobis distances, no values were above 15, suggesting that no multivariate outliers were present among the current sample. Overall, it was evident the data set did not have any influential cases that could significantly alter regression coefficients if removed, so it was determined that the regression model was stable across the model.

Descriptive Statistics and Reliability Analyses for the Measures

Descriptive statistics for all measures were calculated and analyzed to identify the mean, standard deviation, skewness, and the minimum and maximum of the total scores for each variable: personal childhood trauma, shame, supervisory working alliance, and VT. These statistics can be found in Table 4. Skewness was considered acceptable if it fell within a range of +/- 1.5 (Field, 2013). No significant floor or ceiling effects were observed. Reliability analyses were also calculated for all measures. To estimate internal consistency, Cronbach's alpha was used. All Cronbach's alpha values were above .7, indicating the high overall reliability of the questionnaires used in the current study (Field, 2013). The results of these analyses can be found in the following sections.

Table 4

Means, Standard Deviations, Skewness, and the Min/Max of All Variables

	M	*SD*	Skewness	Min.	Max.	Cronbach's α
Childhood Trauma	8.75	4.86	.24	0	20	.80
Shame	15.05	4.89	-.04	2	25	.83
SWA	103.49	16.72	-.64	47	132	.93
Vicarious Trauma	234.61	49.80	.26	134	371	.96

Note. $N = 59$; SWA = Supervisory Working Alliance

**Early Trauma Inventory Self Report-
Short Form (ETI-SR-SF)**

The Early Trauma Inventory Self Report-Short Form (ETI-SR-SF; Bremner et al., 2007) was used in the current study to measure an early career MHP's childhood trauma history before the age of 18. The ETI-SR-SF consists of 27 items with five physical abuse items, five emotional abuse items, six sexual abuse items, and eleven general trauma items. Higher total scores on this scale indicate higher severity of traumas. A global score is obtained by summing the total number of items endorsed out of 27. The ETI-SR-SF total score was used to represent the personal childhood trauma variable. The ETI-SR-SF total score is the sum of the total number of items endorsed. The total score represents the level of severity of trauma across the general, physical punishment, emotional abuse, and sexual events domains. The ETI-SR-SF total score was used to better understand how the combination of different types of traumas can impact the development of VT.

A summary of the scores for the sample (N = 59) is presented below in Table 5. Within this sample, the total ETI-SR-SF score demonstrated good internal consistency (α = .80) on this measure of childhood trauma, consistent with previous research examining the psychometric properties of the measure (Bremner et al., 2007; Jeon et al., 2012). All subscales met acceptable criteria for skewness (i.e., values were within +/- 1.5) and kurtosis (i.e., values were within +/- 3), indicating the mean scores were normally distributed.

Table 5

Descriptive Analysis for the Early Trauma Inventory Self Report-Short Form

	M	*SD*	Range	Skewness	Kurtosis	Cronbach's α
Total Score	8.75	4.86	0-20	.24	-.80	.80
General Trauma	3.08	1.79	0-7	.35	-.42	.47
Physical Punishment	1.66	1.43	0-5	.34	-1.11	.65
Emotional Abuse	2.39	1.73	0-5	.07	-1.19	.77
Sexual Events	1.61	1.96	0-6	.83	-.63	.85

Note. $N = 59$

Trauma and Attachment Belief Scale (TABS)

The Trauma and Attachment Belief Scale (TABS; Pearlman, 2003) is an 84-item self-report questionnaire that was used in the current study to assess the effects of vicarious trauma. The TABS measures an individual's beliefs about oneself, and others related to the five psychological needs (safety, intimacy, trust, control, and esteem) that are commonly altered by exposure to trauma (Pearlman, 2003). The TABS consists of 10 subscales. These subscales represent disruptions in beliefs about oneself and others related to the five psychological needs, including self-safety; other-safety; self-trust; other-trust; self-esteem; other-esteem; self-intimacy; other-intimacy; self-control; and other-control. Higher total scores indicate a greater disruption in beliefs about safety, trust, esteem, intimacy, and control and are therefore associated with high levels of VT. The total score of the TABS was used to represent the VT variable. The TABS total score provides an index of a participant's overall level of disruption across needs areas. For this current study, the total score was used to understand how the

combination of disruptions across beliefs about self and others differed across participant experiences and their personal childhood trauma histories.

A summary of the scores for the sample (N = 59) is presented below in Table 6. Within this sample, the total TABS score demonstrated good internal consistency (α = .93) on this measure of vicarious trauma, consistent with previous research examining the psychometric properties of the measure (Pearlman, 2003). All subscales met acceptable criteria for skewness (i.e., values were within +/- 1.5) and kurtosis (i.e., values were within +/- 3), indicating the mean scores were normally distributed.

Table 6

Descriptive Analysis for the Trauma and Attachment Belief Scale

	M	*SD*	Range	Skewness	Kurtosis	Cronbach's α
Total TABS	234.61	49.80	134-371	.26	-.35	.93
Self-Safety	36.39	10.30	19-66	.60	-.08	.90
Other-Safety	18.56	5.26	9-33	.59	.27	.67
Self-Trust	23.36	4.90	12-33	-.20	-.34	.74
Other-Trust	20.90	5.84	8-35	.28	-.14	.84
Self-Esteem	24.66	7.56	13-45	.65	.16	.90
Other-Esteem	22.78	4.75	15-32	.02	-1.03	.73
Self-Intimacy	22.56	5.36	13-40	.61	.82	.74
Other-Intimacy	22.58	7.30	10-44	.56	-.12	.88
Self-Control	26.66	6.26	12-38	-.23	-.60	.69
Other-Control	16.17	4.59	8-26	.00	-.80	.67

Note. N = 59

External and Internal Shame Scale

The External and Internal Shame Scale (EISS; Ferreira et al., 2020) is an eight-item measure designed to assess the global shame experience to evaluate the propensity to experience external and internal shame. Higher total scores are indicative of higher levels of experienced shame. The EISS has two subscales consisting of four items each: external shame and internal shame. The EISS total score was used to represent the shame variable. The EISS total score encompasses different aspects of one's complex experiences of shame and was used to better understand how shame can impact one's thoughts, feelings, and beliefs about themselves, others, and the world.

A summary of the scores for the sample (N = 59) is presented below in Table 7. Within this sample, the total EISS score demonstrated good internal consistency (α = .83), along with the external shame subscale (α = .70) and the internal shame subscale (α = .73), consistent with previous research examining the psychometric properties of the shame measure (Ferreira et al., 2020; Matos et al., 2021). All subscales met acceptable criteria for skewness (i.e., values were within +/- 1.5) and kurtosis (i.e., values were within +/- 3), indicating the mean scores were normally distributed.

Table 7

Descriptive Analysis for the External and Internal Shame Scale

	M	*SD*	Actual Range	Skewness	Kurtosis	Cronbach's α
Total Shame	15.05	4.89	2-25	-.04	.23	.83
External Shame	7.56	2.54	1-13	.22	.13	.70
Internal Shame	7.49	2.81	1-13	-.38	-.04	.73

Note. N = 59

Supervisory Working Alliance Inventory-Supervisee Form

The Supervisory Working Alliance Inventory-Supervisee Form (SWAI; Efstation et al., 1990) is a 19-item questionnaire designed to measure the supervisee's perception of the quality of the supervisory relationship. The SWAI-SF has two subscales consisting of 12 items and 7 items respectively: rapport and client focus. Higher total scores on the measure indicate a stronger supervisory working alliance. The SWAI-SF total score was used to represent the supervisory working alliance variable. The supervisory working alliance is comprised of three components (i.e., goals, tasks, and bonds) between the supervisor and supervisee. The SWAI-SF total score was used to reflect these components and a supervisee's overall perceptions of the quality of the overall relationship with their supervisors.

A summary of the scores for the sample (N = 59) is presented below in Table 8. Within this sample, the total SWAI-SF score demonstrated good internal consistency (α = .83), along with the rapport subscale (α = .93) and client focus subscale (α = .87), consistent with previous research examining the psychometric properties of the supervisory working alliance measure (Efstation et al., 1990; Ganske et al., 2015; Gunn & Pistole, 2012; McCarthy, 2013). All subscales met acceptable criteria for skewness (i.e., values were within +/- 1.5) and kurtosis (i.e., values were within +/- 3), indicating the mean scores were normally distributed.

Table 8

Descriptive Analysis for the Supervisory Working Alliance Inventory-Supervisee Form

	M	*SD*	Actual Range	Skewness	Kurtosis	Cronbach's α
Total SWAI	103.49	16.72	47-132	-.64	.98	.83
Rapport	67.86	11.26	28-84	-1.19	2.43	.93
Client Focus	35.63	7.45	19-49	-.19	-.40	.87

Note. $N = 59$; SWAI = Supervisory Working Alliance Inventory

Correlational Relationships Among Variables

A correlational analysis was run to determine relationships between variables. The correlation between childhood trauma and ACES was significant, positive, and of moderate strength ($r = .574$, $p < .001$). The correlation between shame and childhood trauma was significant, positive, and moderate ($r = .471$, $p < .001$). The correlation between VT and childhood trauma was significant, positive, and of moderate strength ($r = .535$, $p < .001$). The correlation between VT and shame was significant, positive, and of high strength ($r = .66$, $p < .001$). Correlations are presented below in Table 9.

Table 9

Correlations for Measure Total Scores

Measure	*M*	*SD*	1	2	3	4	5
ACES	3.44	1.86	--				
ETI-SR-SF	8.75	4.86	.57**	--			
EISS	15.05	4.89	.23	.47**	--		
SWAI	103.49	16.72	-.08	-.21	-.05	--	
TABS	234.61	49.80	.23	.54**	.66**	-.22	--

Note. $N = 59$. ACES = Adverse Childhood Experiences Questionnaire ; ETI-SR-SF = Early Trauma Inventory Self Report-Short Form; EISS = External and Internal Shame Scale; SWAI = Supervisory Working Alliance Inventory; TABS = Trauma and Attachment Belief Scale.

**Correlation is significant at the 0.01 level (2-tailed).

Statistical Analyses of the Research Questions and Hypotheses

All statistical analyses were conducted using SPSS Version 29.0. Mediation and moderation analyses were performed using an extension available for SPSS: PROCESS macro v4.2 (A. F. Hayes, 2013). All analyses were tested at an $\alpha = .05$ level to decrease the risk of a Type 1 error. An α level of .05 is a standard α level for behavioral research (Tabachnick & Fidell, 2007). Having an α of .05 allows researchers to have a lesser chance of incorrectly rejecting the null hypothesis, while also not having too small of an area where one would incorrectly accept the null hypothesis. Before each analysis, all assumptions were tested and are described below.

Main Analyses: Research Question 1 and Hypothesis 1

Q1 Among MHPs who have a personal childhood trauma history, does shame help to explain the relationship between personal childhood trauma history and VT?

H1 For those MHPs who have a personal childhood trauma history, shame (as measured by the EISS) will significantly mediate the relationship between personal childhood trauma history (as measured by the ETI-SR-SF) and vicarious traumatization (as measured by the TABS).

Mediation analysis requires several steps to run this type of analysis. First, multiple linear regression was conducted to test the overall fit of the model by examining if there is statistical significance between the predictor variables and the outcome variable. If there is no statistically significant relationship between the predictor variables and the outcome variable, then the regression equation would not accurately predict the outcome variable based on the predictor variables (Field, 2013). If statistical significance is absent, further mediation analysis is not necessary as no potential cause-and-effect relationship exists.

Multiple linear regression analysis requires five key assumptions: (a) linearity, (b) normality, (c) little to no multicollinearity, (d) homoscedasticity, and (e) independence (Field, 2013). The first assumption of linearity emphasizes that the outcome variable must be linearly related to the predictor variables. A linear model must be present to interpret the data and draw conclusions. To test the linearity assumption, scatterplots need to be examined for linearity within these relationships (Field, 2013). To test the overall fit of the model, assumption testing was conducted. To test the assumption of linearity, scatterplots were examined for linearity within the relationships of personal childhood trauma history, shame, and VT. It was determined that the scatterplots demonstrated a linear model, and it was concluded that this assumption was met. To test the assumption of normality, the Kolmogorov-Smirnov (K-S) statistic and the Shapiro-Wilk (S-W) statistic were reviewed for significance (Field, 2013). Neither the K-S nor S-W statistics demonstrated significance at ($p < .05$), and it was concluded that this assumption was met.

To test for the second assumption of normality, the Kolmogorov-Smirnov (K-S) statistic and the Shapiro-Wilk (S-W) statistic are reviewed for significance. If the statistics show non-significance, it is concluded that the assumption of normality is met, and the analyses of the Pearson correlations and the statistically testable assumptions can be reported within a correlational matrix.

The third assumption of little to no multicollinearity is tested by visually examining scatterplots to ensure that there is no perfect linear relationship between any of the predictor variables (Field, 2013). If this assumption is violated, confidence intervals and significance tests that would be produced through analyses would again be invalid and would therefore negatively impact conclusions about the relationships between the variables. To meet this assumption, weighted least squares can be used to weight each case for each predictor by its variance (Field, 2013). To test the assumption of multicollinearity, where more than two independent variables were associated, collinearity diagnostics were conducted by running the linear regression model. In reviewing the collinearity statistics, specifically the tolerance and variance inflation factor values, there were no tolerance values less than 0.1 or variance inflation factor values greater than 10, suggesting multicollinearity should not be a problem in the regression model (Field, 2013).

The fourth assumption of independence asserts that residual terms for any two observations should be uncorrelated. If this assumption is not met, confidence intervals and significance tests would be invalid, making it so conclusions could not be drawn from the data. To test this assumption, the Durbin-Watson statistic can be examined which tests for serial correlations between errors (Field, 2013). If this statistic were to be between one and three, it would be determined that the assumption of independence has been met. To test the assumption

of independence, the Durbin-Watson statistic was examined to look for serial correlations between errors (Field, 2013). Field (2013) suggests that test statistic values under 1 or over 3 are causes for concern and can lead to underestimates of the standard error and thinking that predictors are significant when they are not. The Durbin-Watson statistic value was 1.90 and it was determined the assumption of independence was met.

Lastly, the fifth assumption of homoscedasticity ensures that the residuals at each level of the predictors all have the same variance. If this assumption is violated, confidence intervals and significance tests produced through analyses would again be invalid and therefore negatively impact conclusions about relationships between the variables. To meet this assumption, weighted least squares can be used to weight each case for each predictor by its variance (Field, 2013). To test the assumption of homoscedasticity, a scatterplot of the residuals was examined for patterns and skewness by examining the distribution of points on the scatterplot (Field, 2013). The scatterplot did not have an obvious pattern and the points were equally distributed above and below zero on the X-axis, and to the left and right of zero on the Y-axis (Field, 2013).

If assumptions are met, PROCESS macro v.4.2 by A. F. Hayes (2013) can be used to estimate both the indirect and direct effects in single mediation models (A. F. Hayes, 2013). In the PROCESS macro extension, different model templates help the researcher to test the desired mediation relationships (Stride et al., 2015). In a simple mediation model with only one mediator, Model 4 can be used including a bootstrap test to determine the significance of the indirect effect that the mediator has on the relationship between independent and dependent variables and the direct effect between the predictor variable and outcome variable (Field, 2013). Bootstrapping resamples the original dataset with replacement thousands of times to create simulated datasets. Bootstrapping involves drawing random samples from the original dataset.

The resampling process creates many possible samples that a study could have drawn. The various combinations of values in the simulated samples collectively provide an estimate of the variability between random samples drawn from the same population. The range of these potential samples allows the procedure to construct bias-corrected and accelerated (BCa) confidence intervals and to perform hypothesis testing. Using BCa confidence intervals corrects for bias and skewness in the distribution of bootstrap estimates.

After determining the assumptions were met, multiple linear regression was used to test for H1. This first step was conducted to determine whether the independent variables of personal childhood trauma history and shame predicted the dependent variable of VT. To run this regression, linear regression was selected within SPSS and a standard multiple regression was calculated, meaning that the variance was explained by all variables at one time. VT was entered as the outcome variable and personal childhood trauma and shame were entered as the predictor variables. The regression equation with personal childhood trauma and shame as predictors of VT was significant ($F(2,56) = 127.90$, $p < .001$) with an R^2 of .487. Within the model, both personal childhood trauma and shame significantly predicted VT. Additionally, the results of this analysis showed that personal childhood trauma and shame accounted for 48.7% of the variation in VT within this model (see Table 10).

Table 10

Multiple Linear Regression Test for Hypothesis 1

Variable	*B*	SE B	Beta	*p*
Constant	127.90	14.03	--	< .001
	(98.41, 153.04)			
Childhood Trauma	2.94	1.12	.29	.014
	(.784, 5.147)			
Shame	5.38	1.18	.53	< .001
	(3.160, 7.791)			

Note. R^2 = .49. with 95% bias-corrected and accelerated confidence intervals reported in parentheses. Confidence intervals and standard errors based on 5,000 bootstrap samples.

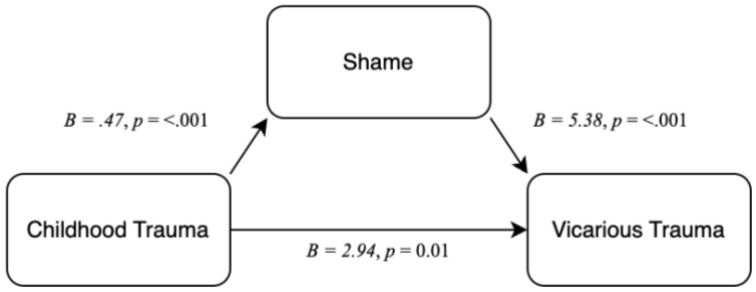
To test Hypothesis 1, a simple linear regression was conducted to test the significance of the total effect between personal childhood trauma history and VT. Personal childhood trauma history was entered as the independent variable and VT was entered as the dependent variable. The total effect of personal childhood trauma history was significant ($\beta = 5.487$, $p < .001$). PROCESS Macro v.4.2 by A. F. Hayes (2013) was used. Model 4 was used to test for simple mediation given that shame is the only mediator proposed in the model. To run this model, the PROCESS_v4.2 option was selected under the regression tab. Model number 4 was chosen from the drop-down menu and VT was entered as the Y variable, personal childhood trauma was entered as the X variable, and shame was entered as the mediator M variable. The default for the number of bootstrap samples is set to 5000 in SPSS.

The direct effect between personal childhood trauma history and shame was significant ($p = .0002$). The effect between personal childhood trauma history ($p = .0095$) and shame

($p < .001$) on the outcome VT was significant ($p < .001$). There was a significant indirect effect of childhood trauma on VT through shame, $B = 2.55$, BCa CI [1.14, 4.32]. The completely standardized indirect effect of childhood trauma on VT through shame represented a moderate effect, $k^2 = 0.25$, 95% Bca CI [0.12, 0.39]. Results of this simple mediation are presented in Figure 2, indicating a partial mediation and confirming the original hypothesis.

Figure 2

Model of Personal Childhood Trauma History as a Predictor Vicarious Trauma Mediated by Shame



Note. The confidence interval for the indirect effect is BCa bootstrapped CI based on 5000 samples.

Main Analyses: Research Question 2 and Hypothesis 2

Q2 Among those MHPs who have a personal childhood trauma history, how does the supervisory working alliance impact the relationship between personal childhood trauma history and VT?

H2 For those MHPs who have a personal trauma history, supervisory working alliance (as measured by the SWAI) will significantly moderate the relationship between personal childhood trauma history (as measured by the ETI-SR-SF) and vicarious traumatization (as measured by the TABS). It is hypothesized that as supervisory working alliance increases, the impacts of childhood trauma on vicarious traumatization will decrease.

Moderation analysis requires several steps. First, multiple linear regression is conducted to test the overall fit of the model by examining if there is statistical significance between the

predictor variables and the outcome variable. If there is no statistically significant relationship between the predictor variables and the outcome variable, the regression equation would not accurately predict the outcome variable based on the predictor variables (Field, 2013).

Multiple linear regression analysis requires five key assumptions: (a) linearity, (b) normality, (c) little to no multicollinearity, (d) homoscedasticity, and (e) independence (Field, 2013). The first assumption of linearity emphasizes that the outcome variable must be linearly related to the predictor variables. A linear model must be present to interpret the data and draw conclusions. To test the linearity assumption, scatterplots need to be examined for linearity within these relationships (Field, 2013). To test the assumption of linearity, scatterplots were examined for linearity within the relationships of personal childhood trauma history, supervisory working alliance, and VT. It was determined that the scatterplots demonstrated a linear model, and it was concluded that this assumption was met.

To test for the second assumption of normality, the Kolmogorov-Smirnov (K-S) statistic and the Shapiro-Wilk (S-W) statistic are reviewed for significance. If the statistics show non-significance, it is concluded that the assumption of normality is met, and the analyses of the Pearson correlations and the statistically testable assumptions can be reported within a correlational matrix. To test the assumption of normality, the Kolmogorov-Smirnov (K-S) statistic and the Shapiro-Wilk (S-W) statistic were reviewed for significance (Field, 2013). Neither the K-S nor S-W statistics demonstrated significance at ($p < .05$), and it was concluded that this assumption was met.

The third assumption of little to no multicollinearity is tested by visually examining scatterplots to ensure that there is no perfect linear relationship between any of the predictor variables (Field, 2013). If this assumption is violated, confidence intervals and significance tests

that would be produced through analyses would again be invalid and would therefore negatively impact conclusions about the relationships between the variables. To meet this assumption, weighted least squares can be used to weight each case for each predictor by its variance (Field, 2013). To test the assumption of multicollinearity, where more than two independent variables were associated, collinearity diagnostics were conducted by running the linear regression model. In reviewing the collinearity statistics, specifically the tolerance and variance inflation factor values, there were no tolerance values less than 0.1 or variance inflation factor values greater than 10, suggesting multicollinearity should not be a problem in the regression model (Field, 2013).

The fourth assumption of independence asserts that residual terms for any two observations should be uncorrelated. If this assumption is not met, confidence intervals and significance tests would be invalid, making it so conclusions could not be drawn from the data. To test this assumption, the Durbin-Watson statistic can be examined which tests for serial correlations between errors (Field, 2013). If this statistic were to be between one and three, it would be determined that the assumption of independence has been met. To test the assumption of independence, the Durbin-Watson statistic was examined to look for serial correlations between errors (Field, 2013). Field (2013) suggests that test statistic values under one or over three are causes for concern and can lead to underestimates of the standard error and thinking that predictors are significant when they are not. The Durbin-Watson statistic value was 2.08 and it was determined that the assumption of independence was met.

Lastly, the fifth assumption of homoscedasticity ensures that the residuals at each level of the predictors all have the same variance. If this assumption is violated, confidence intervals and significance tests produced through analyses would again be invalid and therefore negatively

impact conclusions about relationships between the variables. To meet this assumption, weighted least squares can be used to weight each case for each predictor by its variance (Field, 2013). To test the assumption of homoscedasticity, a scatterplot of the residuals was examined for patterns and skewness by examining the distribution of points on the scatterplot (Field, 2013). The scatterplot did not have an obvious pattern and the points were equally distributed above and below zero on the X-axis, and to the left and right of zero on the Y-axis (Field, 2013).

If assumptions are met, PROCESS macro v.4.2 by A. F. Hayes (2013) can be used to test the desired moderation relationships (Stride et al., 2015). Model 1 of the PROCESS macro is used when only one variable is examined as a moderator including a bootstrap test to determine the observed effect of the moderator on the relationship between independent and dependent variables (Field, 2013). Bootstrapping resamples the original dataset with replacement thousands of times to create simulated datasets. Bootstrapping involves drawing random samples from the original dataset. The resampling process creates many possible samples that a study could have drawn. The various combinations of values in the simulated samples collectively provide an estimate of the variability between random samples drawn from the same population. The range of these potential samples allows the procedure to construct bias-corrected and accelerated (BCa) confidence intervals and to perform hypothesis testing. Using BCa confidence intervals corrects for bias and skewness in the distribution of bootstrap estimates (Field, 2013).

To test H2, PROCESS Macro v.4.2 by A. F. Hayes (2013) was used again to run a moderation analysis using Model 1. Model 1 of the Hayes PROCESS macro is used when only one variable is examined as a moderator. To run this model, the PROCESS v.4.2 option was selected under the regression tab. Model number 1 was chosen from the drop-down menu with VT entered as the Y variable, childhood trauma entered as the X variable, and supervisory

working alliance entered as the moderator variable W. In the PROCESS Options window, “Only continuous variables that define products” was selected to mean center the continuous variables of personal childhood trauma history and supervisory working alliance. The option, “-SD, Mean, +SD,” was selected to generate simple slopes and test them for statistical significance. The regression equation with childhood trauma and supervisory working alliance as predictors of VT was significant ($F(3,55) = 8.18$, $p < .001$), with an R^2 of .31. Results of the moderation analysis can be found in Table 11, indicating that the supervisory working alliance did not moderate the relationship between childhood trauma and VT, which was inconsistent with the proposed hypothesis. H2 was not met.

Table 11

Linear Model of Predictors of Supervisory Working Alliance

Variable	*B*	SE *B*	Beta	*p*
Constant	235.62	5.65	41.69	< .001
	(224.30, 246.95)			
Childhood Trauma	5.55	1.22	4.54	< .001
	(3.09, 8.00)			
SWA	-.33	.34	-.97	.336
	(-1.00, .35)			
Interaction	.06	.07	.89	.379
	(-.06, .20)			

Note. $R^2 = .31$. SWA = Supervisory Working Alliance.

Post Hoc Analyses

Several post hoc analyses were conducted to further examine the data. These analyses were based on the variability in the demographic pool and to better understand how other personal and organizational factors may also influence the development of VT and/or recovery from their trauma experiences. Further questions of interest that were explored but that were not planned as the primary objective in this study included exploring for correlational relationships between participants' workplace agency, percentage of trauma caseload, their own previous trauma treatment, current engagement in outpatient counseling, vicarious trauma, shame, and the supervisory working alliance. Additionally, given that the supervisory working alliance was not significant in the moderation model, it was of interest to explore whether personal and organizational characteristics may be influencing the perceptions of the overall supervisory working alliance in early career MHPs.

Previous research on organizational factors found to predict VT include having a lack of preparation, orientation, training, and supervision in their professions; being newer employees with less experience at their jobs; type or content of the traumatic material; percentage of trauma clients on one's caseload; constant and intense exposure to trauma with little or no variation in work tasks; and a lack of an effective and supportive process for discussing traumatic content of the work (Cunningham, 2003; Dunkley & Whelan, 2006; Fama, 2003; Moulden & Firestone, 2007; Voss Horrell et al., 2011; Williams et al., 2012). Given the evidence to support that the percentage of trauma caseload can impact the development of VT, a correlational analysis was conducted between the percentage of trauma caseload and VT. The correlation between the participants' percentage of trauma on their caseloads and VT was not significant, positive, and of weaker strength (r = .16, p = .235). In addition to the percentage of trauma caseload, another

variable of interest used to explore its relationship with VT was the type of workplace agency as some agencies may have increased exposure to clients with trauma versus others (e.g., community health agency versus private practice). Two other variables of interest to explore were previous trauma treatment and current engagement in counseling due to the potential that individuals who have done their own work in counseling may be increasingly protected from developing VT.

The correlation between participants' type of agency worked for and VT was not significant, (r = -.05, p = .621). The correlation between participants' percentage of trauma on their caseloads and VT was not significant (r = .16, p = .235). The correlation between participants' previous trauma treatment and VT was not significant (r = .01, p = .933). The correlation between participants' current engagement in counseling and VT was not significant (r = -.12, p = .295). The correlation between participants' type of agency worked for and shame was not significant (r = -.04, p = .759). The correlation between participants' percentage of trauma on their caseloads and shame was not significant (r = .07, p = .579). The correlation between participants' previous trauma treatment and shame was not significant (r = -.23, p = .074). The correlation between participants' current engagement in counseling and shame was not significant (r = .03, p = .820). Overall, participants' workplace agency, percentage of trauma caseload, previous trauma treatment, and current engagement in counseling do not appear to have significant relationships with levels of shame, the supervisory working alliance, or VT. Correlations are presented in Table 12.

Table 12

Correlations for Participants' Workplace Agency, Percentage of Trauma Caseload, Previous Trauma Treatment, Current Engagement in Outpatient Counseling, Vicarious Trauma, Shame, and Supervisory Working Alliance

Variable	1	2	3	4	5	6
Workplace Agency	--					
Percentage of Trauma Caseload	-.03	--				
Previous Trauma Treatment	-.11	-.26*	--			
Engaged in Counseling	.02	.01	.34**	--		
Vicarious Trauma	-.05	.16	.01	-.12	--	
Shame	-.04	.07	-.23	.03	.66**	--
Supervisory Working Alliance	-.00	-.15	-.01	.10	-.22	-.05

Note. $N = 59$

**Correlation is significant at the 0.05 level (2-tailed); **Correlation is significant at the 0.01 level (2-tailed).*

CHAPTER V

DISCUSSION

This chapter offers a discussion of the results within the context of existing literature focusing on vicarious traumatization (VT). First, a review of the study rationale and purpose is provided. Then, results are explored related to the demographic variables and each of the research questions. Lastly, clinical and theoretical implications of the current study's findings are discussed followed by limitations and future recommendations for research.

Study Rationale and Purpose

This study aimed to explore the impact that personal factors and organizational factors may have in the development of VT and to close critical gaps in the literature surrounding VT experienced by mental health professionals (MHPs). Personal factors that may lead to the development of VT include social isolation; avoiding one's feelings; withdrawing, assigning blame to others; and a lack of self-care and employment of coping strategies post-empathetic engagement with traumatic material (Harrison & Westwood, 2009; Himelstein et al., 2012; Jordan, 2010; Lee, 2017; Marmaras, 2000; Moulden & Firestone, 2007; Way et al., 2007; Williams et al., 2012). Organizational factors include inadequate preparation, training, and supervision, and exposure to trauma (Cunningham, 2003; Dunkley & Whelan, 2006; Fama, 2003; Moulden & Firestone, 2007; Voss Horrell et al., 2011; Williams et al., 2012). Among all of the factors that may impact the development of VT, a more salient one may be the previous traumatic life experiences and exposures had by MHPs (S. A. Adams & Riggs, 2008; Baird & Kracen, 2006; Dunkley & Whelan, 2006; Moosman, 2002; Sansbury et al., 2015; Sartor, 2016).

To date, researchers have been unable to gain consensus about how an MHP's personal childhood trauma history may connect to the development of VT. Some studies have found that MHPs with a history of personal trauma are at an increased risk for VT (S. A. Adams & Riggs, 2008; Baugerud et al., 2018; Brady, 2017; Bride et al., 2007; Dagan et al., 2016; Radey & Figley, 2007; Shannon et al., 2014). Other researchers have concluded that a personal history of trauma can serve as a protective factor for VT due to past developed coping skills and resilience (Knight, 2013; VanDeusen & Way, 2006). One problem contributing to the lack of consensus is that numerous terms (e.g., *compassion fatigue*, *burnout*, and *secondary traumatic stress*) have been used interchangeably due to overlapping characteristics and symptoms (Branson, 2019). Due to a lack of operationalized terms between concepts of VT and neighboring constructs, many research inconsistencies exist due to the use of incorrect terminology when designing and conducting research (Branson, 2019). Although various personal and organizational factors have been a point of discussion among researchers and their impact on the development of VT, to date, shame as a personal factor and the supervisory working alliance as an organizational factor have not been thoroughly examined quantitatively as potentially impactful in the development of VT.

Research studies show that a significant number of MHPs have experienced childhood trauma (Jaffe et al., 2003; Michalopoulos & Aparicio, 2012; Nikčević et al., 2007; VanDeusen & Way, 2006). This is important because MHPs may be motivated to help others due to their own experiences of trauma (Branson, 2019; Manson, 2019). It is of particular importance to better understand how an MHP's childhood trauma history can impact the development of VT since MHPs are exposed to traumatic material by hearing their clients' stories (Conchar & Repper, 2014; Michalopoulos & Aparicio, 2012). Vicarious trauma is associated with disruptions to one's

schema in five possible areas: safety, trust, esteem, intimacy, and control (McCann & Pearlman, 1992). Schemas associated with these needs are formed from early experiences and can influence perceptions of oneself, others, and the world (McCann & Pearlman, 1992). Engaging in empathic listening as an MHP to repeated stories of human suffering challenges deeply held beliefs, assumptions, and expectations (Evces, 2015), which can manifest as intrusive thoughts and images associated with intense emotions. MHPs with personal childhood trauma histories may experience pervasive feelings of shame in response to vicarious trauma.

Mental health professionals (MHPs) working with trauma clients are at risk of developing vicarious trauma (VT) which can be influenced by personal childhood trauma and experiences of shame (Hernandez-Wolfe et al., 2015; Pearlman & Saakvitne, 1995; Su & Stone, 2020). Shame has been linked to posttraumatic stress symptoms (PTSS; Dunmore et al., 2001; Feiring & Taska, 2005; López-Castro et al., 2019; Schumm et al., 2006; Taylor, 2015; Way et al., 2007). The study aimed to explore the mediational role of shame between childhood trauma and VT in early career mental health professionals.

Supervision plays an integral role in the development of early career MHPs. The supervisory working alliance (Bordin, 1983) consists of the mutual understanding of the goals, tasks, and emotional bond between supervisor and supervisee is a measure of the quality of the supervision relationship. Research suggests that a strong supervisory working alliance can lead to lower levels of VT and work-related distress (Dunkley & Whelan, 2006; Fama, 2003; Ladany et al., 1999; McCann & Pearlman, 1990; Sommer, 2008; Sterner, 2009; Taylor & Furlonger, 2011). The study aimed to explore the relationship between childhood trauma, the supervisory working alliance, and VT and how the supervisory working alliance may moderate the relationship between childhood trauma and the development of VT in early career MHPs.

Shame, Childhood Trauma History, and Vicarious Trauma

For Hypothesis 1 (H1), it was predicted that shame would mediate the relationship between an early career MHP's personal childhood trauma history and VT. This hypothesis was based on previous research supporting the relationship between shame and posttraumatic stress symptoms in addition to the crossover between posttraumatic stress symptoms and VT (Dunmore et al., 2001; Feiring & Taska, 2005; López-Castro et al., 2019; Schumm et al., 2006; Taylor, 2015). In the current study, it was found that shame did partially mediate the relationship between an early career MHP's childhood trauma history and the development of VT. Significant relationships including the direct effect between personal childhood trauma history and VT, and an indirect effect of childhood trauma on VT through shame were found.

There are many possibilities as to why there is a significant direct effect between personal childhood trauma history and VT. An early career MHP's personal childhood trauma can impact the development of VT because of the devastating effects that trauma can have on an individual's psychological and emotional well-being (Felitti et al., 1998; Teicher & Samson, 2016; Van der Kolk, 2015). Trauma can result in disruptions to neurodevelopment in the areas of pleasure, control, engagement, and trust (Van der Kolk, 2015). Other impacts of trauma result in heightened emotional sensitivity, depression, anxiety, stress, an adoption of health-risk behaviors, and social problems (Cicchetti et al., 1991; Felitti et al., 1998; Humphreys et al., 2020; Kascakova et al., 2020; Mergler et al., 2018; Moustafa et al., 2021). When an MHP who has experienced trauma hears about a client's experienced trauma, this can trigger memories and feelings related to personal trauma and may lead to re-traumatization (S. A. Adams & Riggs, 2008; Camerlengo, 2002; Dickes, 2001; Pearlman & Mac Ian, 1995; Radey & Figley, 2007; Schauben & Frazier, 1995; Shannon et al., 2014; Trippany et al., 2004; Young & Ahmad, 1999).

Furthermore, exposure to the trauma of others can trigger feelings of helplessness in witnessing clients' suffering, which can be particularly distressing for MHPs who have experienced their own trauma (Neumann & Gamble, 1995). As a result, it is important for early career MHPs who have experienced their own trauma to be aware of the potential development of VT and take active steps to protect their own emotional and psychological well-being when interacting with clients who have experienced trauma.

There are a few possible explanations for the significant indirect effect of childhood trauma on VT through shame. Researchers have found that shame plays a critical role in poor adjustment in adulthood as a result of childhood trauma (Dunmore et al., 2001; Feiring & Taska, 2005; López-Castro et al., 2019; Schumm et al., 2006; Taylor, 2015). First, as evidenced by previous literature, constructivist self-development theory (CSDT), and schema theory, an individual's development of a healthy sense of self begins in early childhood. If a child experiences abuse at a young age, this could elicit feelings of being a failure, being defective, being unworthy, and feeling unlovable (Beck et al., 2011; Dorahy & Clearwater, 2012; McCann & Pearlman, 1992; Ross et al., 2019; Su & Stone, 2020; Young et al., 2003).

Schema theory conceptualizes shame as one of the most powerful and dangerous early maladaptive schemas as the result of traumatic experiences in childhood (Young et al., 2003). Additionally, both CSDT and schema theory posit that early maladaptive schemas are dysfunctional to a significant degree and can be elaborated throughout one's lifetime including how an individual organizes information, shifts future experiences, and has the potential to play a role in the development of VT (McCann & Pearlman, 1992; Young et al., 2003). Negative self-appraisals such as shame fuel persistent negative beliefs and perceptions of the self as defective (Dunmore et al., 2001). When unchecked, shame motivates social withdrawal, avoidance, and

the maintenance of posttraumatic stress symptoms isolating the trauma survivor from the potentially buffering and reparative force of social connection (Dunmore et al., 2001; Feiring & Taska, 2005; Schumm et al., 2006; Taylor, 2015). MHPs working with clients who share stories of traumatic material are in danger of having interference and shifts in their feelings, cognitive schemas and worldview, memories, and sense of safety (Hernandez-Wolfe et al., 2015; Pearlman & Saakvitne, 1995). These changes and shifts are central to the development of VT (Hernandez-Wolfe et al., 2015; Pearlman & Saakvitne, 1995; Way et al., 2007).

One MHP characteristic that may influence the development of VT includes their meaning of traumatic life events (Pearlman & Mac Ian, 1995). Shame can be associated with threats to a sense of self, perceptions that the world is not as safe or predictable as one thought, and increased distrust in relationships with others (Taylor, 2015). When MHPs are exposed to trauma through their clients, the details in their stories may feed into an MHP's already more activated fear response and personal vulnerabilities (Taylor, 2015). When exploring client trauma, memories or disruptions in the self and relationships have the power to evoke an MHP's personal experience and pain. These disruptions can undermine an MHP's self-esteem and professional identity (Pearlman & Saakvitne, 1995). MHPs who have these disruptions may feel shame by acknowledging the pain or distress reactions from hearing trauma stories or their fear surrounding their ability to heal themselves after their own traumas (Pearlman & Saakvitne, 1995). MHPs experiencing high levels of distress may not know where to go for help or may be reluctant to acknowledge their need for help out of fear of judgment by others or being perceived as weak (Neumann & Gamble, 1995). Lastly, shame can result from feelings of being jaded, cynical, suspicious of other people's motives, and expecting the worst from people leading to disruptions in an MHP's personal and professional identity (McCann & Pearlman, 1990).

In the current study, it was found that shame partially rather than fully mediated the relationship between an early career MHP's childhood trauma history and the development of VT. This means that VT did not occur exclusively through shame and that shame was not necessary for VT to occur in the presence of childhood trauma. Given that there was a significant direct effect between personal childhood trauma history and VT and an indirect effect of childhood trauma on VT through shame, the criteria for a full mediation was not met. One explanation for this could be that while shame plays an important role in the development of VT, previous research has suggested that personal wellness, attachment style, resilience, and the presence of coping strategies may help buffer the development of VT (Dayal et al., 2015; Hernandez & Mendoza, 2011; Marmaras et al., 2003; Pearlman & Saakvitne, 1995; Williams et al., 2012). Individuals who engage in personal wellness and coping skills can help maintain hope, positivity, optimism, and improve one's physical, emotional, and mental health. Secondly, resilient individuals tend to have more adaptive strategies in managing stress, handling adversity, using problem solving, seeking social support, and overcoming obstacles that come from traumatic experiences (McCleary & Figley, 2017). Lastly, individuals with more secure attachment styles tend to have more adaptive coping strategies, greater senses of comfort and security towards those around them and are more likely to seek out and rely on the emotional support of others (Lahousen et al., 2019).

Supervisory Working Alliance, Childhood Trauma History, and Vicarious Trauma

For Hypothesis 2 (H2), it was anticipated that the supervisory working alliance would moderate the relationship between an early career MHP's personal childhood trauma history and VT. This hypothesis was based on previous research suggesting that clinical supervision could affect the relationship between an MHP's childhood trauma history and VT as it aids to help

MHPs to normalize their reactions to trauma work, avoid professional isolation, and promote greater self-awareness in their reactions to what is discussed in the therapy room (McCann & Pearlman, 1990; Sommer, 2008). In the current study, it was found that the supervisory working alliance did not moderate the relationship between an early career MHP's personal childhood trauma history and VT, meaning that the supervisory working alliance did not significantly weaken this relationship. Specifically, the supervisory working alliance did not significantly correlate with VT, indicating that there was no relationship between these two variables. Additionally, the supervisory working alliance did not significantly correlate with personal childhood trauma, also indicating that there was no relationship between these two variables.

Given the results of the current study indicated there was no relationship between supervisory working alliance and VT, this seems to contradict previous research suggesting that a strong supervisory working alliance could have an impact on VT and disrupt cognitive beliefs (Bober & Regehr, 2006; DelTosta et al., 2019; Dunkley & Whelan, 2006; Pearlman & Mac Ian, 1995; Williams et al., 2012). It is possible that these lack of relationships between the moderator and independent and dependent variables influenced the results of the moderation model. One potential explanation as to why the supervisory working alliance was not associated with VT could be due to differences in the goals and tasks agreed upon in supervision or a lack of understanding of VT by both the supervisor and supervisee. If the goals and tasks of supervision do not intentionally include discussion on VT, then time may be spent focusing on other clinical tasks thereby neglecting important supervision conversations. Additionally, if there is a lack of training on recognizing and discussing VT, the supervisory working alliance may be missing this component unintentionally and therefore have no relationship to VT as it goes unaddressed.

Another possible explanation for this surprising result may be due to supervisees not addressing their personal childhood trauma during supervision as it pertains to their work with clients. It has been suggested that this may be in part due to implicit and explicit messages picked up in their respective training programs that imply that therapists should not be reactive to their clients' challenges (Neumann & Gamble, 1995). Early career MHPs may also feel ashamed of their intense reactions to hearing trauma and may worry about the repercussions of sharing their experiences with supervisors such as being perceived as weak, facing stigma, or potentially losing their job (Neumann & Gamble, 1995). A supervisee who shares or resonates with a client's traumatic experience may also try to avoid discussing the experience because that client's issues trigger painful memories and reactivate the professional's own trauma reactions (Bicknell-Hentges & Lynch, 2009; Otgaar et al., 2018; Sexton, 1999; Substance Abuse and Mental Health Services Administration (SAMHSA, 2014; Trippany et al., 2004).

Post Hoc Analyses of Personal and Organizational Factors and Vicarious Trauma

Previous research has posited that an MHP's estimated proportion of one's caseload comprising time spent with trauma clients is significantly related to negative outcomes (e.g., VT, secondary traumatic stress, compassion fatigue, and burnout; Bride et al., 2004; Cieslak et al., 2014; Devilly et al., 2009; Tosone et al., 2012). Given the evidence to support that one's percentage of trauma caseload can negatively impact the development of VT, a correlational analysis was conducted between the percentage of trauma caseload and VT. There was no significant relationship between these variables. This contradicts previous research suggesting that the level of VT is impacted by an MHP's percentage of trauma caseload. One possible explanation for this could be that there were not enough participants in each percentage group to determine reliable between-group differences in comparing the development of VT. A larger

sample size can increase the likelihood of finding significant correlations (Field, 2013). Another possible explanation could be that it is unknown how often an MHP is seeing their clients with trauma or the percentage of sessions that are actually discussing trauma material versus other presenting concerns. For example, an MHP may have 80% of their clients hold a trauma history but may not see them for weekly sessions, therefore, reducing the amount that an MHP consistently hears their trauma stories. Additionally, a client's trauma may be just one piece of their concerns and sessions may allude to their previous trauma experiences but may not be the focus in addressing one's concerns.

Mental health agencies differ in the types of treatment offered and what populations they serve such as specializing in trauma treatment or offering a broader range of services. Agencies that focus specifically on trauma may have a higher proportion of clients who have experienced trauma and may therefore be more susceptible to developing VT. For example, agencies that serve sexual assault survivors, combat soldiers with PTSD, domestic violence survivors, and children in the foster care system may be more exposed to client trauma stories. The *National Mental Health Services Survey (N-MHSS): 2020* provides the percentage of agencies that offer specific services. When looking specifically at the differences in agencies who provide dedicated or exclusively designed programs for persons who have experienced trauma, 94% of certified community behavioral health clinics, 92% of Veterans Affairs medical centers, 49% of outpatient mental health facilities, 45% of general hospitals, and 39% of residential treatment centers offered these services (SAMHSA, 2021). Given the difference in the number of trauma services offered between agencies, it is possible that serving different populations can impact an MHP's exposure to trauma. In the current study, correlation analysis was conducted between the participants' type of agency worked for and VT. There was no significant relationship between

these variables. This finding suggests that despite varying degrees of trauma exposure across types of agencies and populations served, the type of agency does not affect the development of VT. There is evidence to support that certain types of traumas are on the rise across the United States (U.S.) including mass shootings, the COVID-19 pandemic, racial injustice, political polarization, and natural disasters which could be flooding many different types of agencies (Holingue et al., 2020; Lowe & Galea, 2017; Shi et al., 2022). The U.S. is facing an unprecedented national mental health crisis among people of all ages (The White House, 2022).

The *2022 COVID-19 Practitioner Impact Survey* found that practitioners reported that demand for anxiety and depression treatment remained elevated and the demand for treatment for trauma- and stressor-related disorders and substance use disorders increased. Additionally, this survey illuminated that 60% of practitioners reported that do not have openings for new clients, 46% reported they have been unable to meet the demand for treatment, and 72% have longer waitlists than before the pandemic. Additionally, 66% of providers reported seeing an increase in the severity of symptoms among patients in 2022 (APA, 2022). Given the apparent scarcity of resources available to clients, clients may be seeking whatever resources have openings to seek relief even though specific types of agencies may better suit their needs or have more specified treatments for their concerns. If clients are entering into any agency that is available regardless of presenting concern, it is possible that agencies that provide less specialized services in trauma treatment may be seeing more trauma clients. This could possibly explain why there was no significant relationship between the participants' type of agency worked for and VT given the apparent lack of availability of services in specialized agencies, therefore, exposing a broader range of employees to VT from different types of agencies.

Research suggests that the type of traumatic events that MHPs have encountered and how they address them may affect how they approach their work with clients who present with trauma material (Bicknell-Hentges & Lynch, 2009; Otgaar et al., 2018; Sexton, 1999; Substance Abuse and Mental Health Services Administration (SAMHSA, 2014; Trippany et al., 2004). Two variables of interest explored were an MHP's previous trauma treatment and current engagement in counseling. Therapy can serve many roles including assisting clients to work through their concerns, gain insight, achieve personal fulfillment, and transform their symptoms, self-perception, and experiences with their social environment (American Psychiatric Association, 2022b). Taking into consideration the benefits that therapy may have in influencing symptoms and beliefs about self, others, and the world, in the current study, correlation analysis was conducted between both previous trauma treatment and current engagement in counseling with VT. There were no significant relationships between past or current treatment with VT. This finding could suggest that personal therapy may not be the frontline defense in combating VT and MHPs may want to explore other options to reduce the potential of developing VT. This may be due to a variety of reasons. One potential explanation could be that an MHP's therapist is not trained or experienced in working with VT. If therapists have limited knowledge of VT, this could limit identifying and addressing the symptoms of VT (Fairburn & Cooper, 2011; Neumann & Gamble, 1995; Trippany et al., 2004).

Previous research shows that there is insufficient, formal coursework on trauma or vicarious trauma (Ciarlelglio, 2013; Foltz et al., 2023). One explanation posited was that few APA-accredited require the completion of coursework in trauma-informed care and the overall heavy course degree requirements in counseling programs place a heavy burden on student schedules leaving limited space for elective courses (Foltz et al., 2023). Secondly, if an MHP

continues to have ongoing exposure to traumatic client stories', therapy may serve to provide temporary relief from symptoms but may take longer to create long-term lasting relief from VT (Figley, 1995; Pearlman & Mac Ian, 1995; Stamm, 2010). If MHPs are continuously exposed to trauma without reprieve from traumatic content, a more immediate goal for therapy may be focused on minimizing stress, providing coping strategies, and providing emotional support. A longer-term goal would be to address the complex issues surrounding VT, modifying an MHP's ways of thinking and acting, making connections to past events, and processing feelings of past events. If MHPs who are engaging in therapy are more focused on short-term goals for therapy (e.g., coping and symptom management) given that they continue to see clients with trauma on an ongoing basis, they may not be seeing as much of a benefit in therapy specifically regarding processing and managing the development of VT. This may be a possible explanation as to why there was no significant relationship between MHP engagement in treatment and VT.

It should be noted that the above results were based on post hoc analyses and therefore should be interpreted cautiously until future researchers can confirm the results of these analyses. Post hoc analyses may suffer from a lack of statistical power to detect true effects, which can lead to false negatives or Type II errors (Field, 2013). Additionally, exploratory analyses may require larger sample sizes than confirmatory analyses to obtain meaningful results (Field, 2013).

Implications

Theoretically, the findings of this current study supported both constructivist self-development theory (McCann & Pearlman, 1992) and schema theory's (Young et al., 2003) conceptualization of shame as a result of early trauma experiences as shame was found to partially mediate the relationship between personal childhood trauma and VT. This provided further evidence to support the process that poor adjustment in adulthood first involved

experiencing a traumatic and/or emotionally distressing event, which challenged cognitions and beliefs about the self, others, and the world creating early maladaptive schemas in five possible areas: safety, trust, esteem, intimacy, and control (McCann & Pearlman, 1992), Changes to cognitive schemas are central to the development of VT as schemas relate to psychological needs, disruptions, and memory (Hernandez-Wolfe et al., 2015; Pearlman & Saakvitne, 1995; Way et al., 2007).

The results of this study offer up some important clinical implications for MHPs treating clients with trauma material. Specifically, the results of the current study showed that in this sample of early career MHPs, personal childhood trauma had an impact on the development of VT both directly and indirectly through shame. This information might help early career MHPs better understand the significant impact that their personal childhood trauma histories may have on both personal and professional well-being. According to the APA's (2017) Multicultural Guidelines, Guideline 8 dictates that psychologists must be aware of "how developmental stages and life transitions intersect with the larger biosociocultural context, how identity evolves as a function of such intersections, and how these different socialization and maturation experiences influence worldview and identity" (p. 76). Additionally, Guideline 2 emphasizes that psychologists must be increasingly aware of their own "attitudes and beliefs that can influence their perceptions of and interactions with others" (p. 47).

With respect to addressing shame on a personal level, early career MHPs should take a proactive role in managing their personal mental and emotional well-being (Posluns & Gall, 2020). Some potential ways to accomplish this would be to seek out supportive relationships or engage in therapy to identify one's sources of shame, make connections from past experiences to ongoing shame, develop self-compassion, challenge disrupted or maladaptive beliefs, and safely

explore feelings of shame without fear of stigma from others (Dolezal & Gibson, 2022; Gibson, 2019). Trauma-informed approaches have attempted to integrate an understanding of how traumatic experiences can impact mental and physical health, emotional well-being, and social outcomes (Dolezal & Gibson, 2022; Poole & Greaves, 2012). Using a trauma-informed approach allows clients to shift from “What is wrong with you?” to “What happened to you?” (Dolezal & Gibson, 2022). Narrative therapy has also been shown to address shame by clients reclaiming their past and projecting new emerging positive images of themselves (Snoek et al., 2021).

Training programs and clinical supervisors may want to strive to support early career MHPs to mitigate their shame experiences. This may be accomplished through acknowledging, respecting, supporting, and advocating for students/supervisees who come from adverse and marginalized backgrounds (APA, 2023). Faculty and supervisors need to educate themselves on the impacts that trauma, inequity, and marginalization may have on their students and their shame experiences. This education could help those to acknowledge and challenge potential biases or assumptions they may have in shame experiences and potential student readiness to help clients with their challenges. It may also be imperative for faculty and supervisors to foster a supportive and non-judging environment that encourages learning by normalizing mistakes and the need to do one’s own work and promoting self-compassion during trainee development (APA, 2023).

Given that formal coursework exploring trauma is limited across graduate programs (Ciarlelglio, 2013; Foltz et al., 2023), early career MHPs may not be aware of what vicarious trauma is, how to recognize it, and also how to address it if it happens. Training programs should more explicitly address how trauma can impact both personal and professional lives to better prepare their students in working with clients who share trauma stories (Lanier & Carney, 2019).

In recognizing the heavy course requirements in counseling programs (e.g., APA's Discipline Specific Knowledge requirements; Foltz et al., 2023), requiring trauma courses may place strain on students, training faculty need to then be proactive in providing VT educational content in other courses (e.g., practicum and ethics).

Additionally, training programs should adhere to and uphold the APA's (2023) guidelines set on *Equitable and Respectful Treatment of Students in Graduate Psychology Programs*. Guideline 1 dictates that psychology programs should aspire to support the "physical, psychological, and financial wellness of graduate students" (p. 6). Programs should also seek to "provide professional resources and support and to promote and protect the personal and interpersonal safety of graduate students within their program" (p. 6). One potential way that this could be addressed is by having faculty actively promote self-care, self-reflection, and personal well-being. If faculty could contribute to the education and encouragement of these practices, this may reduce an MHP's development of VT as it has been previously demonstrated that personal wellness and coping strategies may help buffer the development of VT (Dayal et al., 2015; Hernandez & Mendoza, 2011; Marmaras et al., 2003; Pearlman & Saakvitne, 1995; Williams et al., 2012). Additionally, faculty serve an important role as gatekeepers for the profession and for the safety of clients therefore establishing and promoting skills and competencies to maintain personal wellness should be a priority in training programs. Given the detrimental impacts that VT can have on a trainee both personally and professionally, it is imperative for faculty to create safe spaces for students to explore VT and to prepare students with the skills to be the best therapists for clients with trauma. Faculty need to place the safety and wellbeing of clients above all else while helping trainees learn how to be competent in delivering trauma treatment services. If a trainee is unable to provide quality services to clients,

faculty play an important role in providing accountability to students and clients to prevent further harm.

Additionally, clinical training faculty should foster compassion, trust, and acceptance in their relationships with their students to provide safe spaces for students to openly process their feelings, and experiences, and to seek help if needed. Lastly, training programs need to take a proactive stance in addressing systemic issues by recognizing the role that power and privilege can have within relationships with their students, providing adequate training and learning opportunities, and supplying sufficient resources for the overall wellness of their students. Power imbalances have been demonstrated to create a sense of powerlessness in individuals who hold less power, produce pathology, increase negativity in self-appraisal, and lower self-esteem (Dutton & Painter, 1993). All of these have the potential to impact how an MHP organizes information, shifts future experiences, and has the potential to play a role in the development of VT (McCann & Pearlman, 1992; Young et al., 2003). Negative self-appraisals such as shame fuel persistent negative beliefs and perceptions of the self as defective (Dunmore et al., 2001).

Results of the current study showed that the supervisory working alliance did not modify the strength of the relationship between personal childhood trauma and VT. This has implications for better understanding how supervisees utilize supervision and to what extent supervisees feel comfortable disclosing their personal trauma and exploring their trauma reactions. It is possible that even if a supervisee views their relationship with their supervisor as trusting and safe, personality and social factors may prevent a supervisee from disclosing their personal trauma including challenges expressing emotions, cultural or societal norms, anxiety, perfectionism, wanting to be viewed more favorably by their supervisors, and wanting to focus more specifically on clients than personal experiences. It would be important to understand the

barriers that may prevent a supervisee from disclosing their trauma especially as it pertains to client work. If barriers to disclosing could be identified, this opens up the opportunity to better enhance supervision, improve supervisee senses of safety in sharing vulnerable topics, and potentially buffer the development of VT.

Additionally, it is important to also understand supervisor comfort in addressing supervisee trauma as this may impact how supervision is used. Just as supervisees may feel uncomfortable discussing trauma, the same could apply to supervisors. If a supervisor were to feel uncomfortable addressing trauma, this could have negative impacts on the supervisory relationship. Some of these impacts could include reducing the level of connection between a supervisor and supervisee, increased fear by supervisees that they are being judged, and leaving important clinical implications left unaddressed. If supervision could potentially be improved to address these concerns including discussions of transference and countertransference issues, this has the potential to improve an MHP's ability to help their clients and the quality of care that clients receive.

Study Limitations

The current study had multiple limitations. A major limitation in this study and any other study examining VT to date is the current lack of consensus for the field to operationally define VT and differentiate it from neighboring constructs (e.g., secondary traumatic stress, burnout, PTSD, and compassion fatigue). Due to a lack of operationalized terms between concepts of VT and neighboring constructs, many research inconsistencies exist due to the use of incorrect terminology when designing and conducting VT research (Branson, 2019). Additionally, the American Psychiatric Association (2022a) only offers specific criteria for posttraumatic stress disorder (PTSD) with one criterion that is "work-related" exposure to trauma in the 5th edition of

the *Diagnostic and statistical manual of mental disorders (DSM-5-TR)*. This study chose to operationalize VT based on the conceptualization set forth by McCann and Pearlman (1990). The lack of consensus made it difficult for this researcher to be consistent with other studies, as the definitions remain in flux and neighboring constructs have been mislabeled as VT.
More research must be done in the field to reach a consensus on the symptom criteria and measurement of VT. If the accepted definition or symptom criteria of VT changes, the findings of this study may need to be reassessed using the new definition and criteria of VT.

Secondly, the sample was small and predominantly comprised of White and female early-career MHPs, which made it difficult to generalize results to more diverse samples of early-career MHPs. An important note is that according to the APA's 2022 report on the "Demographics of the U.S. Psychology Workforce," 69% of the workforce identifies as female along with 80.85% identifying as White (APA, 2022). Although the results of this study might provide insight into the experiences of White, female early career MHPs, it remains possible that early career MHPs of different genders and racial and ethnic identities might have different experiences related to the development of VT that this study could not account for.

Third, this current study relied on the use of self-report measures addressing trauma experiences for data collection. Given that this study collected data through an anonymous online survey that utilized self-report measures, it was not possible to externally validate the responses, which left room for bias and potentially inaccurate or skewed responses (Northrup, 1997). Additional limitations of self-report measures include social desirability bias, memory bias, and interpretation bias (Chan, 2010). Self-report measures are more likely to be influenced by social desirability where individuals try to present themselves and their experiences in a more socially acceptable manner depending on the questions being asked (Northrup, 1997). Memory bias

involves participants potentially having difficulty recalling specific events or details accurately, especially if events happened a long time ago. Interpretation bias involves participants interpreting questions differently than intended leading to a misinterpretation of the construct being measured (Chan, 2010).

In consideration of measures utilized in the current study, the ACES Questionnaire (Felitti et al., 1998) may have presented some unique limitations as it only presents ten different types of childhood traumatic events and does not encompass other types of childhood trauma (e.g., bullying, low socioeconomic status, community violence, and sibling abuse) that could be included as an adverse childhood experience. Due to this, participants may have been screened out of the study despite experiencing early childhood trauma that was not captured on the ACES Questionnaire.

Lastly, this current study focused solely on the perceptions of the supervisory working alliance from the supervisee perspective. It is possible that supervisors may have not felt comfortable discussing trauma during supervision or held different views on the strength of the supervisory working alliance with their supervisees, which was unable to be captured in this study.

Future Research Recommendations

Considering present findings, multiple recommendations are made for future research. Given the limitations of self-report measures of childhood trauma (Anda et al., 2020; Hulme, 2004; Roy & Perry, 2004; Spinhoven et al., 2014), a study utilizing a clinical interview that can assess the severity, frequency, and duration of childhood traumatic events might help to capture an early career MHP's personal childhood trauma experience more accurately and fully. For example, two people who share the same self-reported trauma score may have vastly different

lifetime experiences, numbers of exposures, timings of exposures (e.g., trauma during sensitive developmental periods), positive experiences, or protective factors that affect the biology of stress (Anda et al., 2020). Additionally, a person with a lower score may have experienced intense, chronic, and unrelenting exposure to a single type of abuse, whereas another person who has experienced low-level exposure (e.g., intensity, frequency, and chronicity) to multiple adversities may have a higher score. Such different experiences of trauma need to be accounted for in similar studies.

Additionally, given the trajectory of professional development, a longitudinal study could measure shifts in VT as an MHP's time and experience in the field increases. Levels of VT may decrease as an MHP continues to gain competence, confidence, resilience, and expertise in working with trauma as their exposure and skills increase (Knight, 2013; VanDeusen & Way, 2006). For example, if an MHP has developed support including coping skills, social support, organizational support, and self-care routines, they may be more protected from the development and consequences of VT (Knight, 2013; VanDeusen & Way, 2006; Williams et al., 2012).

As discussed in the limitations of the current study, it is also recommended that the current study be replicated with a larger and more diverse sample to increase the potential for more generalizability of the results. The current study specifically focused on early-career MHPs from counseling master's and doctoral programs. Later career MHPs and MHPs from other graduate programs (e.g., social work, clinical psychology, and school psychology) may also be susceptible to the development of VT and can be greatly impacted by the long-term consequences that are associated with VT. Additionally, it would be beneficial to be increasingly specific and clear when discussing inclusion and exclusion criteria so that individuals feel that the study may apply to them and elect to take part in the study. One limitation in this study was

the use of language in the inclusion criteria surrounding the use of “counseling.” This may have impacted some psychologists from electing into this study as there is a differentiation between counseling and psychology. Future studies examining mental health professionals from various levels should clearly indicate who can participate in the study to ensure a diverse sample of mental health professionals.

It is recommended that future research further examine the construct of shame with VT. Further research may want to qualitatively explore the construct of shame to better understand the experiences of shame following traumatic experiences and how shame may continue to be perpetuated in response to (a) intrapersonal shame (i.e., any changes in self-concept), (b) interpersonal shame at the intimate level (i.e., any changes in personal relationships), and (c) interpersonal shame at an occupational and societal level (i.e., issues of loss, isolation, and exclusion; Taylor, 2015). Additionally, some other studies may want to look at how specific and targeted interventions to address experiences of shame influence one’s perception of themselves, others, and the world.

Lastly, as discussed in the limitations of the current study, it is also recommended that the current study be replicated including the perspectives that supervisors have on the supervisory working alliance and comfort in discussing trauma during supervision. This could help better capture the supervisory relationship between a supervisor and supervisee. This may also shed light on potential discrepancies that exist in the perceptions of the strength of the relationship between a supervisor and supervisee in addition to providing information on potential barriers that exist during supervision when discussing trauma.

Conclusion

This study aimed to explore the impact that personal factors and organizational factors may have in the development of VT and to close critical gaps in the literature surrounding VT experienced by MHPs. With the incidence of trauma in the U.S. continuing to be on the rise, MHPs inevitably are being exposed to more distressing stories of abuse, trauma, and disempowerment. Most MHPs will therefore work with trauma survivors at some point in their careers (Bride, 2004; Trippany et al., 2004).

The current study sought to determine the impact that an early career MHP's personal childhood trauma had on the development of VT. Additionally, the current study sought to address a gap in the literature by identifying a potential variable that might help explain the relationship between personal childhood trauma history and VT given the direct link between higher levels of shame and the development and maintenance of posttraumatic stress symptoms following exposure to trauma (Badour et al., 2020; Beck et al., 2011; Ginzburg et al., 2009; Leskela et al., 2002; Pineles et al., 2006; Street & Arias, 2001). The current study looked at the relationship between an early career MHP's personal childhood trauma and VT through a mediation model where shame was hypothesized to mediate between personal childhood trauma and VT. Lastly, the current study sought to determine if the supervisory working alliance impacted the relationship between personal childhood trauma history and VT using a moderation model where the supervisory working alliance was hypothesized to moderate between personal childhood trauma and VT. This current study was the first of its kind to attempt to integrate several factors (i.e., shame and the supervisory working alliance) to understand the relationship between an early career MHP's own childhood trauma history and the development of VT. Additional relationships were explored including the type of workplace agency worked for, the

percentage of trauma caseload, previous trauma treatment, and current engagement in counseling with VT post hoc.

The current study found that within a sample of early career MHPs living in the U.S., many were experiencing VT in response to their personal childhood trauma. Additionally, the results provided evidence that shame partially mediated the relationship between personal childhood trauma and VT. Results of the current study showed that the supervisory working alliance did not appear to have a significant impact on the strength of the relationship between personal childhood trauma and VT. Post hoc analyses revealed that correlational relationships were non-significant between the type of workplace agency worked for, the percentage of trauma caseload, previous trauma treatment, and current engagement in counseling with VT. This study opens the potential for further research examining these factors.

This study provides numerous implications for counseling MHPs who work with clients who discuss trauma. This study furthers prior research in defining and conceptualizing VT to combat consequences such as intra- and interpersonal difficulties (Butler et al., 2017; Jordan, 2010; McCann & Pearlman, 1990; McCormack & Adams, 2016; Trippany et al., 2004). It is hoped that the results of this study will continue to expand upon the field's understanding of VT, improve the experiences of early career MHPs, reduce the number of MHPs who leave the field, and improve the care that clients receive.

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APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL LETTER

UNIVERSITY OF
NORTHERN COLORADO

Institutional Review Board

Date:	03/16/2022
Principal Investigator:	Kady Barthelemy
Committee Action:	**IRB EXEMPT DETERMINATION – New Protocol**
Action Date:	03/16/2022
Protocol Number:	2202035899
Protocol Title:	Childhood Trauma History and Vicarious Traumatization in Early Career Mental Health Professionals: The Roles of Supervisory Working Alliance and Shame
Expiration Date:	

The University of Northern Colorado Institutional Review Board has reviewed your protocol and determined your project to be exempt under 45 CFR 46.104(d)(702) for research involving

Category 2 (2018): EDUCATIONAL TESTS, SURVEYS, INTERVIEWS, OR OBSERVATIONS OF PUBLIC BEHAVIOR. Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met: (i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects; (ii) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or (iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by 45 CFR 46.111(a)(7).

You may begin conducting your research as outlined in your protocol. Your study does not require further review from the IRB, unless changes need to be made to your approved protocol.

As the Principal Investigator (PI), you are still responsible for contacting the UNC IRB office if and when:

UNIVERSITY OF
NORTHERN COLORADO

Institutional Review Board

- You wish to deviate from the described protocol and would like to formally submit a modification request. Prior IRB approval must be obtained before any changes can be implemented (except to eliminate an immediate hazard to research participants).
- You make changes to the research personnel working on this study (add or drop research staff on this protocol).
- At the end of the study or before you leave The University of Northern Colorado and are no longer a student or employee, to request your protocol be closed. *You cannot continue to reference UNC on any documents (including the informed consent form) or conduct the study under the auspices of UNC if you are no longer a student/employee of this university.
- You have received or have been made aware of any complaints, problems, or adverse events that are related or possibly related to participation in the research.

If you have any questions, please contact the Research Compliance Manager, Nicole Morse, at 970-351-1910 or via e-mail at nicole.morse@unco.edu. Additional information concerning the requirements for the protection of human subjects may be found at the Office of Human Research Protection website - http://hhs.gov/ohrp/ and https://www.unco.edu/research/research-integrity-and-compliance/institutional-review-board/.

Sincerely,

Nicole Morse
Research Compliance Manager

University of Northern Colorado: FWA00000784

APPENDIX B

RECRUITMENT EMAIL

Dear Prospective Participant,

My name is Kady Barthelemy, and I am a Ph.D. student in Counseling Psychology at the University of Northern Colorado (UNC). I am conducting a research study with an examination of early career mental health professionals, their personal and professional experiences with trauma, and their experiences and perceptions of receiving clinical supervision. Participation in this study is completely voluntary and should you choose to participate, the survey will not ask any identifying information (e.g., name and address).

In order to participate in this study, you must meet the following criteria:

a) You are at least 18 years old and live in the United States
b) You have pursued a master's or doctoral level counseling program
c) You are post-graduation and within ten years of graduate degree completion
d) You are actively receiving clinical supervision at least once a month
e) You work with clients who discuss trauma

If you meet the above criteria and are interested in participating, please click on the link below. Those that choose to participate will be presented with the informed consent form followed by a brief childhood trauma screening measure to determine the presence of exposure to childhood trauma. You are also able to withdraw from the current study at any point in time by exiting the survey.

To participate, please follow this link:

https://unco.co1.qualtrics.com/jfe/form/SV_4U87fcyqdEdHTn0

Thank you so much for your time.

Best,
Kady Barthelemy, B. A.
Ph.D. Graduate Student
University of Northern Colorado
bart1207@bears.unco.edu

Lu Tian, Ph.D.
Dissertation Chair
University of Northern Colorado
lu.tian@unco.edu

APPENDIX C

INCLUSION CRITERIA

Please confirm that you meet the following criteria.

__ I am at least 18 years old and live in the United States

__ I have pursued a master's or doctoral level counseling program

__ I am post-graduation and within ten years of my degree completion

__ I am actively receiving clinical supervision at least once a month

__ I work with clients who discuss trauma

APPENDIX D

INFORMED CONSENT

Consent Form for Human Participants in Research
University of Northern Colorado

Project Title:	Childhood Trauma History and Vicarious Traumatization in Early Career Mental Health Professionals: The Roles of Supervisory Working Alliance and Shame
Researchers:	Kady Barthelemy, B.A., Doctoral Student in Counseling Psychology
Email:	bart1207@bears.unco.edu
Research Advisor:	Dr. Lu Tian, Ph.D., Applied Psychology and Counseling Education
Phone:	(970)351-2819
Email:	lu.tian@unco.edu

Purpose and Description: The purpose of this study is to better understand the ways that early career mental health professionals are impacted by personal and professional exposures to trauma. The researcher would like to invite you to participate in up to five survey questionnaires. In the first questionnaire, you will be asked about your exposure to childhood trauma before you turned 18. In the following questionnaires, you may be asked about the frequency of your exposures to trauma, your responses to various types of traumas and how these responses impact you today, and your experiences with receiving clinical supervision. Your honesty in completing these surveys is essential to ensure overall validity within the research project. If you agree to participate, the survey will be completed in your own time at a location of your choosing. It is expected that completion of this survey will take between 30-45 minutes depending how much time you spend on each question.

At the end of the survey, you will be directed to a click a link to a separate page if you wish to enter the drawing for one of five $20 Visa gift cards. Eligibility for one of the gift cards will be reserved for participants who meet initial screening criteria and completed the study. Email addresses will be stored in a separate database from the research data and your email address cannot be connected back to your survey responses.

Confidentiality: Participants are intended to remain confidential. Data cannot be traced back to the original source from numbered identifiers used in the data records. It is impossible to guarantee confidentiality and information submitted electronically or on a public forum cannot be considered secure. Participant consent forms and collected data will be destroyed 3 years after the conclusion of the study.

Risks and Benefits: It is possible that some participants may find answering questions about traumatic and stressful life events distressing or embarrassing. If you become upset or uncomfortable at any time and wish to discontinue the survey or simply choose not to answer a particular question, you are free to do so. The questionnaire will have prompts directing you towards resources that are available in the event you need additional support.

The research being conducted will not have a direct benefit to you as the participant. However, participation in research studies will be an important contribution to the proposed research questions for this study. This information has the potential to provide useful insight for educators and mental health professionals.

By selecting "I consent to participate in this study," you are acknowledging that:

Your participation in this study is voluntary. However, given the sensitive nature of the questionnaires, you may decide either skip questions or withdraw participation at any time. I will respect your decision and it will not result in a loss of confidentiality if you choose to withdraw or questionnaires are not completed. If you have further questions regarding the study or research methods, please feel free to contact the researcher. If you have any concerns about your selection or treatment as a research participant, please contact Nicole Morse, IRB Administrator, Office of Research, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-1910.

Having read the above document:

__ I consent to participate in the study

__ I do not consent to participate in the study

APPENDIX E

ADVERSE CHILDHOOD EXPERIENCES QUESTIONNAIRE (FELITTI ET AL., 1998)

ACEs Questionnaires:

The questionnaires are not copyrighted, and there are no fees for their use. If you include the ACE Study questionnaires in your research, a copy of the subsequent article(s) is requested (send to dvpinquiries@cdc.gov).

Taken from:

Centers for Disease Control and Prevention. (2022, April). *Adverse childhood experiences resources*. https://www.cdc.gov/violenceprevention/aces/resources.html#print

Adverse Childhood Experiences (ACES) Questionnaire

Purpose: Identify and tally types of abuse, neglect, or household dysfunction participant has experienced within their childhood.

Directions: Select “yes” or “no” for the following questions. There are no right or wrong answers.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often ...
   Swear at you, insult you, put you down, or humiliate you? **or**
   Act in a way that made you afraid that you might be physically hurt?
   Yes No

2. Did a parent or other adult in the household often ...
   Push, grab, slap, or throw something at you? **or**
   Ever hit you so hard that you had marks or were injured?
   Yes No

3. Did an adult or person at least 5 years older than you ever...
   Touch or fondle you or have you touch their body in a sexual way? **or**
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No

4. Did you often feel that ...
   No one in your family loved you or thought you were important or special? **or**
   Your family didn’t look out for each other, feel close to each other, or support each ther?
   Yes No

5. Did you often feel that ...
   You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? **or**
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it.
   Yes No

6. Were your parents ever separated or divorced?
   Yes No

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her? **or**
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? **or**
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No

10. Did a household member go to prison?
   Yes No

APPENDIX F

EARLY TRAUMA INVENTORY SELF REPORT-SHORT FORM (ETI-SR-SF) (BREMNER ET AL., 2007)

Mapi Research Trust

SPECIAL TERMS No78144

These User License Agreement Special Terms (Special Terms) are issued between Mapi Research Trust ("MRT") and Kady Barthelemy (User).

These Special Terms are in addition to any and all previous Special Terms under the User License Agreement General Terms.

These Special Terms include the terms and conditions of the User License Agreement General Terms, which are hereby incorporated by this reference as though the same was set forth in its entirety and shall be effective as of the Special Terms Effective Date set forth herein.

All capitalized terms which are not defined herein shall have the same meanings as set forth in the User License Agreement General Terms.

These Special Terms, including all attachments and the User License Agreement General Terms contain the entire understanding of the Parties with respect to the subject matter herein and supersedes all previous agreements and undertakings with respect thereto. If the terms and conditions of these Special Terms or any attachment conflict with the terms and conditions of the User License Agreement General Terms, the terms and conditions of the User License Agreement General Terms will control, unless these Special Terms specifically acknowledge the conflict and expressly states that the conflicting term or provision found in these Special Terms control for these Special Terms only. These Special Terms may be modified only by written agreement signed by the Parties.

1. User information

User name	Kady Barthelemy
Category of User	Student
User address	501 20th St, Greeley, 80639, United States
User VAT number	
User email	bart1207@bears.unco.edu
User phone	7608144798
Billing information	501 20th St, Greeley, 80639, United States

2. General information

Effective Date	Date of acceptance of these Special Terms by the User : 03 Nov 2022
Expiration Date (Term)	Upon completion of the Stated Purpose
Name of User's contact in charge of the request	Kady Barthelemy

3. Identification of the COA

Name of the COA	ETI-SR-SF - Early Trauma Inventory Self Report - Short Form
Author	Bremner JD, Bolus R, Mayer EA
Copyright Holder	J.Douglas Bremner
Copyright notice	ETI-SR-SF © J.Douglas Bremner, MD 2007 - not for use without permission
Bibliographic reference	Bremner JD, Bolus R, Mayer EA. Psychometric properties of the Early Trauma Inventory-Self Report. J Nerv Ment Dis. 2007 Mar;195(3):211-8 (Full text article)
Module(s)/version(s) needed	• ETI-SR-SF

4. Context of use of the COA

The User undertakes to use the COA solely in the context of the Stated Purpose as defined hereafter.

4.1 Stated Purpose

Other project

Title	Childhood Trauma History and Vicarious Traumatization in Early Career Mental Health Professionals: The Roles of Supervisory Working Alliance and Shame
Disease or condition	
Planned Term*	Start: 12/2022 End: 04/2023
Description (including format or media)	Doctoral dissertation with quantitative methods examining childhood trauma history and vicarious traumatization in early career mental health professionals.

4.2 Country and languages

MRT grants the License to use the COA on the following countries and in the languages indicated in the table below:

Version/Module	**Language**	**For use in the following country**
ETI-SR-SF	English	the USA

The User understands that the countries indicated above are provided for information purposes. The User may use the COA in other countries than the ones indicated above.

5. Specific requirements for the COA

- The Copyright Holder of the COA has granted ICON LS exclusive rights to translate the COA in the context of commercial studies or any project funded by for-profit entities. ICON LS is the only organization authorized to perform linguistic validation/translation work on the COA.
- In case the User wants to use an e-Version of the COA, the User shall send the Screenshots of the original version of the COA to MRT or ICON LS for review and approval. The Screenshots review may incur additional fees.
- In case the User wants to use an e-Version of the COA, ICON LS shall update (if needed) and populate the COA translations into the User's or IT Company's system and the User shall send the Screenshots of the translations of the COA to ICON LS for approval. The update (if needed), population of translations and the Screenshots review may incur additional fees.

Early Trauma Inventory
Self Report-Short Form (ETI-SR-SF) ©

Participant Name or ID:_____ DOB:_____ Age:____ Assessment Date:_____

Part 1. General Traumas. Before the age of 18

1. Were you ever exposed to a life-threatening natural disaster?	YES	NO
2. Were you involved in a serious accident?	YES	NO
3. Did you ever suffer a serious personal injury or illness?	YES	NO
4. Did you ever experience the death or serious illness of a parent or a primary caretaker?	YES	NO
5. Did you experience the divorce or separation of your parents?	YES	NO
6. Did you experience the death or serious injury of a sibling?	YES	NO
7. Did you ever experience the death or serious injury of a friend?	YES	NO
8. Did you ever witness violence towards others, including family members?	YES	NO
9. Did anyone in your family ever suffer from mental or psychiatric illness or have a a "breakdown"?	YES	NO
10. Did your parents or primary caretaker have a problem with alcoholism or drug abuse?	YES	NO
11. Did you ever see someone murdered?	YES	NO

Part 2. Physical Punishment. Before the age of 18

1. Were you ever slapped in the face with an open hand?	YES	NO
2. Were you ever burned with hot water, a cigarette or something else?	YES	NO
3. Were you ever punched or kicked?	YES	NO
4. Were you ever hit with an object that was thrown at you?	YES	NO
5. Were you ever pushed or shoved?	YES	NO

Part 3. Emotional Abuse. Before the age of 18

1. Were you often put down or ridiculed?	YES	NO
2. Were you often ignored or made to feel that you didn't count?	YES	NO
3. Were you often told you were no good?	YES	NO
4. Most of the time were you treated in a cold, uncaring way or made to feel like you were not loved?	YES	NO
5. Did your parents or caretakers often fail to understand you or your needs?	YES	NO

Part 4. Sexual Events. Before the age of 18

1. Were you ever touched in an intimate or private part of your body (e.g. breast, thighs, genitals) in a way that surprised you or made you feel uncomfortable?	YES	NO
2. Did you ever experience someone rubbing their genitals against you?	YES	NO
3. Were you ever forced or coerced to touch another person in an intimate or private part of their body?	YES	NO
4. Did anyone ever have genital sex with you against your will?	YES	NO
5. Were you ever forced or coerced to perform oral sex on someone against your will?.	YES	NO
6. Were you ever forced or coerced to kiss someone in a sexual rather than an affectionate way?	YES	NO

If you responded "YES" for any of the above events, answer the following for the one that has had the greatest impact on your life. In answering consider how you felt <u>at the time of the event</u>.

1. Did you experience emotions of intense fear, horror or helplessness?	YES	NO
2. Did you feel out-of-your-body or as if you were in a dream?	YES	NO

ETI-SR-SF – United States/English
ETI-SR-SF_AU1.1_eng-USori.docx

APPENDIX G

EXTERNAL AND INTERNAL SHAME SCALE (FERREIRA ET AL., 2020)

From: Ana Galhardo <anagalhardo@ismt.pt>
Date: Wednesday, January 13, 2021 at 12:15 AM
To: Barthelemy, Kady <Kady.Barthelemy@unco.edu>
Subject: [External]Re: Dissertation instrument

Dear Kady Barthelemy,

Thank you for your interest in using the EISS in your studies. Please find the scale and the paper as attachment files.

Good luck for your work!

Kind regards,
Ana Galhardo
Clinical Psychologist, PhD
Assistant Professor - ISMT, Coimbra
Associate Researcher - CINEICC, University of Coimbra, Portugal

www.ismt.pt
Largo da Cruz de Celas, nº 1
3000-132 Coimbra
Tel: (+351) 239 488 030
Fax: (+351) 239 488 031

EISS

(C. Ferreira, M. Moura-Ramos, M. Matos & A. Galhardo, 2020)

Below are a series of statements about feelings people may usually have, but that might be experienced by each person in a different way. Please read each statement carefully and circle the number that best indicates how often you feel what is described in each item.

Please use the following rating scale

0 = Never	1 = Rarely	2 = Sometimes	3 = Often	4 = Always

	In relation to several aspects of my life, I FEEL THAT:	0	1	2	3	4
1	other people see me as not being up to their standards	0	1	2	3	4
2	I am isolated	0	1	2	3	4
3	other people don't understand me	0	1	2	3	4
4	I am different and inferior to others	0	1	2	3	4
5	other people are judgmental and critical of me	0	1	2	3	4
6	other people see me as uninteresting	0	1	2	3	4
7	I am unworthy as a person	0	1	2	3	4
8	I am judgmental and critical of myself	0	1	2	3	4

APPENDIX H

SUPERVISORY WORKING ALLIANCE-SUPERVISEE FORM (EFSTATION ET AL., 1990)

PsycTESTS®

Supervisory Working Alliance Inventory

PsycTESTS Citation:
Efstation, J. F., Patton, M. J., & Kardash, C. M. (1990). Supervisory Working Alliance Inventory [Database record]. Retrieved from PsycTESTS. doi: https://dx.doi.org/10.1037/t02667-000

Instrument Type:
Inventory/Questionnaire

Test Format:
Both the Supervisor (23 items) and the Trainee version (19 items) of the Supervisory Working Alliance Inventory uses a 7-point Likert response format that is anchored from almost never (1) to almost always (7).

Source:
Efstation, James F., Patton, Michael J., & Kardash, CarolAnne M. (1990). Measuring the working alliance in counselor supervision. Journal of Counseling Psychology, Vol 37(3), 322-329. doi: https://dx.doi.org/10.1037/0022-0167.37.3.322

PsycTESTS®

doi: 10.1037/t02667-000

Supervisory Working Alliance Inventory
SWAI

Items

Supervisor's Version

1 . I help my trainee work within a specific treatment plan with his/her trainee.
2. I help my trainee stay on track during our meetings.
3. My style is to carefully and systematically consider the material that my trainee brings to supervision.
4. My trainee works with me on specific goals in the supervisory session.
5. In supervision, I expect my trainee to think about or reflect on my comments to him/her.
6. I teach my trainee through direct suggestion.
7. In supervision, I place a high priority on our understanding the client's perspective.
8. I encourage my trainee to take time to understand what the client is saying and doing.
9. When correcting my trainee's errors with a client, I offer alternative ways of intervening with that client.
10. I encourage my trainee to formulate his/her own interventions with his/her clients.
11.I encourage my trainee to talk about the work in ways that are comfortable for him/her.
12. I welcome my trainee's explanations about his/her client's behavior.
13. During supervision, my trainee talks more than I do.
14. I make an effort to understand my trainee.
15. I am tactful when commenting about my trainee's performance.
16. I facilitate my trainee's talking in our sessions.
17. In supervision, my trainee is more curious than anxious when discussing his/her difficulties with clients.
18. My trainee appears to be comfortable working with me.
19. My trainee understands client behavior and treatment technique similar to the way I do.
20. During supervision, my trainee seems able to stand back and reflect on what I am saying to him/her.
21. I stay in tune with my trainee during supervision.
22. My trainee identifies with me in the way he/she thinks and talks about his/her clients.
23. My trainee consistently implements suggestions made in supervision.

Trainee's Version

1 . I feel comfortable working with my supervisor.
2. My supervisor welcomes my explanations about the client's behavior.
3. My supervisor makes the effort to understand me.
4. My supervisor encourages me to talk about my work with clients in ways that are comfortable for me.
5. My supervisor is tactful when commenting about my performance.
6. My supervisor encourages me to formulate my own interventions with the client.
7. My supervisor helps me talk freely in our sessions.
8. My supervisor stays in tune with me during supervision.

PsycTESTS®

doi: 10.1037/t02667-000

Supervisory Working Alliance Inventory
SWAI

Items

9. I understand client behavior and treatment technique similar to the way my supervisor does.
10. I feel free to mention to my supervisor any troublesome feelings I might have about him/her.
11. My supervisor treats me like a colleague in our supervisory sessions.
12. In supervision, I am more curious than anxious when discussing my difficulties with clients.
13. In supervision, my supervisor places a high priority on our understanding the client's perspective.
14. My supervisor encourages me to take time to understand what the client is saying and doing.
15. My supervisor's style is to carefully and systematically consider the material I bring to supervision.
16. When correcting my errors with a client, my supervisor offers alternative ways of intervening with that client.
17. My supervisor helps me work within a specific treatment plan with my clients.
18. My supervisor helps me stay on track during our meetings.
19. I work with my supervisor on specific goals in the supervisory session.

APPENDIX I

TRAUMA AND ATTACHMENT BELIEF SCALE (PEARLMAN, 2003)

unlocking potential

Rights & Permissions

Certificate of Limited-use License

License #: CON643

Date: May 5, 2022

Principal Investigator's name and title: Kady Marie Barthelemy, B.A. and B.S., Doctoral Candidate

Name of the Assessment: Trauma and Attachment Belief Scale (TABS)

Permitted number of uses: 100 total uses

Description of the study:

"Childhood Trauma History and Vicarious Traumatization in Early Career Mental Health Professionals: The Roles of Supervisory Working Alliance and Shame."

Reference terms dated 28Apr'22.

Use of the Adult Test/Profile Form

Method of administration:

Administration via a secure, password-protected online environment with database-style scoring.

The required copyright notice that must be affixed in its entirety to each reprint/viewing of the assessment:

Albert Ayala

Digitally signed by Albert Ayala
DN: cn=Albert Ayala gn=Albert Ayala c=US United States l=US United States o=Western Psychological Services ou=Rights & Permissions
Reason: I am approving this document
Location:
Date: 2022-05-05 11:26-07:00

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APPENDIX J

DEMOGRAPHICS QUESTIONNAIRE

Demographics Questionnaire

Age: _____

Gender:

a) Female
b) Male
c) Transgender
d) Genderqueer/Genderfluid
e) Not listed here: _____

Ethnicity/Race:

a) African American, Black
b) Asian American, Pacific Islander, Asian
c) Caucasian, European American, European
d) Latino/a/x American, Hispanic, Chicano/a/x
e) Native American
f) Biracial/multiracial
g) Not listed here: _____

Graduate Major: _____

Program Level:

a) Master's
b) Ph.D. or Psy.D.

How many years have you been in the mental health field post-graduate degree? _____

Frequency of clinical supervision:

a) Weekly
b) Bi-weekly
c) Monthly
d) Not listed here: _____

What approximate percentage of your workload involves trauma work?

a) 10%
b) 20%
c) 30%
d) 40%
e) 50%
f) 60%
g) 70%
h) 80%
i) 90%
j) 100%

Type of Workplace Agency:

a) College/University
b) K-12 School
c) Community Mental Health
d) Private Practice
e) Medical Hospital
f) Psychiatric Hospital
g) Residential Treatment Center
h) Alcohol and Drug Rehabilitation Facility
i) Corrections Center
j) Not listed here: _____

Have you previously received trauma specific treatment related to your childhood trauma?

a) Yes
b) No

Are you currently engaged in outpatient counseling?

a) Yes
b) No

Region of Practice

a) West
b) Southwest
c) Midwest
d) Northeast
e) Southeast

APPENDIX K

DEBRIEFING STATEMENT

Thank you for your participation!

The purpose of this study is to better understand the antecedents that potentially may impact the severity and presence of vicarious traumatization symptoms and experiences in early career mental health professionals.

If you have any questions about the study or would like to be informed about the eventual results, please contact the principal investigator at bart1207@bears.unco.edu.

This is a sensitive topic, and some people may feel uncomfortable with these questions. If you are struggling with previous or current trauma and other non-related issues, please know that counseling is an option.

Below are resources and phone numbers for organizations that can provide information and referrals for these challenges.

National Suicide Prevention Lifeline
https://suicidepreventionlifeline.org/
1-800-273-TALK (8255) [24/7 hotline]
1-888-628-9454 (Spanish)
1-800-799-4889 (TTY)

National Child Abuse Hotline
https://childhelphotline.org/
1-800-422-4453

National Domestic Violence Hotline
https://www.thehotline.org/
1-800-799-7233
1-800-787-3224 (TTY)

National Sexual Assault Hotline
https://www.rainn.org/
1-800-656-4673 [24/7 hotline]

National Association for Children of Alcoholics
https://nacoa.org/
1-888-554-2627

Psychology Today
https://www.psychologytoday.com/us/therapists

Good Therapy
https://www.goodtherapy.org/find-therapist.html