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# Boundary Crossings and Violations: A Case Study on Trauma-Informed Supervision in Counseling

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**ABSTRACT**

Considering the frequency of client sexually inappropriate behavior experienced by mental health practitioners in the workplace, supervisors and training programs have a responsibility to employ an approach that is both proactive in preventing incidents, and sensitive to the adverse impacts following an event. Trauma-informed supervision (Borders et al., 2023; Kim et al., 2024) coupled with the principles of trauma-informed ethical decision making (Stark et al., 2022) show promise in addressing the unique contextual factors associated with these incidents and ensuring adherence to codes of ethics. This case study utilized a descriptive, linear analytic, single case design (Yin, 2014) to describe the events experienced by one counselor-in-training. Emergent themes and missed opportunities for trauma-informed supervision are also discussed.

**Keywords:** Trauma-informed supervision, counselor education, boundary crossing, boundary violation, counselor-in-training

Behavioral health professionals are exposed to numerous hazards, from supervision and administration related stressors to client microaggressions, and physical and sexual assault. Mental health occupations experience the second highest rate of workplace violence (21 per 1,000), with law enforcement experiencing the highest rate of violent crimes (48 per 1,000; United States Department of Justice, 2011). Prevalence rates of sexual violence and harassment towards health practitioners by clients/patients remain fragmented, with estimates often focusing on occurrence in in-patient and residential facilities (Barnett, 2020), and sexual violence and harassment of psychiatrists (Kavanagh & Waters, 2010),



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and psychologists (deMayo, 1997). Mental health workers (e.g., counselors, social workers, and paraprofessionals) also experience disproportionate rates of sexual violence and harassment by clients/patients, with as many as 48–67% (n = 901) experiencing nonverbal or verbal sexual harassment (Vaupel et al., 2024).

Higher acuity treatment settings see higher prevalence of sexual acting out by clients/patients towards providers, with these behaviors frequently associated with certain psychiatric symptoms (e.g., hypersexual behavior associated with manic states, inadvertent exposing of one's genitals during psychosis; Barnett, 2020). Sexual acting out of clients/patients includes a spectrum of behaviors, from receiving a "suggestive look" or making sexual or sexist remarks, to suggestively exposing body parts or touching the clinician in an inappropriate way (deMayo, 1997). Exposure to workplace sexual harassment is associated with a variety of negative effects, to include poor mental and physical wellbeing, symptoms of post-traumatic stress, decreased organizational commitment, and lower job satisfaction (Vincent-Hoper, 2020; Willness et al., 2007).

Considering the impact of client sexually inappropriate behavior experienced by mental health practitioners in the workplace, supervisors and training programs have a responsibility to employ an approach that is both proactive in preventing incidents, and sensitive to the adverse impacts following an event. Counselor education programs have received criticism for failing to provide adequate training regarding the occupational hazards of physical assault, and sexual harassment and assault by clients/patients (Ellison, 2019). Furthermore, there is a paucity of scholarship regarding training counselors to respond to client/patient sexual acting out, grooming, and harassment towards the clinician.

Trauma-informed supervision (Borders et al., 2023; Kim et al., 2024) coupled with the principles of trauma-informed ethical decision making (Stark et al., 2022) showed promise in addressing the unique contextual factors associated with these incidents and ensuring adherence to codes of ethics. This collaborative case study illustrates the application of core principles from trauma-informed ethical decision-making (Stark et al., 2022) and trauma-informed supervision (Borders et al., 2023; Kim et al., 2024) to a real-life series of events experienced by a counselor-in-training during their fieldwork. Case study accounts can expose ethical concerns regarding potential identifiability of persons described. To address this, masking strategies have been used to reduce the likelihood that persons described are identifiable. To further reduce identifiability a composite approach is used to disguise information regarding the persons described (Jerolmack & Murphy, 2019) by changing gender identities, as well as age and ethnic identifiers.

Although a complete application of these approaches is beyond the scope of this article, emerging themes coupled with core trauma-informed concepts shed light on the importance of trauma-informed supervision in counselor training. The case example described occurred over the course of 10 months, during which the client was provided out-patient counseling by the counselor-in-training (CIT). The authors have a special interest in the case, one as a counselor educator and mentor providing support for clinicians who experience sexually inappropriate behavior, and the other as a clinician who has experienced sexually inappropriate behaviors by a client. This case study contributes to existing research by providing an in-depth exploration of one CIT's experience of client-perpetrated grooming and sexual acting out, and failure of the student's university and on-site supervisory supports to provide a trauma-informed response.

## METHODS

### Collaborative Case Study

This case study utilized a descriptive, linear analytic, single case design (Yin, 2014) to describe the events experienced by one counselor-in-training. The researchers collaboratively created a case narrative following a linear timeline. Aspects of reflective practice informed this process, as researchers considered their internal processes while discussing the events, and the writing process (Preez, 2008). The case narrative was drafted in one file, edited using a file sharing platform that allowed collaborative editing. The CIT involved in this case study provided verbal permission for authors to review the artifacts used as data sources. They were also involved in initial formation of the timeline and narrative but asked not to be included as an author to remain anonymous. During construction of the case narrative, the researchers met on a regular basis to discuss analysis of case-related artifacts, which included email communications associated with the original incidents, and discussion with peers who had knowledge of the events when they occurred. Researchers then adjusted the narrative informed by this interactive process.

Following completion of the case narrative, the researchers completed three rounds of analysis. In line with Yin's (2014) approach, the coding process borrowed from grounded theory, e.g., initially using open coding, followed by axial, then selective coding (Corbin & Strauss, 2007; Glasser & Strauss, 1967). Each of the two researchers coded the narrative and artifacts independently, then utilized Atlas.ti's (Version 24; ATLAS.ti Scientific Software Development GmbH, 2024) Artificial Intelligence (AI) feature to code the case narrative. The researchers met to review the concepts and themes they and AI identified; this process enabled triangulation of researchers (Stark & Scroggins, 2023), thus contributing to the accuracy and trustworthiness of results (Carter et al., 2014). The write up of results follows a linear, descriptive format, describing the events chronologically while weaving in emergent themes and concepts. Where appropriate, elements of trauma-informed practice that may have been helpful, as well as existing literature that speaks to specific aspects of the case are also shared. Each section includes description of events, followed by core themes and relevant literature regarding client behavior, CIT response, and supervisor response.

## RESULTS

### The Case of Jane and Dave

When Jane (they/them) a non-binary CIT met their client Dave (he/him), they were 11 months into working with clients in her practicum and internship placement at an intensive outpatient program in a rural location, owned by the clinical director and supervisor, Jason (he/him). The rural intensive outpatient program supported clients with substance use disorders who fit the American Society for Addiction Medicine (ASAM) levels .5–2.1 criteria, generally individuals who were in recovery or who were stepping down from inpatient treatment (ASAM, 2023). Dave was the third client that Jane worked with at the program.

***Early Supervision Experiences with Supervisor Jason***

Jane's supervisor invited them and a female-identifying clinician to have triadic supervision at his house to discuss a therapy group Jane was starting. He explained that the supervision needed to be completed at his home because he was watching his children (three under 10 years old). Jane noticed feeling discomfort going to his home for supervision, but due to having another clinician present and their supervisor's assurance that it was a common practice in the field ("I used to meet my supervisor at her home all the time."), they decided to attend. When at their supervisor's house they noticed feeling uneasy and struggling to decide what to share about their clients and the topic of the group around his young children, who were present.

Prior to this experience, Jane remembered two occasions in which her supervisor asked them to do individual supervision at a restaurant. They attended and noticed feeling uncomfortable discussing supervision topics in a public space, especially as many people in the restaurant seemed to know their supervisor and came up to talk to him during their supervision time. In another previous instance, they described their supervisor being out of town and having individual supervision via phone call. Once on the phone call, they heard people in the background of their supervisor, and he disclosed he was walking through town and ordering a coffee.

**Session One – Month Three.** Dave, a 64-year-old cisgender, heterosexual man, was placed with Jane at the intensive outpatient program after completing an initial assessment with Licensed Addiction Counselor Jennifer, who was also the front office manager. As was customary with the client onboarding process, Jennifer completed the assessment with Dave, which included providing diagnoses. Jennifer diagnosed Dave with alcohol use disorder, moderate, in early remission and major depressive disorder. When they began their work together, Dave was six months into his recovery, which he defined as "total abstinence" from alcohol.

Jane and Dave initially focused on his goal of maintaining sobriety after sustaining severe injuries from an alcohol-related accident. Due to his injuries and his distance from the office, they agreed to telehealth sessions. At this time, Dave also had a male primary therapist who was supporting him in his non-substance related therapy goals. Jane and his primary therapist did not consult, as their supervisor Jason stated that this was not necessary since Dave had some time maintaining his sobriety. Jane received individual supervision once per week, as well as group supervision weekly. Entering month three, Dave maintained his sobriety through the holidays. He made comments in session about his appreciation for Jane, sharing sentiments such as, "You're a great therapist" and "Thank you for your work with me." Jane shared these statements with their supervisor, remembering feelings of pride and gratitude when receiving Dave's comments. Their supervisor affirmed the work they were doing with Dave to support his therapy goals.

***Themes: Counseling as a Social Microcosm & Assessing Felt Sense in Supervision.*** Interpreted individually, these client behaviors might be viewed as efforts to "people please," a pattern of behavior the client engages in outside of therapy, that is also present in the counseling space. Counseling is considered a microcosm in which clients often re-

enact behaviors they also engage in in the social context(s), and community (Neukrug & Hays, 2022). Dave may also have idealized Jane, having experienced their provision of non-judgement, empathy, and congruence as reflective of their skillfulness as a therapist. The idealization of the clinician, or 'putting them on a pedestal 'is not uncommon in counseling, particularly in the early stages (Slochower, 2011, 2014; Spera, 2015). Some clients misinterpret the core conditions of non-judgement and empathy as the counselor showing personal interest in their story, or having romantic feelings towards them (Robasco et al., 2023).

Utilizing a trauma-informed lens, the supervisor might have explored the intersections of identity for the client, CIT, and how these appeared in the counseling space. For instance, the supervisor may have asked Jane what it was like for them as a CIT to receive compliments from a client. Jane mentioned feelings of pride and gratitude, what physical sensations did they notice in the moment? How might these feelings have impacted how they responded to Dave during these sessions, and how they will respond in future sessions? Inquiring about supervisees" 'felt sense" or somatic experience during session is a critical component of trauma-informed supervision and provides important cues regarding supervisor's guidance regarding CIT's possible next steps (Borders et al., 2023). Assessing the space between the CIT and client and how client behaviors impact this space allows the supervisor to continually monitor changing dynamics over time.

**Months Four – Five.** In January, Dave changed jobs and continued his telehealth sessions with Jane. He experienced a recurrence in late January in which he bought and drank a bottle of liquor over a day's time. Dave's occurrence was Jane's first time supporting a client through a lapse and they sought supervision to support him. Jane's supervisor urged them to encourage Dave to join the facility's substance use recovery group. Jane reminded their supervisor that the client was living a significant distance from the office and that he was a telehealth client. He encouraged them to get Dave in Alcoholics Anonymous (AA) meetings.

In January, Jane observed Dave making occasional comments about their appearance. The comments included "Your hair looks nice today" and "That's a great sweater on you." They brought these comments to supervision for support, and inquired about the appropriateness of these comments and how to address them with Dave. Jason encouraged them to ask Dave, "Would you tell a man this?"

During January, Jason asked Jane if they wanted to have individual supervision at restaurants near the office, or at his home while he was caring for his children. Jason shared that when he was an intern, he frequently had supervision at his past supervisor's house. Jane remembered feeling uncomfortable with having individual supervision in public spaces and around children and felt inhibited with what they could share about their clients 'challenges, as they wanted to use language in public that protected their clients ' confidentiality. Additionally, Jane wanted to use developmentally appropriate language around Jason's children (i.e., not talking about her clients' experiences of abuse). Jason reiterated that completing supervision at his home was "not a problem," and that this was the arrangement that worked best for him. Jane asked three of their colleagues who were

men receiving supervision from Jason if they have been asked to have supervision at Jason's house. They denied Jason ever asking to have supervision at his house.

***Themes: Boundary Crossings - Need for Supervisor Reflexivity and Collaboration in Supervision.*** During months four and five there were multiple critical ethical considerations that emerged in both supervision and sessions with Dave. Jane noted a shift in Dave's compliments from general comments about their professional practice, to specific comments about their body and appearance. Dave's comments had crossed the boundary from professional to personal, and Jane shared their concerns about these boundary crossings with Jason in supervision. Client perpetrated boundary crossings include behaviors that are outside of the norms, expectationf by month four. Had he identified this pattern, the supervisor would have been able to review available information related to the case and explore the three Es of trauma-informed practice: The events, experiences, and effects associated with the traumatic experiences (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Although Jane's experiences with Dave during these first few months were not necessarily described by Jane as "traumatic," should Jason have employed a trauma-informed approach he might have noted each event or incident with Dave, attending to Jane's experience with and the effects of Dave's behaviors. Jason might have further supported Jane by engaging in role play, practicing the use of immediacy in session, empowering them to name how Dave's compliments incited feelings of discomfort. Jason might also have supported Jane's practice of reinforcing professional boundaries, preparing them to ask that Dave not comment on their physical appearance. Furthermore, Jason missed the opportunity to recognize his own crossing of boundaries with Jane regarding his requirement that they attend supervision at his home.

Had Jason employed a trauma-informed approach to supervision, he would have engaged in ongoing reflexive practice (Varghese et al., 2018). Increased reflexivity might have increased awareness regarding the perpetuation of boundary crossings Jason experienced as a supervisee completing supervision at his supervisor's home. Additionally, intentional reflection around the intersection of the supervisor's identities, and how these interface with the CIT's identities, may have brought to awareness his inherent biases in supervision setting requirements. Specifically, this practice might have increased Jason's awareness regarding his tendency to meet male supervisees at the practice, and unique requirement for only certain supervisees (specifically Jane and women supervisees) to travel to his home for supervision.

**Month Six.** Jane and Dave continued working together on Dave's therapy goals. Jane was required to record a session with several clients for their graduate program and submit the recording for feedback. They received permission from Dave to record one of their sessions. Jane described the importance of getting feedback on their session with Dave regarding working with a client who has a substance use disorder and occasional lapses. They also shared that they wanted support from their instructor and classmates on how to address the comments that Dave made that felt like boundary testing. At the end of their recorded session, Dave said "to whoever is listening, Jane is the best therapist in the world and deserves a raise."

Jane submitted this recording to their university internship professor, as well as told their supervisor about the recorded session and how it felt important to get feedback on the areas of growth they mentioned. Jane received a perfect grade on the recording with no feedback from the professor. During February, Jane struggled to get individual supervision from Jason.

Jason and the facility staff attended a career fair to recruit new clinicians, and cancelled his individual supervision with Jane and stating that they can "just talk between sessions if you need support." Jason then shared that he was going on vacation for two weeks, a week before he left, without individual supervision planned for Jane. Jane told Jason that they felt uncomfortable going nearly a month without individual supervision due to the acuity of clients on their caseload. Jason then scheduled Jane for one triadic supervision via telehealth with Jennifer, who is an addictions counselor but not a credentialed mental health counselor.

Jane consulted with a professor at their university training program regarding their struggles to receive supervision that was consistent and in private spaces to protect confidentiality. The professor provided support on how Jane could ask for their supervision needs to be met and offered to step in to support if Jane's conversation with Jason did not go as Jane hoped. Jane had a conversation with Jason to ask for consistent in-person individual supervision in confidential spaces without children present and requested that if he is unable to provide this, he find an adequate replacement of someone who could provide this support. Jason agreed to try to provide confidential supervision.

Jane had a session with Dave, and at the end of the session Dave said, "Thank you so much for your help. I love you. Bye." Jane ended the telehealth session immediately after his statement and added Dave's "I love you" to their list of topics to review in supervision with Jason. Jason returned from his vacation and texted Jane the morning of their supervision, stating that his children were sick and that they could have a phone call for supervision while he took care of them. Jane asked for either a telehealth individual supervision in which he was in a space in his home without his children present, or for supervision with a credentialed mental health and addictions clinician who was available that same morning. Jason said they could not have supervision with the available clinician, and that he would call Jane for supervision. During the call Jane could hear his children in the background. Jason advised Jane to explore Dave's statement in the next session. Jane sought support from the other clinician who was also free that morning regarding Dave's comment, attempting to resource themselves to support their client while addressing his comment.

***Themes: Safety, Collaboration, and Supervisor and Instructor Support.*** Jane experienced a series of boundary crossings with client Dave, as he shifted from compliments to stating "I love you." They continued to seek support in supervision, both regarding the client's inappropriate behavior and the increasing severity of alcohol use concerns. Jason's inconsistent provision of supervision and own boundary crossings (e.g., settings and privacy of supervision) with Jane contributed to continued lack of identification and addressing of Dave's pattern of behavior. The CIT's university instructor's failure to provide timely and specific feedback regarding the recorded session

served as another missed opportunity to intervene and provide Jane with additional support. At this point, Dave's behavior could be interpreted as grooming as he continuously engaged in intentional yet subtle crossing of professional boundaries to cultivate romantic and/or sexual feelings (Wohlberg, 2006). This behavior may also be indicative of a lack of understanding of the nature of the counseling relationship and that a sexual or romantic relationship between client and counselor is harmful and not allowed (Robasco et al., 2023).

Applying the lens of trauma-informed supervision, Jason, and Jane's university supervisor had an obligation to ensure Jane's emotional and physical safety when serving clients (Stiles et al., 2020). Jane evinced increasing discomfort and support-seeking in supervision, yet their professional supports seemed inadequate. Coordinating peer support and employing collaboration and mutuality to highlight "partnership and dismantle power differences" (Stiles et al., 2020, p. 5) during discussions with Jane may have supported early and direct intervention. This may have included identifying Dave's increasing acuity and boundary crossings with Jane as evidence that Dave required a higher level of care, and a more seasoned independently licensed clinician. Furthermore, Jason initially stated that coordination of care was not necessary for Dave due to his six months of sobriety. When Jason learned that the client had resumed substance use with increasing frequency and severity of intoxication symptoms, he needed to revisit the possible need for coordination of care between Dave's primary therapist and CIT Jane.

**Month Seven.** In Jane's next session with Dave, they addressed how he told them he loved them. He shared feelings of embarrassment and said that it "felt like an automatic thing" he said when ending a call with someone. Jane asked for clarification on whether he was experiencing any romantic feelings toward them. He denied romantic feelings. During this time Dave's major depressive disorder symptoms became more acute, and he disclosed struggling with motivation, isolation, and personal hygiene. The clinician had observed that he logged into his sessions from his bed, often sharing that he woke up from naps shortly before their session began.

Dave experienced more frequent occurrences with alcohol, for which Jane sought supervision to provide appropriate interventions and support for him. Jason continued to encourage them to connect him with AA meetings or the facility's recovery group. Jane logged into her next session with Dave and observed that he was not wearing a shirt and was lying in bed. His speech appeared slurred, and he was struggling to keep his eyes open. Jane asked Dave to put a shirt on so they could continue their session. Dave appeared affronted and said, "Okay." He sat up in bed and Jane saw that he was completely nude. As he sat up, his entire body, including his genitals, were exposed to Jane. He sat on the side of his bed, still in full view of the camera and began to pull on a shirt. Jane remembered saying, "I'm going to give you privacy" and ended the session.

Jane called Jason and told him that their client attended their session fully nude. Jason affirmed their action of ending the session and calling him right away. He told them that they did not have to communicate with Dave for the rest of the day and that he was going to seek consultation on how to address the situation. They discussed Jane's discomfort in

continuing to work with Dave after seeing his genitals and Jason assured them that they did not have to continue their role as his clinician if they were uncomfortable doing so.

Jason's plan to address the situation was as follows: Jason, as clinical director, called Dave the next day to discuss what had happened in his session with Jane and to explain the impact his behavior had on the therapeutic relationship. Jason stated that he would refer Dave to another practice due to the violation that occurred in session and recommended a higher level of care. Jason obtained a release of information (ROI) to talk with Dave's primary therapist and discussed what happened. Dave and the clinician also discussed recommendations for substance use support, including working with a clinician who is a man. Jason offered referrals to Dave and had a check-in call later in the month to see if he could offer any other support.

In their next supervision together, Jane and Jason discussed how the situation was handled and how Jane felt after the incident. Jane remembered telling Jason how they felt betrayed and frightened by what occurred. Jason reflected that he thought Dave may have been grooming Jane in their sessions together. Jason encouraged Jane to file a police report, but said the option was up to her. Jane told Jason that they wanted to think more about that option, but that at the time it did not feel necessary. Jane was also preparing to take their graduate program's comprehensive exam and licensing exam in the next two weeks and felt a need to focus on those milestones.

In the next supervision, Jason stated that he wanted to file a police report on behalf of his practice and told Jane that they should file one too. Jane expressed discomfort with this option, and Jason said that he might still file a police report regardless because it "felt right to me." Later in the week, Jason called Jane and shared that he had consulted with two lawyers and that both stated it was a risk to Jason's and Jane's licenses to file police reports, reporting that it was a Health Information Portability and Accountability Act (HIPAA) violation to file a police report on what occurred in the session. He told Jane that they could not file a police report if they wished to do so.

Jason stated that he had shared what happened with Jane's internship professor. Jane then received an email the next week from the clinical mental health coordinator in their graduate program expressing concern for what happened and stating that they needed to talk to the department chair. Jane received an email from the clinical mental health coordinator a couple of days later, expressing that they and the department chair determined that they needed to tell the dean of the college of education what happened to Jane. Jane received an email from the university's Director of the Office of Institutional Equity and Equity Officer/Investigator expressing concern and offering resources.

***Trustworthiness and Transparency, Collaboration in Decision Making, Empowerment Voice and Choice.*** Several boundary crossings preceded Dave's boundary violation of indecent exposure, to include: The client stating, "I love you" at the end of a session, joining telehealth appointments from bed, and attending session while actively intoxicated. Boundary violations are distinct from crossings, in that they clearly defy the American Counseling Association (ACA) code of ethics and have an adverse impact on the therapeutic alliance and ability to continue the professional relationship (Herlihy & Corey, 2014). Boundary violations are often preceded by less severe crossings; this process

of continuous challenging or ignoring of boundaries, whether by the client or counselor, is described as "ethical bleaching" (Tenbrunsel & Messick, 2004). These authors believe that trauma-informed supervision can provide a critical antidote to ethical bleaching, as it encourages attention to one's somatic experience (Borders et al., 2023), cultural, gender, and historical dynamics, and transparency in ethical decision-making (Stiles et al., 2020).

When Dave engaged in a clear and serious boundary violation by exposing his genitals to Jane during a telehealth session, a flurry of events followed. Jane responded appropriately, immediately ending the session and seeking supervision. Jason initially responded in a trauma-informed manner, highlighting the importance of Jane's sense of safety, providing space for them to voice their experience and needs, and allowing them the choice in how to respond. After consulting with a legal representative, Jason changed his response to the incident and required Jane to comply with a specific course of action: They are not allowed to report what occurred and must document it in their clinical notes in a vague and inaccurate way. Similar incidents have been reported to law enforcement, and the client/patient charged with "indecent exposure" (Herbst, 2015; Patton, 2022). As a healthcare professional, Jane has a right to a safe work environment and to recourse when the victim of a crime (Occupational Safety and Health Administration [OSHA], 1970). Furthermore, Jane's counseling with Dave was required fieldwork as part of their counseling program; thus, the university had a duty to ensure that their on-site supervisor provided adequate supervision and screening of clients.

Jason's failure to maintain a collaborative approach and include Jane in his ethical decision-making resulted in the removal of Jane's voice and choice in the process. Collaboration, empowerment, voice and choice are the foundation of trauma-informed supervision and organizational culture (Shatto et al., 2023). Attention to these trauma-informed principles in supervision have been associated with vicarious resilience, where clinicians experience both fatigue and positive effects from their interactions with clients. These positive effects include changes in perspective, admiration of clients 'continued persistence and resourcefulness despite adversity (Engstrom et al., 2008). Jason's supervisory approach also failed to consider any cultural or historical factors that contributed to Jane's experience during and immediately following the indecent exposure. Unknown to Jason, Jane was/is a survivor of sexual assault. Jason's failure to inquire about the traumatizing impact of this incident and understand its relevance to Jane's current and past experiences contributed to their retraumatization.

**Month Eight.** Jane worked on finishing the documentation for Dave, including a discharge summary note. They used a couple of sentences from the progress note from the incident in the "reason for termination" section, explaining "I didn't want to relive it by writing it again in a different way, so I copied and pasted a couple sentences about what happened." Their discharge summary note was reviewed by Jennifer, who was the front office manager as well as a licensed addiction counselor. Jennifer said that Jane violated Dave's privacy by copying and pasting the sentences about the incident from his progress note into his discharge summary report. She asked Jane to rewrite the sentences, which Jane did and submitted again for Jennifer's review. Jennifer requested a meeting with Jane to review the discharge summary note.

During the meeting Jennifer went over the discharge summary note section by section with Jane, offering feedback. When they reviewed the section that described the incident in the last session with Dave, Jennifer asked Jane to read what happened out loud. Jane shared that they remember feeling uncomfortable and noticed their heart beginning to race and feeling lightheaded and teary. They read out loud about how they saw their client's genitals in the session and Jennifer gives feedback on Jane's word choices, never checking in with how they were doing emotionally. Jennifer then gives feedback that they are providing too much information in the discharge summary report, potentially violating Dave's privacy by saying what happened in his session. Jane attempted to push back by sharing that it felt important to them that Dave joining his session nude was documented in his chart. Jane remembered Jennifer saying, "Well, you already documented that in the progress note." Jennifer told Jane to rewrite the section of the discharge summary that described the incident, using vague language instead such as "something inappropriate occurred."

Jane explained their feelings about collaborating with Jennifer on documentation as, "I can't believe how un-trauma-informed it was. I just wanted to get through it so I could stop thinking about it. She made me read it out loud without checking in at any time on how I was feeling. I had other clients to support. I was working toward graduating next month. I also wanted to try to move past it."

***Realize, Recognize, Respond, and Resist Re-traumatization.*** The agency staff member Jennifer did not seem to realize nor recognize Jane's witnessing of indecent exposure by their client as a potentially traumatic event. Failing to acknowledge the traumatizing nature of the incident led to a non-trauma-informed response and re-traumatization of Jane. Indecent exposure is a form of unwanted sexually aggressive behavior. For 5%–10% of perpetrators, this form of exhibitionism is part of an escalation of acts that shift from no-contact to contact sexual behaviors (McNally & Fremouw, 2014). Persons subjected to indecent exposure are more likely to experience hypervigilance, and "carry around maps in their head, overlaid with the traumas of past encounters" (Kale, 2021, para. 15). Jane's trauma response was evident in their somatic experience, as they described feeling uncomfortable, lightheaded, and teary during the event and while recounting the experience with Jennifer.

Requiring Jane to read the narrative describing Dave's indecent exposure out loud, while providing criticism of the details disclosed in the report and failing to acknowledge Jane's dysregulation, culminated in a highly retraumatizing experience. Resisting traumatization is a critical component of trauma-informed care (SAMHSA, 2014) and applies both to the client and supervisee (Berger & Quiros, 2014; Jordan, 2018; Knight, 2018). Jane's fieldwork site had a responsibility to resist retraumatization, particularly in this instance, as Jane was in the early stages of development as a counselor-in-training and needed appropriate scaffolding and support (Rønnestad & Skovholt, 1993). Having experienced sexual acting out from the client so early in their clinical development, Jane's professional identity development and development of internal working templates for their counseling practice were interrupted.

**Month Nine.** Jane graduated from their counseling program and started a private practice. They cited their top reasons for starting a private practice as "choosing a supervisor they can trust," feeling more in control of their aspirational ethics, and being able to create a trauma-informed environment for both themselves and their clients.

**One Year Post Incident.** Over a year after the incident with Dave, Jane noticed feeling triggered when working with a telehealth client who had similar demographics as Dave as well as similar maladaptive attachment behaviors with Jane in session (e.g., flattery of Jane's skills as a clinician, gender-based comments, sexual language). When this client used sexual language or swung the phone camera toward his lower body, Jane noticed experiencing physiological reactions in their nervous system such as hypervigilance, sweating, heart racing, and hands shaking.

Jane sought supervision for how to address the maladaptive attachment behaviors in session with their new client, as well as bringing the incident with Dave to their therapist to process. Jane shares, "I really wanted to heal from what happened so that I can feel safe and comfortable at my job, as well as show up more regulated to support my clients. I want to be able to address what's happening in session with this new client with less physiological stress inside."

Jane told their therapist that they wanted to focus on working on the incident with Dave, prefacing that they felt afraid of hearing from the therapist that the incident "isn't that bad," or that they "need to be tougher to be in this field." They worry that a clinician may say they're "a bad therapist" who should have been able to see how they were "being groomed" by Dave. Their therapist responded to her fears by saying, "You experienced something serious. It's not like he was going through a rough time and logged in while in bed and was naked." Jane told their therapist that Dave logged into his session from bed while naked during a potential recurrence. Jane's therapist then said, "Well, most people have the decorum to turn their camera away when they're not wearing pants in session." Jane told their therapist that their personal and professional boundary is asking clients to wear pants to their therapy sessions.

Jane's therapist then asked Jane what it would have felt like to tell Dave "Put your dick in your pants!" explaining to Jane that "gritty addictions therapists" sometimes must be assertive. Their therapist continues to explain that "you can niche down to seeing who you're comfortable with" and that not every therapist has the "gritty addictions" personality. Jane described feeling anger during this conversation and telling their therapist that they should not be expected to tell their clients to "put their dicks away" during therapy sessions. Jane shared that they terminated sessions with this clinician a couple days later. They expressed feeling "scared to share this with anyone else now, even future therapists," fearing that other mental health professionals will share the same opinions as this therapist.

***Response from Other Professionals*.** Jane's clinician's response to their disclosure of the traumatic impact of Dave's indecent exposure highlights the importance of trauma-informed practice by all counseling providers. It seems that Jane's role as a fellow clinician may have compromised their personal therapist's ability to provide unconditional positive

regard, and empathy in their sessions with Jane. Their clinician's statements about Jane needing to be "tougher" and that the incident "wasn't that bad" invalidate Jane's experience and discount their symptoms of post-traumatic stress. Jane's clinician's failure to resist retraumatization left Jane questioning their fit and ability to persist in the field, and led to the internalization of blame – that were they a "tougher" clinician they would have told Dave to "put his dick away" and would not have been bothered by the experience.

This dismissiveness towards victims of indecent exposure and other unwanted sexually aggressive behaviors remains a challenge at large and speaks to the commonality of dismissing the experience of victims/survivors and failing to address red flag/harmful behaviors. Many individuals who have experienced sexual violence–to include physical assault–report healthcare providers responding to their disclosure in dismissive and minimizing ways. Survivors describe providers as treating them differently after disclosure, often seeming detached and cold (Lanthier et al., 2018; Waddell-Henowitch et al., 2024). Jane reports symptoms that align with post-traumatic stress disorder, symptoms that are not uncommon among persons who have experienced unwanted sexual behavior (Stensvehagen et al., 2022). Regardless of Jane's counselor's perspective regarding the incident, the presence of symptoms and its negative impact on their ability to be present with male telehealth clients, warrants treatment.

Clinicians who provide counseling services to other clinicians may be more apt to experience countertransference due to the similarity in roles. One interpretation of the clinician's non-affirming response to Jane may be that their "reactions…are based on the therapists 'unresolved conflict" (Betan et al., 2005, p. 890). With the frequency of unwanted client sexual behavior in the workplace (Barnett, 2020; deMayo, 1997), it may be surmised that Jane's clinician may have had their own parallel experiences and were activated by Jane's disclosure. No matter the rationale for the clinician's non-affirming response to Jane, counselors must practice bracketing and bridling when confronted with particularly triggering experiences (Stutey et al., 2020).

## LIMITATIONS

The single case design utilizes a sample of one, which severely limits the breadth and diversity of information analyzed. Although the sample size significantly limits the generalizability of results, it does provide a depth of understanding of "the intricate details" of a phenomenon (Kennedy, 1979, p. 669). Readers are encouraged to consider how results might apply to their own experience (Kennedy, 1979) particularly in counselor education, supervision, and provision of clinical mental health counseling in community settings.

## DISCUSSION AND IMPLICATIONS

This single case study (Yin, 2014) may serve as a resource for clinicians, CITs, and supervisors who encounter client indecent exposure during a counseling session. The narrative presented herein provides insight regarding the many impacts of client in-session sexual behavior on the therapeutic alliance, clinician personal and professional wellbeing, and supervisory alliance. Use of a trauma-informed lens to examine the case narrative and

artifacts enabled the identification of missed opportunities for employing trauma-informed practice. These missed opportunities include attending to the three Es of trauma-informed practice (events, experiences, and effects associated with the traumatic experiences; [SAMHSA, 2014]) in supervision, identification of client's escalation of grooming behaviors, and problematic boundary crossings perpetrated by the client and site supervisor. Additionally, the case illustrates how failure to employ the trauma-informed principles of safety, collaboration, support, voice, and choice (SAMHSA, 2014) in supervision following a traumatic boundary violation by a client can influence a CIT/supervisee's personal and professional development and wellbeing.

Counselor subjection to client indecent exposure while in session challenges clinicians ' sense of safety in a space that can be vulnerable for both client and clinician. In this case, the CIT's developmental stage, coupled with failure of supervisory supports to provide adequate oversight and a trauma-informed approach resulted in re-traumatization and moral injury. Jane's supervisor's failure to provide support following the incidents leading up to the client's indecent exposure induced feelings of betrayal. Jason's directive that Jane not report the incident to law enforcement required them to engage in behavior against their beliefs and values. Jane's experience following the incidents aligns with those signs and symptoms associated with moral injury, to include post-traumatic stress symptoms (e.g., nervous system activation when working with male clients via telehealth), and demoralization as they experienced feelings of depression and hopelessness (Watson et al., 2022). The lack of trauma-informed response by Jane's supervisory supports played a significant role in their experience of moral injury, and post-traumatic stress symptoms.

## CONCLUSION

Jane's case serves as a cautionary tale of what may occur when supervisors involved in supporting a CIT's fieldwork experience fail to employ the principles of trauma-informed supervision (Borders et al., 2023; Kim et al., 2024), and practice (SAMHSA, 2014). Trauma-informed supervision is critical when supervising a CIT whose client tests and crosses boundaries by attempting to engage in intimate or sexual dialogue or behaviors. Supervisors are mandated to provide ongoing and consistent supervision, with boundaries that parallel those maintained with clients. In the case of Jane and Dave, trauma-informed practices could have better supported both CIT and client wellbeing and potentially circumvented the client indecent exposure that preceded termination of counseling. Key trauma-informed practices that might have been implemented in this case include assessing supervisee somatic experience in supervision; safety, collaboration, supervisor and instructor support; ensuring trustworthiness and transparency, and empowerment, voice, and choice with decision-making. Jane's experience of moral injury, and nervous system activation when providing services to male clients, highlight the negative outcomes associated with non-trauma-informed practice.

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