Bond University

Australian Journal of Clinical Education

Volume 3 Issue 1

2018

Is the Wounded Healer or the Psychologically Inflexible Healer in Undergraduate Psychology and Social Work Programs More Empathic or Willing to Violate Professional Boundaries?

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Abstract

The term ‘wounded healer’ is sometimes used to describe people with a personal experience of adversity who enter a helping profession. Wounded healers have been thought to be both especially suited to counselling - perhaps through greater empathy for those in need - and at increased risk of making poor decisions due to the influence of their own psychopathology. Undergraduate students in psychology and social work (N=112) completed online questionnaires measuring childhood adversity, parentification, empathy, psychological inflexibility and a measure developed for this study of propensity to violate professional boundaries. Despite a high prevalence of childhood adversity among respondents, neither childhood adversity nor parentification were associated with empathy or willingness to violate boundaries. Instead, higher psychological inflexibility was associated with greater propensity to violate boundaries and more personal distress in response to others’ suffering. Notwithstanding the limitations of the study, these results suggest educators selecting graduates for counselling training programs and supervisors should be careful not to let candidates’ personal histories influence judgments about their suitability for the profession.

I INTRODUCTION

There is a frequent association between having personal experience of adversity and choosing a vocation within the helping professions, a phenomenon encapsulated by the 'wounded healer' archetype (Newcomb, Burton, Edwards & Hazelwood, 2015). Higher rates of childhood adversity are reported by students of medicine (Vaillant, Sobowale, & McArthur, 1972), psychology (DiCaccavo, 2002; Gail-Horton, Diaz, & Green, 2009; Halewood & Tribe, 2003; Nikčević, Kramolisova-Advani, & Spada, 2007) and social work (Black, Jeffreys, & Hartley, 1993; Doran et al., 2013; Marsh, 1988; Rompf & Royse, 1994; Russel, Gill, Coyne, & Woody, 1993; Thomas, 2016) than students of other professions. Higher childhood adversity has also been found among practicing psychotherapists and social workers when compared to professionals in other fields (Bamber & McMahon, 2008; Elliott & Guy, 1993; Fussell & Bonney, 1990).

One plausible theoretical mechanism for this association is "parentification", a role reversal in which children or adolescents assume developmentally inappropriate levels of responsibility in their family that often go unrecognised (Lackie, 1983). Parentification is likely to occur in the context of a household affected by substance addiction (Burnett, Jones, Bliwise & Ross, 2006), mental illness (Aldridge, 2006), or neglect and abuse (Fitzgerald, Schneider, Salstrom, Zinzow, Jackson & Fossel, 2008), all of which are reported at higher rates in the childhoods of therapeutic practitioners (Bamber & McMahon, 2008; Black, Jeffreys, & Hartley, 1993; Thomas, 2016). Additionally, psychology students report higher levels of retrospective parentification than students of unrelated disciplines (Yew, Siau and Kwong, 2017). Lackie (1983) suggests that such children are rewarded for their helping behaviours and may develop values and expectancies that direct their career choice.

Concerns have been raised about wounded healers being drawn towards the helping professions. Maeder (1989) proposes that such therapists may see their work as a way to revisit their past and attempt to right whatever wrongs they had been unable to prevent as children. In an international study exploring the motivations of psychotherapists for choosing their career, almost half stated that they had hoped to use the occupation as a means of exploring and resolving their own personal problems (Orlinsky & Ronnestad, 2005). Newcomb and colleagues (2015) warn that such personal agendas may result in a professional who has a greater propensity to violate therapeutic boundaries.

Therapeutic boundaries define the roles and limitations of the relationship between practitioner and client (Smith & Fitzpatrick, 1995). A boundary *crossing* occurs when the practitioner permits interactions that transgress these roles (Gutheil & Gabbard, 1993). A boundary *violation* occurs when the practitioner seeks his or her own gratification at the expense of the client's well-being (Smith & Fitzpatrick, 1995; Plaut, 2008; Lazaras, 1994). Therapeutic relationships are complex, varying with client and setting, making it impossible to anticipate every ethical dilemma that a therapist might encounter and provide specific instructions to maintain ethical conduct (Gutheil & Gabbard, 1993). As such, each practitioner is required to continually make judgments about the appropriateness of his or her behaviour when interacting with clients. A frequent concern is that wounded healers may have especially strong emotional responses to clients' reports of their difficulties and thereby be prone to inappropriate self-disclosure (Newcomb *et al.*, 2015), excessive self-sacrifice (Adam & Riggs, 2008), over-involvement (Lackie, 1983) and to disregard supervision (Ivey & Partington, 2014). Consistent with these concerns, physicians receiving disciplinary actions for serious boundary violations report higher rates of family-of-origin dysfunction compared to other physicians (Samenow, Yabiku, Ghulyan, Williams & Swiggart, 2012; MacDonald et al., 2015). Other research suggests that childhood adversity predicts altered, if not necessarily impaired, professional judgement. Compared to their colleagues, family protection workers with childhood experiences of domestic violence and abuse have been found less likely to recommend that victims seek police intervention (Pecnik & Bezensek, 2011), and more likely to believe testimonies from child victims (Nuttall & Jackson, 1994). Preliminary evidence suggests that a worker's lived experience influences how they will perceive their clients and how they will make professional judgements.

Although experience of personal adversity may confer increased risk of detrimental practices, it has also been argued that the wounded healer might be especially suited to helping. Jung (1963) theorized that a therapist must be able to respond to the client's pathology by drawing from their own experience, writing "the doctor is effective only when he himself is affected. Only the wounded physician heals." (p.133). The notion that past adversity makes for a professional with enhanced therapeutic ability has received some empirical support. In two studies of post-graduate psychotherapy programs, trainees who reported having grown up in harsh family environments were endorsed by their supervisors as being significantly more sociable and therapeutically effective (Watts, Trusty, Canada, & Harvill, 1995; Trusty, Skowron, Watts, & Parrillo, 2004). Qualitative evidence also suggests that psychotherapists with personal histories of psychiatric hospitalisation enjoy greater understanding and feel greater compassion towards their clients (Cain, 2000). Ivey and Partington (2014) found that selectors of post-graduate psychology applicants tended to favour prospective trainees who reported a history of adversity but only when it appeared that the trainees had successfully resolved and grown from these experiences. The selectors in this study explained their decision using observations similar to Lackie (1983): they felt that from the applicants' descriptions of their difficult childhoods they could identify an individual more emotionally-attuned and with a greater capacity for empathy (Ivey and Partington, 2014).

The development of enhanced empathy for clients with mental health problems has been cited as a particular benefit of the wounded healer archetype: the ability to better understand the adversity faced by others would make them more effective in their work (Cain, 2000). Therapist empathy, as perceived by others or as measured by self-report, is a consistent predictor of client engagement and improvement (Elliott, Bohart, Watson, & Greenberg, 2011). Davis (1983) distinguished between two empathic abilities: 1) Perspective Taking, where another's perspective is spontaneously adopted; and 2) Empathic Concern, feelings of warmth, compassion, and problem-focused concern for others. Both empathic abilities have been described as reflecting desirable characteristics of therapeutic practitioners (Constantine, 2001). Although yet to be determined, it is possible that personal adversity facilitates the development of both.

Certain abilities that are sometimes considered to be components of empathy, may more accurately be described as sympathy: personal distress, affective discomfort from witnessing another's suffering; and fantasy, the ability to identify with characters from stories in films or books (Yarnold, Bryant, Nightingale, & Martin, 1996). This distinction appears important in medicine: physicians who respond to patients' suffering sympathetically rather than empathetically, recall less information, order more tests, are slower to cease cardiopulmonary resuscitation when it is unsuccessful and have stronger preferences to intubate (Nightingale, Yarnold, & Greenberg, 1991; Yarnold et al., 1996). It is worth recognising that the most popular measure of empathy, the Interpersonal Reactivity Index (IRI, Davis 1983) measures both empathy and sympathy. Building on findings with physicians, we might expect wounded healers to be prone to both great empathy and greater sympathy, with greater sympathy potentially indicating impaired judgment, although this is yet to be established in a psychotherapy context.

Whether a wounded healer's personal history of adversity leads to therapeutically advantageous or therapeutically deleterious outcomes, may depend on how the individual responds to these previous experiences. When an individual has a painful memory or experiences an aversive emotion such as guilt, they will often seek relief by engaging in behaviour to terminate it, a phenomenon described as experiential avoidance (Hayes, Wilson, Gifford, Follette & Strosahl, 1996). Psychological flexibility encompasses several related abilities: to tolerate and accept discomfort, detach from negative automatic thoughts, remain clearly aware of an important course of action, and follow it through (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). A wounded healer who lacks the ability to defuse from memories and beliefs established in an adverse childhood environment, and whose motives in caring interactions are driven by the desire to avoid their own emotional discomfort, might be prone to making decisions which disadvantage his or her clients. Alternatively, wounded healers who can discriminate motives driven by their elicited memories, emotions and urges to act, from courses of action that best serve the people they help

– in other words, those with high psychological flexibility - would likely make excellent helping professionals.

A *The Current Study*

The purpose of this study is to investigate the wounded healer hypothesis among students who enrol into university courses intent on eventually becoming therapeutic practitioners: to test whether there is an association between history of childhood adversity and one possible danger (boundary violations) and one possible benefit (empathy). We further sought to test whether psychological flexibility moderates the effect of childhood adversity on both outcomes.

II METHOD

A *Participants and Procedure*

Ethics approval for participant recruitment was obtained from the Human Research Ethics Committee of the University of South Australia (Application ID: 36788). In August 2017, a single invitation was sent to the email accounts of all 2,086 undergraduates enrolled in the University of South Australia Psychology and Social Work programs. This was primarily a sample of convenience to obtain a sufficient sample size, although we also wanted to investigate a more diverse population of potential helpers than might be found within a single discipline. We were interested in the responses of those who had not yet received so much professional training that they might have overlearned the "correct" expected responses to scenarios entailing potential boundary violations and restricted variance. The email provided information regarding confidentiality and instructed that the undertaking of the survey was an indication of their informed consent. Contacts for mental health emergency and support were provided at the beginning and end of the questionnaire.

A total of 153 (7.3%) students responded. Incomplete surveys belonging to 32 students were excluded. All students were initially asked whether they intended to pursue a career in a therapeutic profession and 9 who indicated '*No*' were subsequently also excluded. Data from all remaining 112 students were used in the main analysis, this number sufficiently meeting the a-priori estimation of 84 needed to achieve a medium effect size (.15), desired level of power (.80) and statistically significant probability level (.05) using four predictor variables.

The final sample of undergraduate students was split evenly between the University of South Australia's Social Work (50.4%) or Psychology programs. The majority were female (88.4%), Caucasian (79.3%) and between the age of 18 and 24 (51.2%) and undertaking the first year of their degrees (33.1%) with the remainder spread evenly from years two to four.

B *Measures*

1 *Boundary Violation Propensity*

We were unable to locate a suitable instrument to measure a student's propensity to violate client boundaries so we developed one, hereafter referred to as the Boundary Violation Propensity Questionnaire (BVP-Q). After reviewing literature relevant to ethical issues arising within the therapeutic relationship (e.g. Pope & Vasquez, 2016) we developed 16 vignettes, each describing a therapeutic practitioner who undertakes a questionable course of action when faced with an ethical dilemma involving a client. With permission from the authors, we borrowed an additional 4 items from the Boundaries in Practice Scale (BIP; Kendall, Fronek, Ungerer, Malt, Eugarde, & Geraghty, 2011), a self-report questionnaire designed to measure a practitioner's professional judgement. The BIP was unsuitable for this study because it was designed for fully-qualified working professionals and so contained items that our respondents could not be reasonably expected to answer. We recruited a panel of individuals who had experience providing clinical supervision to either social workers or psychologists to provide feedback on the suitability of our item pool across two rounds of correspondence. In the first round, the panel was asked to provide

qualitative feedback on item wording which led to refinements. In the second round the panel were asked, “If a trainee or student indicated willingness to take the same action as the worker in the vignette, how concerned would you be?”, responding on a scale of 1 (*Not at all concerned*) to 10 (*Extremely concerned*). Three items were eliminated for failing to achieve a mean rating ≥ 7 (*i.e.,* not examples of problematic professional conduct). Inter-rater agreement was also assessed by calculating the intraclass correlation coefficient on the remaining 17 items via the SPSS 24.1 scale procedure, using a two-way model (where items and raters were assumed to be random variables). Items with negative or low item-total correlations were removed, iteratively, to improve internal consistency. An average intraclass correlation of .84 was reached on a final scale of 11 vignettes, one of which had been borrowed from the BIP.

On the final BVP-Q to be completed by students undertaking courses in counselling professions, respondents were asked to estimate how likely they would be to take the same course of action as the worker in each hypothetical scenario, from 1 (*Definitely not*) to 6 (*Definitely*). The scale total is the sum of ratings across the 11 items, with a potential range from 11 to 66. Higher scores indicate a greater propensity to violate client boundaries. In this study, the BVP-Q was normally distributed and the range used was 11 to 50.

Although the following data is no substitution for independent verification, some data from the present study supported the scale’s validity. In the two programs represented in our sample, professional ethics is taught far more frequently in social work than psychology at the undergraduate level: on the BVP-Q, social work students (M = 22.24, SD = 6.40) scored significantly lower on the scale than the psychology students (M = 27.13, SD = 7.85), $t(110) = -3.62$, $p < .001$, consistent with their likely greater exposure to ethical training. In addition, across both disciplines, Kendall’s tau-b indicated the presence of a significant weak correlation between year of study and propensity to transgress client boundaries, $\tau = -.24$, $p = .001$. This suggests that the more students have been exposed to education relevant to professional ethics throughout their time studying, the less likely they are to report willingness to violate professional boundaries. Internal consistency of the BVP-Q was acceptable in our student sample (Cronbach $\alpha = .77$). We were unable to conduct test-retest reliability for the instrument nor have it validated independently prior to its use in this study. Therefore, implications of its findings should be considered cautiously until the scale can be further investigated.

2 *Adverse Childhood Experience*

The Adverse Childhood Experiences Questionnaire (ACE-Q; Felitti et al., 1998) consists of 10 items each describing a different type of adverse event, including physical and emotional abuse and neglect, exposure to domestic violence, mental illness, criminal activity and parental separation happening in an individual’s family-of-origin prior to the age of 18. Respondents indicate whether each occurred (*yes* or *no*) and the number of affirmative responses is summed, with higher totals indicating greater childhood adversity. The ACE-Q is a refined amalgamation of several other widely used childhood adversity measures, each with good evidence of construct and criterion-related validity (Dong et al., 2004). Test-retest reliability for the items over a period of more than twelve months resulted in adequate reliability (kappa coefficients falling between .40 and .75; Dube, Williamson, Thompson, Felitti, & Anda, 2004). An ACE-Q score of four or above is a commonly used marker denoting an increased likelihood of problematic outcomes occurring in adulthood (Anda et al., 2006). Internal consistency in the present sample was acceptable (Cronbach $\alpha = .78$).

3 *Parentification*

The Parentification Questionnaire (PQ; Jurkovic & Thirkield, 1998) consists of 30 items, comprising three subscales which measure the recollection of three dimensions of parentification occurring in the family-of-origin: Emotional, Instrumental and Perceived Fairness. Respondents rate their agreement with statements on a 5-point scale ranging from *strongly disagree* to *strongly agree*. Higher scores indicate greater parentification and perceived unfairness. High (.86) test-retest reliability after two-weeks has been demonstrated (Burt, 1992). High PQ scores correlate with symptoms of anxiety and depression (Hooper & Wallace, 2010). Internal consistency in the

present sample was excellent (PQ-Emotional, PQ-Instrumental α = .86; PQ-Perceived Unfairness α = .94).

4 *Empathy*

The Interpersonal Reactivity Index (IRI; Davis, 1983) consists of 24 items, comprising four subscales each measuring a distinct facet of empathy: Perspective Taking (PT) – cognitively taking the perspective of another; Empathic Concern (EC) – feeling emotional concern for others; Personal Distress (PD) – uncomfortable feelings in reaction to another's distress; Fantasy (Fs) – emotional identification with fictional characters. Respondents rate items on a 5-point scale ranging from *does not describe me well* to *describes me very well* with higher scores indicating higher degrees of empathy. The IRI has shown modest test-retest reliability ranging from .62 to .71 (Davis, 1983). Internal consistency for all four subscales in the present sample was acceptable (Empathic Concern: α = .76) to good (Personal Distress: α = .86).

5 *Psychological Flexibility*

The Acceptance and Action Questionnaire (AAQ-II; Bond et al., 2011) consists of 7 items rated on a 7-point scale ranging from *never true* to *always true* where higher scores indicate higher *inflexibility* and lower scores, more psychological flexibility. Bond and colleagues (2011) found the instrument to have good test-retest reliability after 12 months (α = .79). Internal consistency in the present sample was excellent (Cronbach α = .93).

III Results

A *Sample Characteristics*

The sample displayed substantial childhood adversity (ACE: *M* = 3.63, *SD* = 2.65), with 45.5% reporting four or more adverse childhood events, a rate 3.6 times higher than found across undergraduates of all disciplines (McGavock & Spratt, 2012). Instrumental Parentification (*M* = 22.84, *SD* = 8.85), Emotional Parentification (*M* = 30.49, *SD* = 9.26) and Perceived Fairness (*M* = 30.77, *SD* = 11.38) were all within 1 standard deviation of the means for university students (Hooper & Wallace, 2010). Scores on the IRI subscales were similar to other samples of Australian undergraduates (Butrus & Witenberg, 2013): Personal Distress: *M* = 17.52 (5.66); Fantasy: *M* = 24.97 (5.74); Perspective Taking: *M* = 27.62 (4.15) and Empathic Concern: *M* = 29.82 (4.00). Mean psychological *inflexibility* (AAQ-II *M* = 21.74, *SD* = 9.39) was lower than score ranges identified to be associated with increased risk of psychological distress (Bond *et al.,* 2011). Willingness to violate boundaries was low as evidenced by the mean lying nearly two standard deviations below the scale midpoint of 38.5 (*M* = 24.60, *SD* = 7.52).

B *Boundary Violation Propensity*

Zero-order correlations indicated no significant association between ACE and BVP-Q scores (*r* = .02, *p* = .803) or between any PQ subscale or its total, and BVP-Q scores (range: with PQ Total *r* = - .02, *p* = .879 to with Emotional Parentification, *r* = .14, *p* = .145). There was a significant weak correlation between BVP-Q and AAQ-II scores (*r* = .26, *p* = .006).

C *Empathy*

Zero-order correlations indicated no significant association between ACE and any IRI subscale or its total (range: Personal Distress, *r* = - .25, *p* = .790 to Fantasy, *r* = .11, *p* = .273). The only significant association between an IRI subscale and a PQ subscale was between Fantasy and Emotional Parentification, *r* = .22, *p* = .020. There were significant weak correlations between the AAQ-II and the Personal Distress (*r* = .38, *p* < .001), and Fantasy (*r* = .27, *p* = .004) subscales of the IRI, but not the Empathic Concern (*r* = - .07, *p* = .439) and Perspective Taking (*r* = - .07, *p* = .437) subscales.

D *Relationships Between Empathy and Boundary Violation Propensity*

Two of the IRI subscales were correlated with the BVP-Q: Fantasy (r = .26, p = .005) and Personal Distress (r = .21, p = .028). Correlations between the BVP-Q and Perspective-Taking (r = - .02, p = .897), and Empathic Concern (r = .08, p = .430) were not significant.

IV DISCUSSION

Contrary to our hypotheses, direct relationships were not found between childhood adversity and either boundary violation propensity nor empathy among aspiring therapeutic practitioners. Regarding boundary violations, our findings contrast with past research which has shown higher rates of childhood adversity among medical physicians who have committed serious boundary violations (Samenow et al., 2012; MacDonald et al., 2015). Perhaps culpable practitioners are incentivised to exaggerate past hardships, creating a biased representation of the adversity-boundary violation association. Alternatively, because the BPV-Q measures intentions rather than actual behaviour, the responses in this study may be prone to optimistic biases: our student sample may have underestimated its likelihood of violating these boundaries. The idea that past adversity could increase a therapeutic practitioner's propensity to violate therapeutic boundaries is the most frequently cautioned adverse outcome of the wounded healer profile (Lackie, 1983; Maeder, 1989; Halewood & Tribe, 2003; Newcomb et al., 2015). Our findings suggest that this oft-raised concern is hardly inevitable and suggests the need to investigate other contextual factors that might explain if and when childhood adversity elevates risk of boundary violation in helping professionals.

Regarding empathy, we found no support for the widely held notion that wounded healers would have enhanced abilities (e.g. Cain, 2000; Jung, 1963; Newcomb, et al., 2015). Although our participants' rates of childhood adversity and parentification replicated the finding that high rates of childhood hardship are reported among those aspiring towards careers in the helping-professions, these experiences did not appear to affect their tendency to take others' perspective or feel concern for others. It should be noted that while childhood adversity was not related to elevated empathy, neither was it associated with a deficit in empathy. These findings, along with the non-relationship between childhood adversity and boundary violation propensity, could serve to curb the assumption that a professional's lived experience will inevitability impact their work. Undermining unwarranted preconceptions about the potential for both professional malpractice and enhanced healing abilities is important to prevent bias when selecting candidates for helping professional courses (Ivey & Partington, 2014), and unfair scrutiny or favouritism throughout training, internship programs and workplace supervision.

By contrast, psychological flexibility – or rather, psychological inflexibility - was significantly related to willingness to violate boundaries, irrespective of personal history. Psychological inflexibility is an inability to set aside automatic thoughts, emotions and urges to act, and take the course of action the situation warrants rather than one that relieves discomfort or that would be taken habitually. Unsurprisingly, psychological inflexibility was positively correlated with level of distress in response to others' suffering. This could mean that low psychological flexibility makes people more likely to experience distress in response to others' suffering, or that those more likely to feel distress in response to others' suffering find it harder to accept and defuse from their automatic psychological responses, or there could be a reciprocal relationship. The reason for the significant positive correlation between psychological inflexibility and the IRI Fantasy subscale is less apparent, but sympathetic identification with fantasy characters might reflect a tendency to fuse with mental ideas and images; in other words, to get easily absorbed in mental activity and drawn psychologically away from a "centred" perspective where one has an equal awareness of a stable sense of self outside one's thoughts and emotions, one's values and possible courses of value-consistent action. Alternatively, it could reflect that escape into over-identification with fantasy serves an experiential avoidance function for many people. Together they may constitute more promising risk factors for identifying less suited, aspiring therapeutic practitioners than history of adversity.

Consistent with Yarnold and colleagues' (1996) investigations into physician judgment, the sympathy characteristics of personal distress in response to others' suffering and identification with fantasy characters were significantly associated with propensity to violate boundaries, whereas the empathy characteristics of perspective taking and empathic concern were not (supporting the validity of the BVP-Q). That psychological inflexibility, sympathy characteristics and propensity for boundary violations correlated together illustrates a coherent portrait of how some counsellors may be at risk of the adverse judgment attributed to the wounded healer phenomenon. Situations such as those captured in the BVP-Q might illicit unpleasant feelings like pity and guilt in some counsellors; most likely those susceptible to experiencing distress in response to others' suffering. Those lacking psychological flexibility would have difficulty tolerating such emotions and seek to rapidly alleviate them. Boundary violations are likely to occur when a worker seeks to relieve their own discomfort by deviating beyond the limits of their professional role to alleviate the apparent short-term distress of their clients. The promising as-yet untested implication of this analysis is that if individuals can be trained to increase psychological flexibility, the impact of sympathetic tendencies toward poorer clinical judgment might be reduced.

A *Limitations*

There are a number of limitations to the present findings. The cross-sectional design of the study limits our ability to draw causal conclusions. The low response rate (7.3%) limits the extent to which these conclusions can be generalised to the population of aspiring counselling students. There were no extrinsic incentives to participate and no resources to boost participation. It is not clear whether those who responded might differ from those who did not, but it seems likely that responders might be more conscientious and agreeable. More conscientious responders might be less likely to engage in boundary violations but more agreeable responders might be more prone when the situation involves complying with an inappropriate client request. On the other hand, our sample reflected the proportion in each year level and gender ratio consistent with other recent samples of social work and psychology students (Thomas, 2016; Yew et al., 2017), increasing the likelihood that the sample was representative of undergraduate counselling students at this university. It could also be argued that it was inappropriate to combine social work and psychology students as the former have clearly selected themselves as interested in becoming helping professionals whereas the same cannot be assumed of the latter group, for whom motivations to take the degree are likely to be more variable. Our assumption that this represents a sufficiently homogeneous sample perhaps reflects a local bias where disciplines of psychology and social work exist within the same school at the university and may not extend to other undergraduate psychology and social work student samples.

A limitation to be addressed in future studies is that the BVP-Q is yet to be independently validated. An important part of its validation remains to explore how prone to social desirability the scale is. The mean willingness to violate boundaries was low in this study, and it is not clear whether this is because the items do not sufficiently entice endorsement of poor judgement in susceptible respondents, whether the socially desirable response is transparent or whether this sample had previous experience, knowledge or talent for exercising sound judgment. We attempted to mitigate the risk of socially desirable responding through assuring confidentiality and collecting data online to heighten perceived anonymity (Ward, Clark, Zabriskie, & Morris, 2012). Nevertheless, a possible next step in the development of the measure might be to test the value of embedding some items to detect social desirability bias, some items for which the protagonist in the vignette avoids boundary violations to detect whether low willingness is specific to the boundary violation vignettes, and to explore correlations with social desirability questionnaires. Finally, the BVP-Q requires validation via predicting the occurrence of actual boundary violations.

V CONCLUSION

We found no evidence of the wounded healer phenomenon in a sample of undergraduates undertaking psychology and social work degrees. Instead, psychological inflexibility appeared to be a more important factor associated with the risk of impaired judgement often attributed to individuals with backgrounds that fit the wounded healer archetype. Although requiring more development, we have introduced a new potential measure for detecting propensity to violate boundaries that may be useful for course educators and selection panels in both recruiting and training professional and ethical conduct in counselling students.

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