A rationale for trauma-informed postgraduate supervision

Dr Katrina McChesney

University of Waikato, New Zealand

Author details

Dr Katrina McChesney

Division of Education, University of Waikato, New Zealand

Email: k.mcchesney@waikato.ac.nz

ORCID: 0000-0002-3991-6265

Twitter: @krmcchesney

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A rationale for trauma-informed doctoral supervision

ABSTRACT

Doctoral researchers are our present and future knowledge-makers. Social justice requires democratic opportunities for knowledge creation, and to this end doctoral supervision theory and practice have become increasingly inclusive, flexible, culturally responsive, and person-centred over time. However, consideration of trauma and trauma-informed practice has remained absent from this work. This conceptual paper signals the need to recognise that doctoral cohorts will include those with lived experiences of trauma. The paper then presents a rationale for developing trauma-informed approaches to doctoral supervision, theorising this approach in relation to wider inclusive education efforts in higher education, Universal Design for Learning, and the social model of disability. Intersections with current trends in doctoral supervision literature and practice are considered, and core principles of trauma-informed practice are identified that can inform work in the specific context of doctoral supervision. The paper offers a fresh perspective on inclusive doctoral education and directions for future work.

KEYWORDS

Supervision, doctoral education, postgraduate education, higher education, trauma, trauma-informed practice

A rationale for trauma-informed doctoral supervision

Introduction

Traumatic experiences are—sadly—a fact of life for many. World Health Organisation data suggests that over 70% of people will experience traumatic event/s during their lifetimes, with a mean of 3.2 lifetime trauma exposures per capita (Kessler et al., 2017). The particular types of trauma people are most likely to experience vary with socio-demographic factors including gender, ethnicity, national context, education level, age, marital status, and previous trauma history (Benjet et al., 2016; Hinton & Good, 2015; Kendall-Tackett, 2004; Magruder et al., 2017; McLaughlin et al., 2019). However, no group of society is exempt from experiencing traumatic events (SAMHSA, 2014b), and, therefore, it is unreasonable to expect that doctoral cohorts will not include people with lived experiences of trauma.

It is inequitable to ignore considerations of trauma in relation to doctoral education, because to do so would either exclude or risk perpetuating harm to a subgroup of doctoral students. McKenna et al. (2022, p. 4) have argued that social justice in higher education "entail[s] not just equitable physical access to university but also would importantly include equitable epistemic access to powerful knowledge within it." Trauma-informed doctoral education, proposed for the first time in the present paper, would help ensure that those with lived experiences of trauma are able to experience this equitable access to knowledge and knowledge-creation.

This paper builds on current trends toward inclusion and care within the higher education literature as well as the increasing understanding of trauma and trauma-informed practices evident in other professions and fields. The aim of this paper is to establish a robust rationale for exploring trauma-informed approaches to doctoral supervision. I link trauma-informed supervision to wider theoretical perspectives and practical approaches: the social model of disability, inclusive education, Universal Design for Learning, and trauma-informed practices in other settings. It is hoped that this

paper will open new possibilities for research, thinking, and praxis as we aspire to support and supervise our diverse doctoral cohorts in socially just ways.

Background: Understanding trauma and its impacts

It is important to clarify early in this paper that I am not proposing that doctoral supervisors should ever take on, or be expected to take on, the roles of counsellors, psychiatrists, or psychologists. These are highly specialised and distinct roles[1]. However, to be able to discuss or enact trauma-informed supervisory practice, it is necessary to first establish a basic understanding of trauma and its associated impacts. This section of the paper provides such a foundation.

Definitions of trauma vary (Wright, 2020). The term 'trauma' may refer to a single triggering event, as reflected in the American Psychiatric Association's (2013) *DSM-V* definition. However, 'trauma' is also used to denote an extended (and sometimes ongoing) experience (Hinton & Good, 2015) or a collection of linked events (Hinton & Good, 2015) that are overwhelming or threatening. Some use the term 'trauma' to refer to an acute, lasting stress response that follows such an event or events (Bond & Craps, 2019; Wright, 2020), recognising that not everyone who experiences a particular event will necessarily be 'traumatised' as a result (Isobel, 2021). Still others see the term 'trauma' as encompassing the combination of a triggering event (or events) as well as a person's experience of and response to those event(s) (Altmaier, 2019; SAMHSA, 2014a).

The latter, broader aggregation of trauma as encompassing both events and responses is taken for the remainder of the present article. This stance is considered appropriate since 'two people may be exposed to the same event or series of events but experience and interpret these events in vastly different ways' (SAMHSA, 2014b, p. 7). For the purpose of the discussion in this paper, an inclusive stance towards trauma means recognising that either traumatic experiences

[1] Except, of course, where one of these is the supervisor's specialist field! Even in these cases, however, a supervisor would be explicitly taking on a supervisory role and despite their therapeutic expertise would not be acting as a therapist for their doctoral student/s. Maintaining these boundaries is an important characteristic of doctoral education in therapeutic fields.

and/or trauma responses may shape how a doctoral student experiences their institution, supervision, and research journey.

Compounding the confusion around what the word 'trauma' means, past and present conceptualisations of traumatic events and responses have been criticised for being both overly narrow and overly broad, as well as for reflecting Western, patriarchal, and medical hegemonic biases (Bond & Craps, 2019; Herman, 2015; Hinton & Lewis-Fernández, 2011; Isobel, 2021; Petrone & Stanton, 2021; Tseris, 2017; Tseris, 2013). The types of events associated with trauma have been contested (North et al., 2016; Pai et al., 2017), and over time there has become greater recognition of both complexity and diversity around trauma experiences and PTSD diagnostic criteria (Bond & Craps, 2019; Hinton & Lewis-Fernández, 2011; Isobel, 2021). This has included understanding: that trauma can result from sustained unsafe experiences rather than just from a single acute event (Bond & Craps, 2019; Hinton & Good, 2015); that trauma can result from hearing about or witnessing the experiences of others (Ravi et al., 2021; SAMHSA, 2014b); and that trauma can occur in whole communities, either immediately (e.g. when experiencing war, natural disasters, or terrorism) or over multiple generations (e.g. in relation to the impacts of colonisation on Indigenous communities) (Fortuna et al., 2022; O'Neill et al., 2018; SAMHSA, 2014b). It is beyond the scope of this paper to précis each of these types of trauma, and in-depth knowledge of traumatology is not necessary for the kind of trauma-informed doctoral supervision that this paper proposes. The key point is to recognise that trauma is a real, complex, and widespread phenomenon that is explored from a wide range of medical, clinical, social, and cultural perspectives (Bond & Craps, 2019).

Responses to traumatic events can be temporary, sustained, delayed, or immediate and can take emotional, physical, cognitive, behavioural, and existential forms (American Psychiatric Association, 2013; SAMHSA, 2014a, 2014b). The specific impacts of trauma also vary from person to person, influenced by individual resilience, sociocultural history, and support resources as well as the nature of the traumatic event(s) experienced. Table 1 lists some common responses to trauma, although this is of necessity an incomplete list representing a highly individualised experience.

Table 1 about here

Table 1. Some common trauma responses (adapted from SAMHSA, 2014b)

Emotional responses: • Anger • Sadness or depression • Shame or guilt • Denial • Grief • Feeling out of control or helpless • Fear or anxiety • Difficulty regulating emotions • Overwhelming emotions • Emotional numbing/detachment • Mood swings • Feeling unreal, disoriented, or dissociated
Physical responses • Hyperarousal • Sleep disturbance • Tension, easily startled, shaking • Elevated cortisol levels • Appetite/digestive disturbance • Somatization (physical symptoms arising from emotional distress) • Reduced immunity and biological systems function
Cognitive responses • Beliefs/perceptions of being unsafe, incompetent, unworthy, damaged, guilty, a failure etc • Hypervigilance and overestimating the likely danger of a situation • Feeling different or alienated from others who have not experienced this trauma • Excessive or unfounded guilt • Unhealthy bonding to, or idealisation or rationalisation of, trauma perpetrator • Delusions or hallucinations • Triggers, flashbacks, and 'flooding' of trauma-related thoughts and memories • Dissociation, depersonalisation, and derealization • Suicidal thoughts
Behavioural responses • Substance abuse, self-harm, problematic eating, or risky/destructive behaviours • Compensatory, obsessive, or compulsive behaviours • Learned helplessness, lack of decision making, or inaction • Re-enacting the traumatic event(s), including through unsafe actions or engaging in destructive relationships • Avoidance of situations, people, or experiences that heighten feelings of anxiety, unsafety, or other negative affects or known triggers
Existential responses • Intensified or renewed faith/spirituality • Despair, hopelessness, purposelessness, cynicism, disillusionment • Questioning (Why this? Why me?) • Redefining the meaning of life, views of self, priorities, and purpose

It is important to recognise that 'traumatic stress reactions are normal reactions to abnormal circumstances ... Although reactions range in severity, even the most acute responses are natural responses to manage trauma— they are not a sign of psychopathology' (SAMHSA, 2014b, pp. 59-60). This is true even of the more marked, sustained responses that meet the clinical diagnostic criteria for Acute Stress Disorder (ASD) or the longer-lasting Post-Traumatic Stress Disorder (PTSD; American Psychiatric Association, 2013). Importantly, however, this acknowledgement should not minimise the distress or debilitating impacts on daily life that such responses can cause (SAMHSA, 2014b). Given that experiencing a traumatic event cannot be undone, the effects of trauma can be lifelong (American Academy of Pediatrics, 2014; Isobel & Angus-Leppan, 2018). As such, the aim of interventions such as therapy and medication is not to 'cure' trauma but rather to help people process their experiences of trauma and/or learn to manage their ongoing symptoms or trauma responses (SAMHSA, 2014b).

There are tensions among disciplines as to the value of medicalised (psychiatric) views of trauma and other mental health issues (Cohen, 2017; Petrone & Stanton, 2021; Tseris, 2017). Antipsychiatry—a movement dating back to the 1960s—problematises the deficit framing of 'mental illness', arguing that 'something is being depicted and treated as medical which is in no way medical and, largely as a consequence, people are being profoundly damaged' (Burstow, 2017, p. 31; see also Tseris, 2017). It is beyond the scope of this article to explore or take a position on this question, but two key aspects of an antipsychiatric stance are relevant to this article. First, what might be described as mental illness can actually be a natural and valid response to social and environmental circumstances—and it is arguably these origins as much as (if not more than) an individual's trauma response that warrant intervention (Burstow, 2017; Tseris, 2017). Second, alternative pathways to support healthy individual and social functioning would celebrate difference, prioritise caring rather than punitive approaches, value self- and other-awareness, and involve the whole community in providing positive supports for everyone's welfare (Burstow, 2017). Both of these perspectives are compatible with the ideas presented in this article around trauma-informed doctoral supervision.

Background: Higher education and doctoral supervision

The idea of trauma-informed doctoral supervision both connects to and extends work that has gone before in the higher education and doctoral supervision literatures. This section reviews such work. First, I trace journeys toward inclusion and care in higher education and doctoral supervision, considering how doctoral cohorts have continued to diversify and how supervision theory and practice have evolved in response. Then, I review existing literature that has specifically considered trauma in relation to higher education or research.

Journeys toward inclusion and care in higher education and doctoral supervision

Doctoral education has changed dramatically over recent decades (Fourie-Malherbe et al., 2016; McCallin & Nayar, 2012; Taylor et al., 2018). Whereas doctoral education has traditionally been a space of privilege for a relatively homogeneous elite (Johnson et al., 2000), the doors have now been (at least on paper) opened to all who can meet the academic and visa requirements. As a result, far more—and far more diverse—students are engaging in doctoral research (Hammond et al., 2010; McCallin & Nayar, 2012; Pearson et al., 2011), and those students bring a wider range of motivations and career aspirations beyond just an academic trajectory (Fourie-Malherbe et al., 2016; St. Clair et al., 2017).

In this climate, the nature of doctoral programmes, supervision practices, and the associated expectations have become increasingly contested and diverse (Fillery-Travis et al., 2017; Fourie-Malherbe et al., 2016; Lee, 2018; McCallin & Nayar, 2012; St. Clair et al., 2017). One important trend has been a shift in discourses around doctoral students, their supervisors, and their work. Doctoral education has often been discussed in procedural, rational, intellectual, or technical terms (Adams-Hutcheson & Johnston, 2019). Such approaches focus on the 'tasks' (and the management of the tasks) of undertaking a higher degree and producing a thesis and/or a scholar (Owler, 2010) and have led to supervision 'often tak[ing] on a functional, project management flavour' (Bastalich, 2017, pp. 3-4). Western concepts of individualism, rationality, linearity, and professionalism underpin such

constructions (Bastalich, 2017; Gravett, 2021) and lead to a sense of the doctorate as something that might happen at 'arms length' rather than in the context of deeply embedded, relational and inner personal contexts (Berryman et al., 2017).

Since the turn of the 21st century, however, there has been increasing critique of such constructions, highlighting the way these views reproduce inequities and particular (e.g. white, male, full-time, unencumbered with care responsibilities) subjectivities (Johnson et al., 2000; Manathunga, 2017, 2019; McCulloch et al., 2008; Pearson et al., 2011). Alternative perspectives have been offered that invite us to consider doctoral students and supervisors as 'whole people', acknowledging relational, affective, identity, socioeconomic, and experiential aspects alongside more cognitive considerations (Gnanadass & Merriweather, 2022, p. 21) (see also Berryman et al., 2017; Callary et al., 2012; Cree, 2012; Henderson, 2018). We now have a significant body of work that emphasises the emotional landscape of doctoral education and acknowledges the interactions between affect, agency, and (intersectional) identity in higher education (Aitchison & Mowbray, 2013; Burford, 2014, 2015, 2017; Cree, 2012; Doloriert et al., 2012; Frick et al., 2014; Gibson, 2022; Grant & Elizabeth, 2015; Masta, 2021; Schriever, 2021; Xu & Grant, 2020). We have affectively-rich accounts of students' experiences (Addison et al., 2022; Callary et al., 2012; Hradsky et al., 2022; Jackman & Sisson, 2022; Schriever, 2021) as well as publications that seek to help students themselves with some of the more challenging affective aspects of doctoral research (Addison et al., 2022; Morrison-Saunders et al., 2010). The mental health and wellbeing of doctoral students have also recently drawn much attention (Goodall et al., 2022; Hazell et al., 2020; Jackman et al., 2022; Jackman & Sisson, 2022; Schmidt & Hansson, 2018; Watson & Turnpenny, 2022). In particular, there is increasing understanding of the impacts of supervisory and institutional influences on students' mental health, wellbeing, and affective and academic outcomes (Cornér et al., 2017; Cree, 2012; Jackman et al., 2022; Jackman & Sisson, 2022; Li et al., 2022; Mackie & Bates, 2019; Wisker & Robinson, 2018), although further work is still needed in this area.

Recently, a number of authors have offered fresh—and potentially challenging—lenses for considering doctoral education. For example, Burford (2015) has used queer theory to explore the affective politics of doctoral education; Taylor and Adams (2020) have proposed pushing beyond 'satisfaction' metrics to explore the possibilities for 'profound happiness' on the doctoral journey (p. 1); Cree (2012) has pondered Western academic constructions of appropriate student-supervisor relationships with reference to an international doctoral student who said, 'I'd like to call you my mother' (p. 451); and Andriopoulou and Prowse (2020) have asked what insights into doctoral supervision we might gain through the lens of attachment theory. These lenses extend the wider trends toward considering doctoral students as whole people and toward exploring affect, care, and wellbeing in doctoral education. Nonetheless, some of these new directions may continue to feel risky given the discursive conditioning that still promulgates 'problematic ... ideas of autonomy and the independent scholar' (Johnson et al., 2000, p. 137) (Gibson, 2022).

It is hoped that the present paper's call for trauma-informed doctoral supervision may similarly stretch boundaries as we consider what it means to be truly inclusive and person-centred in doctoral supervision. While the idea of trauma-informed doctoral supervision has not previously been explored in the literature, the next section traces work that has noted other connections between doctoral research, supervision, and trauma.

Existing work linking doctoral research, supervision, and trauma

There have been occasional discussions in the literature regarding whether doctoral education might be traumatic for some—or even all—students. Fifty years ago, Bottomley (1973) characterised doctoral study as 'entail[ing] the endurance of severe personal distress for a great many candidates', making the degree 'a violent *rite de passage*' (p. 211). Williams and Lee (1999) picked up on this suggestion and explored whether completing a doctorate was an inherently traumatic experience as students were 'forged in fire' (p. 6); the participants in Williams and Lee's (1999) research described their experiences of what they felt were abusive, neglectful, violent, and

traumatic supervisory practices. Interestingly, Williams and Lee noted that 'trauma, abjection, isolation, [and] loss are often read through an improvement discourse as "noise" in the system, noise which could, in principle, be silenced' (p. 8).

A number of papers have used the words 'trauma', 'traumatic', or 'traumatised' when describing doctoral students' experiences with their supervisors and institutions. In some cases, this phrasing came from participants' self-descriptions of their experiences, while in other cases it appeared to be the researchers' interpretation. Trauma has been specifically mentioned in relation to changing supervisors (McAlpine et al., 2012; Schmidt & Hansson, 2021; Wisker & Robinson, 2013), institutional neglect (McAlpine et al., 2012), the difficulties of developing one's academic writing (Ross et al., 2011), and the instability involved in producing work at the shifting edges of knowledge (Green, 2005). There is also mention of a general form of 'disavowed emotional trauma' associated with doctoral education which, if one is not careful, may reproduce itself when a doctoral graduate becomes a supervisor (Henderson, 2018, p. 412) (see also Williams & Lee, 1999).

More recently, however, accounts have been captured from supervisors who explicitly want to enact the opposite sort of approach to that suggested by Williams and Lee (1999). Such supervisors wish to help shield their students from the risk of being traumatised by their higher degree. For example, the UK Council for Graduate Education's (2021) *UK Research Supervision Survey: 2021 Report* quoted supervisors as saying,

> 'I want to try and give future scientists an easier ride that leaves them with less trauma compared to my own experience, I want to detoxify academia. (p. 62)

and

> 'I know from my own and others' experiences how destructive poor supervision can be. I have friends who I think have been literally traumatised by abusive supervisory

relationships. I value being a supportive and informed supervisor who stretches and supports candidates appropriately.' (p. 62)

Such perspectives align with the broader turn toward inclusion and care in doctoral education discussed in the previous section.

A relatively recent thread of research has explored the challenges that arise when doctoral students' research centres on traumatic topics. Students may be interrogating their own past or present trauma as part of their research projects (Joseph & Latona, 2017), or they may be exploring trauma experienced by others (Adams-Hutcheson & Longhurst, 2017; Dominey-Howes, 2015; Velardo & Elliott, 2021)— accounts which, in some cases, may recall and trigger traumas that the researcher has also experienced (Stewart, 2019). The process of researching others' trauma can cause psychological harm (including vicarious trauma) to researchers (Dominey-Howes, 2015; Nicolazzo et al., 2021; Truong et al., 2016) and therefore warrants wise and careful supervision (Joseph & Latona, 2017; Orr et al., 2021).

Another research thread (to date, primarily centred in the USA) has highlighted the experiences of doctoral students who experience intergenerational or racial trauma (McGee et al., 2022; Peters, 2020; Stewart, 2019; Truong & Museus, 2012)[2]. This work has demonstrated that students can experience racism and racial trauma in the context of doctoral education. While not offsetting or excusing racism in higher education settings, this research has also found that ongoing commitment to doctoral education and achieving academic milestones can be meaningful forms of resistance and reclamation for those who have experienced racism (Stewart, 2019; Truong & Museus, 2012).

While the literature reviewed above notes a range of specific intersections between trauma and doctoral education, there is also a broader landscape to consider. Trauma is not only

[2] See also McGee and Stovall (2015) which, though not specifically focused on doctoral education, presents extremely relevant and compelling arguments around the links between higher education, racially minoritised students, mental health, and racial trauma.

encountered *within* or *as a result of* doctoral education. Students may bring trauma histories with them as they enter doctoral study, or they may experience new trauma(s) during the course of their doctorate (but not necessarily related to their study and research). For example, students may live with or be newly affected by the impacts of adverse childhood experiences; being a refugee; living through war or disasters; racism or other forms of discrimination; medical or birth trauma; or experiences of physical, criminal, sexual or domestic violence or abuse.[3] Such events could occur at any time, including during the years of a doctoral enrolment.

At present, we lack literature exploring how previous or current trauma experiences affect students' experiences of and in doctoral education; this is an important area for future research (discussed later in the paepr). However, given what we know at present about the prevalence and impacts of trauma, we must expect that doctoral cohorts will include students who have lived experiences of trauma and significant associated impacts.

A rationale for trauma-informed doctoral supervision

Acknowledging that doctoral cohorts are likely to include students with lived experiences of trauma warrants a response, in line with inclusive and socially just aspirations for doctoral education, but does not in itself automatically indicate a *particular* institutional or supervisory response. Therefore, in the rest of this paper, I wish to present a rationale for a specific response: trauma-informed doctoral supervision. This rationale is in three parts, as I argue that the social model of disability, inclusive education (including, in particular, Universal Design for Learning), and the trend towards trauma-informed practice in other sectors all support the appropriateness and importance of a trauma-informed approach to doctoral supervision.

[3] It is also well-documented that a person's trauma history may motivate them to pursue particular careers (in particular, careers in the "helping professions"; e.g. Bryce et al., 2021, and Hiles Howard et al., 2015). However, no research was able to be located that specifically considered whether past trauma experiences contributed to students' motivation to pursue doctoral education or their experiences while in doctoral education.

The social model of disability

Trauma is not a 'disability'. However, the social model of disability has become an extremely important influence on wider thinking about how we might, in a range of contexts, respond to those who may sometimes be perceived as different or less able due to their physical, emotional, or neurological characteristics. I therefore take this model as the first element of a rationale for trauma-informed doctoral supervision.

The social model of disability emerged in the 1980s (Oliver, 1983, 1991, 2013). The model posits that:

> disability is not an individual problem. Rather, it is a social problem concerned with the effects of hostile physical and social environments upon impaired individuals, or even a societal one concerned with the way society treats this particular minority group. (Oliver, 1983, p. 2)

The social model of disability distinguishes *impairments* (which are recognised as real and as comprising physical, mental, intellectual or sensory forms; United Nations, 2006) from *disabilities* (understood to be the socially generated restrictions on a person's life experiences). This approach argues that if social norms, practices, facilities and environments were different, those with physical impairment/s would not find themselves *dis-abled* through having restricted access to opportunities and experiences that are available to those who do not have similar impairment/s.

Since it was first proposed in the 1980s, the social model of disability has increasingly informed educational thought and practice. For example, in higher education, Boughey and McKenna (2016) have critiqued what they term 'the discourse of the decontextualised learner', a worldview within which

> the student's success or failure is understood to emerge entirely from attributes inherent in the individual, be it their levels of intelligence or motivation or language

> competence, rather than acknowledging that higher education success correlates with and reinforces large social structures, particularly social class. (McKenna, 2021, p. 100)

A social lens has been used to underpin a range of both practical inclusion efforts (Merchant et al., 2020), empirical research (Svendby, 2020), and critical studies (Heleta & Bagus, 2021; Manathunga, 2019) in higher education. Such work has related not only to physical impairments and illnesses (Hughes et al., 2016; Shaw, 2021) but also to mental health issues (Kruse & Oswal, 2018), neurodiversity (Clouder et al., 2020), and socioeconomic and demographic inequities (Gildersleeve et al., 2011; McKinley et al., 2011). The intersectionality among these various dimensions has also been considered (Nieminen, 2022), as has the way these considerations may play out in online and blended learning modes (Whitley-Grassi et al., 2021).

In relation to trauma-informed doctoral supervision, the social model of disability would suggest that people should not have their access to or experiences of doctoral education restricted because of their lived experiences of trauma or the ways those experiences affect them. Institutional and supervisory approaches need to be appropriate and inclusive toward those who experience or have previously experienced trauma.

Inclusive education and Universal Design for Learning

Inclusive education is concerned with ensuring that all students can access education (in the case of this article, doctoral education) and are not inhibited in doing so by disabilities or forms of social, economic, or demographic diversity. Inclusion does not only involve gaining presence or representation (Moriña, 2017); writing in relation to the higher education context, Engstrom and Tinto (2008) argue as follows:

> That institutions do not intentionally exclude students from college does not mean that they are including them as fully valued members of the institution and

> providing them with support that enables them to translate access into success … To promote greater student success, institutions have to take seriously the notion that the failure of students to thrive in college lies not just in the students but also in the ways they [institutions] construct the environments in which they ask students to learn. Institutions have to believe that all students, not just some, have the ability to succeed under the right set of conditions—and that it is their responsibility to construct those conditions. (p. 50)

Some progress has been made in relation to understanding inclusion for a range of cohorts in higher education, including women, non-binary students, LGBTQ+ communities, and those from diverse cultural, ethnic, and socioeconomic backgrounds (Hoffman et al., 2018; Ings, 2014; Kumar & Refaei, 2021); those working, caring, parenting, or dealing with health-related issues (Crawford & Windsor, 2021; Wisker & Robinson, 2018) during their education; and those living with disabilities (Hughes et al., 2016; Merchant et al., 2020) or neurodiversity (Chown et al., 2016). Rich scholarship has emerged in relation to culturally responsive practices, decolonisation efforts (Bhambra et al., 2018; Doharty et al., 2021; Fomunyam, 2019; Kidman, 2020), inclusive physical and interpersonal environments (Moriña, 2017), and flexible expectations and ways of working. There is a great deal further to travel, however (Crawford & Windsor, 2021; Ings, 2014; Moriña, 2017; Sabzalieva et al., 2022; Wisker & Masika, 2017), and doctoral education in particular may still be the 'last bastion' of traditional assimilationist (rather than truly inclusive, socially just, or decolonising) thinking and practice (Antony & Schaps, 2021).

In the 21st century, an approach called Universal Design for Learning (UDL) has become prominent within inclusive education. Whereas inclusive education thinking and practice had previously focused on providing targeted accommodations to cater to individual students' needs (i.e. their deviations from the 'norm'), UDL inverts this approach. The aim of UDL is 'proactively planning to the edges' (Capp, 2017, p. 791) of a student cohort, anticipating the full gamut of possible needs

and diversities and seeking to enact pedagogies that will be appropriate for all and disadvantage none. In practice, given the wide range of human diversity, this requires activating a menu of alternative modes of communication and engagement rather than expecting to find a single normative approach that will work equally well for all (Capp, 2017). While UDL initially emerged in the schooling sector, it is increasingly influencing higher education too (Bracken & Novak, 2019); as Saha-Gupta et al. (2019, p. 5) have suggested, enacting UDL in higher education 'is no longer a question of "when" but "how".'

UDL is typically used when teaching groups of students (classes, workshops etc). This is different from the one-on-one (or two/three-on-one, if there are multiple supervisors) configuration in which doctoral supervision is usually conducted. However, I suggest that the principles of UDL can still be applied when working with one student at a time, in that UDL asks us to anticipate diversity and to plan from the outset to use the most inclusive pedagogies possible as our core way of working with all students.

An important feature of the UDL approach is that it removes the requirement that a student discloses any disability or form of difference in order to receive suitable accommodation. Disclosure (whether of disabilities, neurodiversity, experiences of trauma, gender/sexual diversity, or other forms of difference) places students in a vulnerable and potentially lose-lose position: They risk judgement, stigma, or discrimination if they choose to disclose their needs, but face a more difficult learning journey and potentially unsuitable or less effective learning experiences if they choose not to disclose (Dalton et al., 2019; Grimes et al., 2019; Ings, 2014). For those with experiences of trauma, disclosure may also carry a risk of re-traumatisation.

In terms of trauma-informed doctoral supervision, clearly, there are close alignments between inclusive education and the social model of disability. Both emphasise ensuring access and opportunity for all, regardless of students' forms of difference, and both would place significant responsibility for this work on institutions. However, adding in the lens of UDL moves us away from thinking about how we might cater for an individual trauma-affected student and instead towards

the need for a repertoire of practices that are likely to be safe and supportive for those affected by trauma but that will be deployed as our normative ways of working with all students. This brings us to the concept of trauma-informed practice.

The trend toward trauma-informed practices

Trauma-informed practice[4] is an umbrella term to describe approaches used across a wide range of sectors and professions that recognise the prevalence and impacts of trauma and proactively seek to work in ways that are safe, inclusive, non(-re)-traumatising, and non-discriminatory. Trauma-informed approaches have been deployed in fields such as healthcare, education, policing, leadership and management, justice and corrections, welfare, the military, and emergency services/first responders (Kim et al., 2021; Ko & Ford, 2008; McCartan, 2020).

Advocates of trauma-informed practices suggest that these approaches constitute a kind of 'universal precaution' (Racine et al., 2020, p. 5) in response to the prevalence and impacts of trauma. There have been calls for comprehensive adoption of trauma-informed approaches in public health policy (Magruder et al., 2017), schooling (NAACP, 2014; National Child Traumatic Stress Network, 2017), and higher education (Thompson & Carello, 2022). However, this article is the first to specifically call for trauma-informed doctoral supervision; existing literature on trauma-informed higher education has centred on taught (usually undergraduate) programmes (Barros-Lane et al., 2021; Carello & Butler, 2014; Hunter, 2022; Thompson & Carello, 2022).

A starting point for trauma-informed approaches to doctoral supervision

Based on consideration of the social model of disability, inclusive education and UDL, and the trend in other contexts towards trauma-informed practices, I suggest that there is a need to establish trauma-informed approaches to doctoral supervision. But what might this involve? Here, I

[4] Hereafter, I use the terms 'trauma-informed practice(s)' and 'trauma-informed approach(es)' interchangeably.

present an overview of what trauma-informed approaches involve, highlighting an existing framework that I suggest could inform efforts to conceptualise trauma-informed doctoral supervision.

Recognising the growing interest in trauma-informed approaches and the need for these to be underpinned by appropriate knowledge and principles, the US Substance Abuse and Mental Health Services Administration has published important guidance that spans disciplines and settings: *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach* (SAMHSA, 2014a). The document is informed by research, insights from practice and clinical work, and insights from those with lived experiences of trauma. In calling for trauma-informed approaches, SAMHSA argues that:

> The pervasive and harmful impact of traumatic events on individuals, families and communities and the unintended but similarly widespread re-traumatizing of individuals within our public institutions and service systems, makes it necessary to rethink doing 'business as usual.' (p. 1)

SAMHSA (2014a) identifies four 'key assumptions' that underpin a trauma-informed approach, regardless of setting. These are *realisation*, *recognition*, *response*, and *resisting re-traumatisation*:

- *Realisation* – All those involved in an organisation or system have knowledge and understanding about trauma and its impacts. They realise the reality, nature, and effects of trauma.
- *Recognition* – All those involved in an organisation or system know the signs of trauma, to help them recognise when trauma may be affecting someone they are interacting with.
- *Response* – Trauma-informed principles and practices (see below) are applied globally across all aspects and levels of the organisation or system, resulting in changes to 'language, behaviour, and policies' (p. 8).

- *Resisting re-traumatisation* – There is awareness of how environments, practices, and ways of relating within the organisation or system could cause re-traumatisation, and care is taken to avoid this.

SAMHSA (2014a) note that a trauma-informed approach does not mean 'a prescribed set of practices or procedures' (p. 8). Instead, they offer six principles that should be used to shape contextually relevant approaches: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues (SAMHSA, 2014a). They also name ten specific domains for implementation of trauma-informed approaches, ranging from governance and leadership, policy, and financial management to the physical and interpersonal environments, screening and support services, staff development, and approaches to organisational monitoring and evaluation. To support implementation, they offer a helpful bank of sample questions that can be asked about existing practice in each of these ten domains (SAMHSA, 2014a).

Informed by the SAMHSA guidance, I suggest that a starting point for trauma-informed approaches to doctoral supervision involves four conceptual moves that are within reach of all supervisors, graduate research school staff, and institutional policy makers:

- First, understanding the nature and impacts of trauma on those who experience it.
- Second, recognising that since trauma is a natural and widespread experience, it is likely to have affected (or affect during their candidature) a proportion of doctoral students.
- Third, acknowledging that the systems, practices, and ways of relating found at higher education institutions (and among staff at such institutions) can have differential effects on students who have experienced trauma.
- Finally, recognising that in order to be inclusive and non-discriminatory of trauma as a natural part of the diversity within our doctoral cohorts, it is necessary to review and, where necessary, adapt our systems, practices, and ways of relating to minimise harm and promote equitable opportunities for all students to flourish and to complete high-quality research.

Having made these four conceptual moves, we are then able to explore specific systems, practices, and ways of relating to understand how they intersect with students' lived experiences of trauma. To progress this work, I suggest that the SAMHSA guidelines offer a framework that could be used to develop trauma-informed approaches in the context of doctoral supervision, as has been done in other sectors. Useful practical insights could also be drawn from trauma-informed approaches already developed in contexts with some relevance to doctoral supervision, such as trauma-informed clinical supervision (i.e. professional supervision of practising psychologists, counsellors etc.), trauma-informed schooling, and trauma-informed undergraduate education. It is beyond the scope of this paper to provide detailed practical suggestions for trauma-informed doctoral supervision, although follow-up work in this regard is planned.

Discussion

Having presented a rationale for trauma-informed doctoral supervision, this section seeks to zoom out and consider how such work might align or intersect with other efforts underway in higher and doctoral education. I also offer some future directions for how work in this regard might proceed.

Pursuing trauma-informed approaches to doctoral supervision would align with the wider trends towards inclusion and care in higher and doctoral education (see Background). It would also complement existing work exploring trauma-informed approaches to undergraduate education (Barros-Lane et al., 2021; Carello & Butler, 2014; Thompson & Carello, 2022). There is scope here for future research and practice to consider how trauma-informed undergraduate and postgraduate education might intersect. Future research that looks across these two contexts could inform practice in each as well as help ensure students with lived experiences of trauma have a safe and smooth progression through higher education.

Given the increasing awareness of intergenerational and historic trauma in minoritised communities, trauma-informed supervision also aligns with social justice efforts in higher education

by helping ensure that institutions are safe environments for members of such communities (Kidman, 2020; McAllister et al., 2022; McGee & Stovall, 2015; Steinman & Kovats Sánchez, 2021). Culturally responsive doctoral supervision is relevant here. Culturally responsive supervision is similar to trauma-informed practice in that both involve resisting deficit framings of 'difference' and instead allowing people to be their authentic selves, acknowledging their lived experiences and heritages as we work to '*unlearn* dehumanizing pedagogies and *relearn* more inclusive alternatives' (Berryman et al., 2017, p. 1358; emphasis in original) (see also Blitz et al., 2016; Manathunga, 2017; Qi et al., 2021). Gnanadass and Merriweather (2022, p. 29) also note that a 'humanity mindset', a 'humanistic pedagogy', and the practice of 'seeing ourselves and our students wholistically [sic] with all of our strengths, weaknesses, and needs'—all, I suggest, features of trauma-informed approaches—are consistent with decolonisation efforts in higher education. These may be areas that indigenous researchers, in particular, may wish to explore further.

I see three things that we should take care to remember while working toward trauma-informed doctoral supervision. First, there are undoubtedly dangers in reducing people to their trauma experiences or responses. Trauma does not define a person's future potential, and we must take care not to lower our expectations of someone simply because we may come to know that they have experienced trauma or responded to trauma in a particular way. However, just as we would not seek to discount or deny people's disabilities, cultures, or other forms of difference, we should not simply ignore trauma. As we develop more practical proposals for trauma-informed approaches to doctoral supervision, research will be needed to trace the effects of new practices, particularly through student voice data.

Second, we must recognise that trauma can be experienced by communities as well as by individuals, and we must avoid taking up the position of 'judging' whose trauma—or what forms of trauma—will 'count' and warrant our response. It will be necessary to defer to wisdom from those who specifically research trauma as well as lived accounts from students who choose to share their

experiences of trauma and doctoral study. The latter is an important direction for future research within the field of doctoral education.

Finally, we should not forget that our institutions and supervisory practices can be trauma-*inducing*. Giroux (1992) reminds us that no educational philosophies or practices are truly neutral, including those that we may currently take for granted simply because of their familiarity. To pursue trauma-informed approaches to doctoral supervision requires that we resist the narrative that doctoral education must be inherently traumatic (see Background). While we do not want to lower academic standards in any way, it is important that we are alert to the ways in which higher education institutions and our supervisory practices may *produce*, rather than reduce, trauma (Petrone & Stanton, 2021), and that we work towards more inclusive approaches. Further research is needed to capture specific insights into ways doctoral education can cause, heighten, or re-activate students' trauma.

Conclusion

> Some things are difficult to speak about, seemingly horrific and felt so jarring and angular that for years the experiences remain partially or sometimes completely unwritten, unspoken and unintelligible … Some emotions and affects, however, still appear to be too intimate to make their way into [academics'] work. These emotions and affects, which are too raw, too close and too personal to air in the public spaces of the academy and beyond, often remain invisible. (Adams-Hutcheson & Longhurst, 2017, pp. 43-44)

The quotation above speaks powerfully of the nature of trauma and its simultaneous presence, influence, hiddenness, and lack of space within academic settings. While all who enter academic settings are entitled to dignity and privacy around their personal experiences, they are

also entitled to experience a safe environment that does not cause harm. Higher education settings should allow diverse students and staff to flourish as they conduct excellent academic work. This is a principle we have previously believed and worked toward upholding within higher education in relation to disabilities, neurodiversity, cultural diversity, gender identity and sexual diversity, socioeconomic background, and other categories of difference. I argue that it is a necessary and natural next step to expand these efforts to also encompass working in ways that are appropriate for those with lived experiences of trauma.

This paper has specifically sought to prompt consideration of the need for trauma-informed approaches to doctoral supervision. Given the prevalence and impacts of trauma, similar approaches are also of course needed in relation to coursework in postgraduate programmes as well as in relation to the experiences of staff who may have lived experiences of trauma. However, these are separate considerations beyond the scope of this paper.

In this paper, I have considered how students' trauma experiences and responses might intersect with their doctoral research journeys. I have demonstrated how a trauma-informed approach to doctoral supervision would align with insights from the social model of disability, inclusive education, Universal Design for Learning, and the wider trend toward trauma-informed practice in other settings. Ultimately, through this paper, I argue for new consideration of trauma as an aspect of the human experience that is as ubiquitous as the many other forms of diversity that we have increasingly learned to anticipate, accommodate, and even value in our doctoral student cohorts.

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