Therapists as Wounded Healers:  
The Impact of Personal Psychological Struggles on Work with Clients

A thesis submitted to the Miami University  
Honors Program in partial fulfillment of the  
Requirements for University Honors with Distinction

by

Laura Christine Telepak

May 2010
Oxford, Ohio
Abstract

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By Laura C. Telepak

The prevalence of psychological distress among the therapist population is significantly higher than the general population. However, there is a surprising lack of research on the wounded healer and how being wounded influences the therapeutic relationship and impacts one’s clinical work with clients. The goal of this study was to explore the relationship between a therapist’s history of psychological distress – specifically, depression, anxiety, or substance abuse – and the impact this had on therapy with clients. Interviews with eight therapists were qualitatively analyzed using Interpretative Phenomenological Analysis. The major themes that emerged included: variability in the experience of treatment and stage of recovery, specific countertransference reactivity related to the therapists’ own wounds, benefits and difficult consequences of personal woundedness, and the importance of self-care. The results indicated that participants who had effectively worked through the issues surrounding their own wounds and were both aware of and capable of managing countertransference effectively did consider themselves better able to establish an effective relationship with their clients. However, the relationship between the different themes and the concept of the wounded healer was complex. Participants reported that their experiences as a wounded healer had been both beneficial, but also harmful at times, in terms of their ability to be effective with clients. Personal stigma surrounding the diagnosis and treatment of mental illness was also a concern for many therapists. Directions for future research in this area, both in terms of the need to de-stigmatize mental health issues and to provide guidance to therapists who are themselves wounded healers, are discussed.
Acknowledgments

I would like to thank my advisor, Dr. Margaret O’Dougherty Wright for all her support and guidance throughout my entire involvement on the Wounded Healer Project these past two years. I would also like to thank Larissa Seltmann for being my partner during the qualitative analysis process and for helping in the revisions of this thesis.
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Therapists as Wounded Healers:

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In Western society, therapists and counselors are expected to be able to help others because they themselves know how to live a healthy and well-adjusted life. According to Sussman (1992), “the idealized image of the psychotherapist is that of a paragon of health and maturity” (p. 121). However, contrary to popular opinion, a majority of the therapist population displays a significant history of psychological distress and trauma. Although some of these therapists are considered impaired professionals, those who are able to overcome their history of distress are called wounded healers. This paper will focus on those therapists who have experienced psychological distress, including depression, anxiety, and substance abuse, and explore their perception of how this history influences their work with clients in therapy.

Introduction to the Wounded Healer

The concept of the wounded healer has existed for a couple thousand years and has its origins in Greek mythology. The myth of Asclepius introduces the paradox of the wounded healer through several of its characters. Asclepius is trained in medicine by Chiron, a centaur and a healer, who suffers from an incurable wound. Eventually, his healing powers threaten the gods and Asclepius is struck down by lightening before he himself becomes the god of medicine. The myth suggests that only through being wounded can an individual truly have the power to heal others (Groesbeck, 1975; Kirmayer, 2003). Since its introduction through mythology, the wounded healer has found a place among the Jungian archetypes and can be described as a complex
interaction between the therapist and the client. The paradigm of the wounded healer suggests that there is both a healer and a patient within the therapist and the client. According to this dynamic, the therapist’s own wounds may be activated but they can potentially be used in turn to encourage self-healing in the client (Groesbeck, 1975; Miller & Baldwin, 2000; Sedgwick, 2001).

An important distinction must be made between the concepts of the wounded healer and the impaired professional. Impairment of mental health professionals has been defined as “interference in professional functioning due to chemical dependency, mental illness, or personal conflict” (Laliotis & Grayson, 1985, p. 84). Research has also suggested that mental health professionals with a history of personal conflict, mental or emotional distress, or family of origin issues are more vulnerable to becoming impaired (Pooler, Siebert, Faul, & Huber, 2008). Although wounded healers may experience impairment as a result of their wounds, they differ from impaired professionals in their ability to effectively deal with the issues surrounding impairment. According to Park (1992), it is not necessarily the individuals who have experienced the most sickness that have the power to heal, but whether they have the ability to understand and deal with their own problems. In his words: “They must be people who have suffered enough themselves to understand other people’s pain, but who are no longer controlled by their own disturbance. It is a balancing out” (Park, 1992, p. 26). It is not the presence of the wound but the process of recovery that contributes to healing power (de Vries & Valadez, 2005). A therapist who is wounded and whose distress adversely impacts his or her clinical work would be considered an impaired professional and not a wounded healer.
Another crucial aspect to the wounded healer phenomenon is the acknowledgement that it requires an interaction between two people. Psychotherapy is a relationship between the therapist and the patient. The impact of the therapist cannot be ignored; the therapist brings his or her own experiences to the therapy (Sussman, 1992). Since both the therapist and the client have their problems, where the two meet and interact is where healing and transformation occurs (Sedgwick, 1994). The relationship is essential and can determine whether the dynamic is ultimately helpful in the healing process.

The desire for this interactive relationship with a client is one of the motivations people have for becoming a psychotherapist. Norcross and Conner (2005) suggest that psychotherapists are attracted to the polarity of health and sickness that they see in others as well as in themselves. Histories of woundedness or exposure to mental and/or emotional disturbances as a child have been cited as primary motivations for becoming a psychotherapist (Barnett, 2007; Sussman, 1992). It has been suggested that the therapist’s own psychological problems may contribute to not only the desire but also the ability to heal others (Sussman, 1992). In other words, a personal experience of woundedness may create an empathic environment suitable to promote the healing process in the client, although it is not necessary for the therapist to disclose their history in order to achieve this (Kirmayer, 2003). The development of such an environment may be dependent on the type of wound experienced or shared by the therapist and client.

While there is not much literature on the wounded healer as it applies to depression and anxiety, some research has focused on the wounded healer with regards to
substance abuse. There has been a long history of recovered alcoholics and addicts providing services to the community because they can create that empathic environment with their clients. The debate over their effectiveness as counselors in addictions treatment has centered on their risk of relapse, especially due to job stress. However, former addicts are often capable of a deeper empathic relationship with clients based on their personal understanding of the client’s experiences (White, 2000). It remains to be seen whether wounded healers who struggle with other types of psychological distress, such as anxiety and depression, are able to achieve the same level of therapeutic alliance with their clients.

Countertransference, Personal Therapy, and the Wounded Healer

Countertransference is an issue that all psychotherapists encounter but it is especially relevant for the wounded healer. While transference in therapy occurs when the client transfers his or her feelings for another person to the therapist, countertransference occurs within the therapist. According to the model put forth by Hayes and Gelso (2001), countertransference has five components: origins, triggers, manifestations, management, and consequences. The origins of countertransference are based on the therapist’s unresolved conflicts, which could be family of origin issues, gender and cultural issues, parenting and partnering issues, and unmet needs of the professional and personal self, such as the desire to feel competent or have control. Triggers typically occur within the therapy setting and are what generate the reactivity within the therapist. These consist of client attributes, therapy content, and the therapy process, all of which could include situations or material that is related to the therapist’s
own unresolved issues. The actual experience of reactivity can manifest in several ways. Affective manifestations are typically strong emotions such as anger, sadness, or anxiety that the therapist experiences. Cognitive manifestations occur when the therapist commits errors in perception of the client, is unable to maintain objectivity, or makes decisions about the therapy process that are related to his or her distorted perceptions of the client. Behavioral manifestations are typically expressed through avoidance and distancing from the client, approach and over-identification with the client, or other forms of acting out (e.g. verbally lashing out, acting on sexual attraction) (Cain, 2000; Hayes & Gelso, 2001; Hayes, McCracken, McClanahan, Hill, Harp, & Carozzini, 1998).

It is inevitable that therapists will be emotionally activated by the client but management of countertransference is valuable in reducing the potential negative impact on the therapy. Effective management is facilitated by therapist self-insight, self-integration, anxiety management, empathy, and conceptual understanding of the therapy dynamics (Hayes & Gelso, 2001). The better a therapist is at managing his or her countertransference the more likely the therapy outcome will be favorable. If managed properly, countertransference can be used to strengthen the therapeutic alliance rather than weaken it (Hayes & Gelso, 2001). The reactivity the therapist experiences can be a positive source of information, allowing access to greater empathy, trust, and understanding with the client (Cain, 2000).

Successful management of countertransference is gained primarily through self-awareness, self-reflection, supervision, and the therapist’s own personal psychotherapy. Research and the personal experiences of therapists have dictated the necessity of a
therapist working through his or her own issues and at the very least being aware of them (Kirmayer, 2003; Groesbeck, 1975; Park, 1992; Sedgwick, 1994; Stout, 1993; Sussman, 1992). Denial of one’s wounds can ultimately put the therapist and client at risk for the harmful effects of countertransference (Kirmayer, 2003) or otherwise negatively impact the therapy. Therapists who have not dealt with their psychological distress run the risk of becoming impaired professionals. The problems that impairment creates include the therapist’s inability to focus on the needs of the client and to provide a stable and predictable environment. Additionally, the impaired therapist’s own psychopathology could prevent clear judgment and disrupt his or her ability to emotionally and physically handle distressed clients (Gilroy, Carroll, & Murra, 2001; Guy, 1987).

Aside from helping the therapist manage his or her symptoms, personal therapy has been reported to have a variety of positive consequences for the vast majority of therapists. Several beneficial consequences include: learning about the self, improving one’s own emotional and mental health, appreciation for the therapeutic process from the patient’s perspective, and development of empathy and understanding (Gilroy et al., 2001; Norcross, Strausser-Kirtland, & Missar, 1988; Stout, 1993). In turn, these effects reduce the chances for countertransference in client therapy and help the therapist effectively deal with the stresses of the profession (Norcross et al., 1988). Many therapists also feel that their professional development was strongly influenced by their own therapy; not only are they better able to identify with the therapist role but it may facilitate their relationships with clients (Barnett, 2007; Orlinsky, Norcross, Rønnestad, & Wiseman, 2005). However, some studies based on client outcomes indicate that there is
inconclusive evidence that therapists who have experienced personal therapy are more effective in their work with clients (Clark, 1986; Orlinsky et al., 2005; Sussman, 1992). The suggestion has been made that therapists who have struggled with psychological distress and have undergone personal therapy may be too preoccupied with their own problems and unable to completely focus on the needs of the client (Clark, 1986). This relates to the problem of the impaired professional and how impairment can negatively impact a therapist’s work with clients.

**Why study the Wounded Healer?**

Although there is some research on how therapists benefit from their own personal therapy, there is very little that addresses how the therapists’ recovery processes influence the work these therapists do with clients in therapy. This is unusual considering a large percentage of practicing therapists have struggled with their own psychological wounds. Across studies it has been determined that around 75-85% of therapists have had at least one experience of therapy – which is substantially higher than the 25% found in the general population (Bike, Norcross, & Schatz, 2009; Norcross & Guy, 2005). Although some therapists acknowledge that their reason to pursue therapy was to fulfill a training requirement, the majority seek help for their own psychological or interpersonal problems. The most frequently reported presenting problems for therapists pursuing their own therapy are depression, marital conflicts, and anxiety (Bike et al., 2009; Norcross & Connor, 2005). With regards to the disorders that will be examined later, depression, anxiety, and substance abuse, averaged statistics across several studies reveal that approximately 73% have experienced significant anxiety, 58-62% serious depression, and
11% have had substance abuse (Deutsch, 1985; Gilroy, Carroll, & Murra, 2002; Sherman, 1996; Sussman, 1992). These studies demonstrate that a large percentage of therapists have experienced psychological distress and could be wounded healers. Despite these high figures, there is little research on how these wounded healers use their experiences with psychological distress to inform their treatment of others.

**Stigma of Mental Illness**

Considering the high prevalence of psychological disturbance in the therapist population it is important to understand one of the predominant challenges to the mentally ill, stigma, and its potential effects on the wounded healer. The stigma of mental illness has a profound effect on the treatment of and experiences of those who suffer from a psychological disorder, leading to the tendency to hide one’s distress in order to avoid stigma. Historically, the development of stigma is based on misconceptions that the mentally ill are dangerous, contagious, and incompetent. The experience of stigma has been associated with shame, humiliation, and disgrace in individuals diagnosed with mental illness (Arbodela-Florez, 2003; Watson, Corrigan, Larson, & Sells, 2007).

The very act of a psychiatric diagnosis often results in negative consequences that impact the health of the individual. One of the primary consequences is that people do not seek treatment for their mental illness due to their feelings of anxiety, fear, and shame (Arbodela-Florez, 2003; Dinos, Stevens, Serfaty, Weich, & King, 2004; Hinshaw & Stier, 2008). They may also begin to internalize the negative stereotypes they perceive in their environment – known as self-stigma – which leads to decreased self-esteem and self-efficacy and has the potential to limit their recovery (Watson et al., 2007). In addition,
many individuals experience overt discrimination through violence, harassment, or social isolation (Dinos et al., 2004; Hinshaw & Stier, 2008). All of these consequences contribute to an individual’s attempt to hide his or her psychological distress for as long as possible, including those individuals who work in mental health fields.

Mental health professionals are not immune from the influence of stigma, much of which is associated with the impaired professional. As stated earlier, therapists are assumed to be able to fix their own problems and to have achieved the pinnacle of mental health (Sussman, 1992). If a therapist becomes impaired and is unable to live up to these expectations, he or she may be stigmatized by society and the mental health profession. Therapists have often been portrayed in the media as neurotic, substance abusers, or affected by mental illness themselves (Schulze, 2007). When a therapist does in fact suffer from psychological distress, there can be shame associated with needing psychotherapy and being identified with the population one is trying to treat (Norcross & Connor, 2005). In addition, it is not uncommon for professionals to fear disclosing their psychological distress if questions about their competency could result in the loss of their job (Dinos et al., 2004; Pachankis, 2007). The assumption is that a mental health professional who is impaired is unable to provide the standard of care necessary to be an effective therapist (Forrest, Elamn, Gizara, & Vacha-Haase, 1999; O’Connor, 2001). Jamison (2006) summarizes the view of several professionals who suffer from mental illness: “all made the irrefutable point that it was disingenuous for hospitals and medical schools to expect health-care professionals to be straightforward about mental illness
when their hospital privileges, referral sources, and licenses to practice were on the line” (p. 534).

Most impaired professionals attempt to conceal their distress, which can have a number of negative consequences. Pachankis (2007) developed a model that describes the psychological implications of concealing a stigma such as mental illness. According to the model, these therapists can suffer from anxiety and depression, feel ashamed and insecure, and exhibit strong social avoidance or hostility, all in the attempt to conceal their psychological distress. The very act of avoiding stigma can increase the amount of distress and impairment the therapist experiences, perpetuating the cycle of concealment and distress. As a result, professionals who are wounded healers are unlikely to share their histories if they will be met with the stigma and discrimination associated with the impaired professional. For this reason, there is not a lot of information about therapists’ experiences as wounded healers providing therapy.

Being a wounded healer carries both positive and negative consequences but due to the lack of research the impact of this is not well understood. On the one hand, wounded healers can use the insight derived from their own wounds and struggles to promote healing in their clients; but on the other hand, if they cannot manage the countertransference they experience when their wounds are activated, they might damage the therapeutic alliance. Although there has been no conclusive empirical evidence to indicate that therapists who are wounded and have experienced personal therapy are actually more effective and produce better outcomes for their clients (Clark, 1986; Orlinsky et al., 2005; Sussman, 1992), the experiences do impact the work with clients –
for better or worse – so it remains an important area to study. The therapist is not a passive observer in the clinical encounter but is a participant in a complex relationship. Exploring how he or she responds to the client and deals with issues of countertransference and stigma is to gain further understanding of the wounded healer.

In order to tease apart some of the complexities and consequences of being a wounded healer, this research focuses on the following question: how does a psychotherapist’s personal experience with psychological distress (depression, anxiety, substance abuse) facilitate or impede work with clients in therapy? The goal is to describe the subjective experiences of therapists who can be considered wounded healers and to illustrate the impact that has on their work. Since the individual’s interpretation of his or her experiences is central to this study, a qualitative method and analysis was selected as the best approach. Case examples not only provide an emic, or insider’s viewpoint, but they are better able to capture the unique perspectives of the individual therapists. This process is necessary to achieve a level of understanding and description of therapists’ personal experiences that will fulfill the aims of this study.

Method

Participants

Participants were psychotherapists who responded to a flyer asking for therapists who would be willing to discuss their experiences as a Wounded Healer. The final sample was composed of thirty-two therapists from a variety of regions across the United States who have struggled with a variety of wounds and from this sample eight were selected that had specifically experienced a psychological problem. In this subgroup, the
number of years in practice and/or training ranged from 4 years to 32 years; six were practicing therapists and two were graduate students undergoing doctoral training in clinical psychology or on internship. All participants had at least a Master’s degree, two had a Ph.D. or Psy.D, two were working toward a PhD, and one was working toward an EdD. The participants’ ages ranged from 28 to 63 and there were four women and four men. Seven of the participants were Caucasian and one was an American Indian. Regarding the specific types of psychological distress experienced, three suffered from depression, three from some form of anxiety, and three from substance abuse; one participant had experienced both depression and anxiety and one participant had experienced both depression and an eating disorder. All participants are referred to by pseudonym. For more details on participant demographics see Table 1.

**Procedures**

Participants were individually interviewed by the primary investigator as part of a larger study focusing on therapists who had a history of prior trauma, physical illness, or psychological difficult. The primary investigator has a Ph.D. in psychology and is a clinical psychologist with over 25 years of clinical experience. A semi-structured interview format was used that covered the following areas: background information, general beliefs regarding self-disclosure, personal experiences with self-disclosure, therapist’s own reactivity to client content based on past history, and maintaining personal well-being. Each interview was recorded and in turn transcribed verbatim; pauses more than two seconds were marked, and time-stamps recorded every 4-5
minutes. The resulting transcripts were then formatted with two-inch margins on both the left and the right side to allow room for the coding directly on the transcripts.

The process of qualitatively analyzing each interview followed the procedures of Interpretative Phenomenological Analysis (IPA) (Smith & Osborn, 2003). The goal of IPA is to describe the participants’ subjective experiences of an event, in this case, their experiences as wounded healers. The first stage of analysis was extraction along the left-hand margins; each line of the participant’s response was summarized or paraphrased, with some preliminary interpretation. The questions and responses of the interviewer were not coded. The extraction was fundamentally grounded in the participant’s own words and significant comments were quoted directly. The entire interview was first coded on the left side before moving to the second stage. In the second stage, the initial notes on the left side were transformed into abstract themes along the right-hand margins, all the way through the transcript. The themes were based on psychological theory and concepts (e.g., countertransference, therapist use of self-disclosure, etc.). Like the initial extraction, the themes were specific to the interview but were also broad enough to allow connections across interviews.

The first and second stages of analysis for each individual interview were independently completed by at least two coders trained in IPA. Following this, the coders met together to construct an outline based on the themes in the right-hand margins of one interview at a time. Each transcription was reviewed page by page and the major themes were listed on a separate document. During this process, connections were made between themes and then grouped under super-ordinate categories; each super-ordinate category
describes a subset of related themes. The outline was restructured when necessary; similar categories were combined or smaller categories subsumed into larger categories. After the outline was constructed, the coders went back through the right-hand side, highlighting important details. Details that were considered redundant or unable to add a significant level of description to the corresponding themes were not included. The details were then inserted into the outline to fill out corresponding themes and categories. The completed outline was audited by the lead investigator who then suggested possible additions or deletions to the outline to ensure adequate coverage of the entire interview. The coders returned to the outline, revised it, and submitted it for final approval by the auditor.

After every transcript was coded and an outline for each was constructed, the coders generated a final table of super-ordinate categories and subthemes encompassing all of the interviews. Notations were made under each theme to designate where the theme was found in each individual interview’s transcription. From this table, the super-ordinate themes relevant to the research question were selected (e.g., personal woundedness, countertransference). The final step was to translate these themes into a narrative account that included examples and verbatim text from the transcripts.

Results

The results of the analysis included a variety of super-ordinate themes but for the purposes of this study only the following four will be discussed: the experience of treatment and recovery, countertransference, the impact of personal woundedness, and self-care.
Experience of Treatment and Recovery

This master theme discusses the participants’ experiences of recovery from their particular forms of psychological distress, including the experience of personal therapy, substance abuse treatment, medication use, and other factors that influence recovery.

Personal therapy or treatment

All of the participants reported pursuing some form of treatment for their respective forms of psychological distress. Details of personal woundedness for each participant can be found in Table 1. Forms of treatment ranged from individual psychotherapy, group therapy, prescription medication, and substance abuse treatment programs. Each participant has had at least one experience of personal psychotherapy. Likewise, each participant reported pursuing therapy voluntarily and no one reported being coerced or mandated to attend therapy. Types of psychotherapy that were specifically mentioned included psychodynamic, humanistic, active Rogerian, and cultural therapy in a Native American tradition. Overall, psychotherapy has been variously helpful for the participants and most found it to be a good experience. Therapy helped the participants manage their psychological symptoms and determine the etiology of their distress. For example, Jerry’s work with a psychiatrist helped him make the connection between his survivor guilt following the Vietnam War and his PTSD symptoms that manifested many years later. The process of psychotherapy prompted participants to explore issues they had not explored before and to learn about their own emotional needs and what they could do to meet those needs. In Aaron’s words, a clinical
psychology graduate student who took a leave of absence in order to seek treatment for his panic symptoms:

When I went back home I started doing two days a week of psychotherapy, at first supportive because I was in bad shape. Uh and then uh, you know really getting into some of what my issues were and I really never explored a lot and there were a lot of me that was really impoverished…I mean there was a lot of um things I never received and things I couldn’t do for myself and I started with a wonderful therapist who was really just empathic as heck. And um you know helped me develop some compassion for a good year. (Aaron)

Medication was also a form of treatment pursued by several of the participants. All three participants who have struggled with depression have used or continue to use antidepressants. In addition to personal therapy, medication appears to help these participants successfully manage their symptoms and episodes of depression and has been an important component of their recovery. However, a couple of the participants expressed concern over the efficacy of the antidepressants. Kari, who has been on Prozac for her depressive episodes, described her relationship to the medication throughout a period of personal crises:

I stayed on the medication longer than I’d planned because of a series of crises in my life, and then recognizing that although I was kind of glad I was on the medication it doesn’t change the fact that life is happening and you still cope and you still have to grieve and you still have to, may have difficult times…and honestly many times, um I just thought, I really just wanted to stop the medication because there seemed to be no point in it because I was feeling badly (Kari)

Only one participant refused medication when it was recommended by his therapist. Aaron stated that he felt medication meant he would be incapable of doing the therapeutic work for his panic symptoms and underlying issues. The idea that medication is not a simple solution was expressed by several of the participants.
Those participants who have struggled with substance abuse have generally undergone formal treatment programs as well as personal therapy. Only Conor said that a substance treatment program was unnecessary for him to get his alcohol problem under control. Instead he utilized his graduate clinical training as a therapeutic process. Debra had a positive treatment experience through Al-Anon for her alcohol addiction. Initially she used the program for her husband’s addiction but it forced her to confront her own addiction and inspired her to become a detox therapist. Stacey was the only participant to discuss a thoroughly negative treatment experience. In her words she describes her experience in substance abuse inpatient treatment for her cocaine addiction during college:

> It was…a very horrible clinical experience in terms of the services that I got, was back in the 80s when, when uh drug addiction treatment was handled much different than it is today, um or at least the program that I went through was, was um…you know, you’re a liar, you know it was just a very, very painful - do you know what I mean? - in terms of it was very much in your face…very confrontive, you know it was like even when you were being honest you were still a liar so you know it was just very, very painful (Stacey)

Overall, personal psychotherapy was rated the most highly out of all the forms of treatment undergone by the participants. For some, although medication or substance abuse treatments were necessary, the experience of treatment was not as effective or as helpful as the participants expected.

*Other factors influencing recovery*

In addition to psychotherapy or other forms of treatment, several of the participants discussed other factors that promoted and encouraged the recovery process. For some participants, family support was crucial to their psychological recovery. Family often served as an inspiration for the participants to overcome their symptoms of distress.
Gavin described an episode after which he knew he needed to pursue treatment in order to protect his children from his depressive episodes:

I had taken my kids to this show and it was like kind of a combination circus and it had jugglers and it had, you know, all kinds of entertainment and you know we laughed…and we went home and I stopped at a stop sign on one of, one of the busiest streets in town and the stoplight, I mean the stoplight stopped and I couldn’t stop crying and I couldn’t drive and…always felt like I…like I’ve protected my children from that until then…I went back into therapy at that point in time…and I went on medication (Gavin)

Graduate school training and workshops were other factors that several participants reported as being a positive force in their recovery. Clinical training gave them a sense of self-awareness and by learning how to help others they learned to help themselves. The participants that have attended psychology workshops reported acquiring new tools to help them deal with their own issues. The very act of working with clients has also been an influential factor for some of the participants. Conducting therapy with clients who shared similar wounds helped them come to terms with their own wounds. Stacey described providing services to wounded others as a “cathartic experience.” When Jerry, a Vietnam veteran who struggled with survivor guilt and PTSD, was asked if working with veterans has contributed to his healing process he replied:

Yes, definitely. You’re not supposed to heal yourself when you go to work with other people, but…it happens (Jerry)

Other factors mentioned by the participants included supportive relationships with supervisors and colleagues, spirituality, making motivational notes, and mindfulness training.

In summary, personal treatment was utilized by all the participants and was considered an important part of their recovery but many participants attributed other
aspects of their recovery to other factors such as family support, training experience, and working with clients.

Countertransference

This master theme discusses the participants’ experiences of countertransference including the types of situations that trigger reactivity, consequences of countertransference, and strategies for the management of countertransference.

*Origins, Triggers, and Manifestations of Countertransference*

Although all of the participants have experienced countertransference within the therapy room, the origins of their countertransference issues varied. See Table 2 for specific details of countertransference. Several of the participants’ reactivity was grounded in family of origin issues, such as growing up with needy or emotionally abusive parents or experiencing a significant loss. For these participants, their psychological distress developed as a result of their childhood and young adulthood experiences. On the other hand, the origins of some participants’ reactivity were more directly related to their personal experiences with psychological distress. For example, Gavin experienced reactivity early in his career because he had not yet accepted his struggle with depression and Stacey’s reactivity was due to her negative experience with substance abuse inpatient treatment. These participants experienced reactivity with clients who shared similar experiences or suffered from the same wounds as the participants.

All of the participants were triggered by clients or a therapy setting that reminded them of their own personal woundedness. Countertransference typically occurred when a
client talked about their shared experience, be it depression, substance abuse, or military experience. In the words of Jerry, a Vietnam veteran who did not see combat:

The struggles that I have in talking to the people that evoke emotion in myself is if they went out in the field. They’re taking the weapons and going to set up, uh, an ambush in the middle of the jungle in the middle of the night. And they’re talking about flooding or going across streams and flushing out the enemy and having fire fights, people shot and people dying next to them. And my struggle with the guilt that, you know, I should have been there. (Jerry)

The internal reactivity that the participants experienced included affective, behavioral, and cognitive components. The emotions evoked were frequently strong and often tied to the participants’ own experiences; these included anger, sadness, and frustration. Some participants re-experienced their mental state as well as their emotional state from the time of their psychological distress. Stacey described the emotion and thoughts that flooded her when she first assumed the role of co-therapist in an addictions group during her internship:

Well some of it was the anger and the frustration, the embarrassment, and then part of it also, the addict part of me, just going oh my gosh, you know, do I want to go back there. It, it was crazy…it was really crazy addictive thinking and also just the raw emotions of that time [in treatment]. (Stacey)

Countertransference also manifested in the participants’ behavior towards their clients. Aaron described a time in which he experienced dissociation during a termination session because he could not handle the client’s sadness. Several of the participants reported that in some cases they have over-identified with the client’s experience and become too close or over-involved. Debra shared how her over-identification with clients’ experiences has led her to cry with clients in therapy:

I’m the cry lady and um, and so if I’m gonna cry with people though, I don’t want it to be about me or my stuff if I’m gonna cry with them I want it to be more supportive of them and what they’re dealing with but that’s not always possible.
Uh because sometimes those issues are too close and, and so I struggle with that. (Debra)

Consequences of countertransference on therapy

A few of the participants discussed how their experience of countertransference can impact the progression of therapy. They were concerned that at times they may not be as effective with clients as they should be because a client’s issue could be too close to their own and result in a loss of objectivity. Aaron’s struggles with reactivity towards needy clients have influenced how he responds to their needs:

I think that in terms of very needy clients, um, there are times when I can be a little bit withholding or I struggle with that a little bit, like, how much you know... how much to take care of them and feeling depleted by them, that’s a struggle for me sometimes because I, you know, it’s been part of my, my growth has been learning when to say no and when to trust my own feelings of depletion. (Aaron)

Other participants reported that their countertransference has influenced their perception of a client and may have affected whether or not they give a particular diagnosis. For example, Jerry’s anger evoked by a client’s fabrication of military experience or PTSD symptoms for financial gain has made him unwilling to give a PTSD diagnosis to certain clients. Other examples of the consequences of countertransference are listed in Table 2.

Management of countertransference

All of the participants recognized the importance of dealing with countertransference issues, especially when strong emotions are evoked within the therapist. Each of them has come to develop strategies for managing reactivity and this has influenced their ability to be effective therapists. The various strategies each participant reported with respect to specific countertransference issues are listed in Table 2. Several of the participants noted that self-awareness is vital in preventing
countertransference from negatively impacting the therapeutic process. Self-awareness has helped the participants to acknowledge their limitations, to pay attention to potential triggers, and to be conscious of their thoughts and feelings in response to clients and the therapy process. In addition, they identified the need to place boundaries between themselves and their clients. Many of the participants explained the necessity of keeping their experiences separate and not assuming that their own experience of depression or anxiety is similar to the client’s. Kari described how she is able to maintain that separation between the client’s experience of distress and her own depression:

> When I’m trying to understand their experience I, I want to make sure that what I think they’re grappling with…it’s not just what I’m thinking its that, that I can help them find words that really are accurate and that may not necessarily um, be similar to my experience and trying not to rely on that too much. And that’s where distance becomes better, it becomes more of a…yes distance from the problem, from the issues, personal issues, that helps a lot. (Kari)

Many of the participants attributed their achievement of self-awareness and separation from clients to acknowledging their own issues and working through them. The more understanding they had of themselves, the greater their ability to manage reactivity. Several participants stressed the significance of pursuing their own therapy and seeking supervision or peer support when countertransference issues arise. They are aware that the process of recovery is ongoing and they acknowledge the value of continuing to learn about the origins and triggers of their reactivity. Conor, who values his own experiences of reactivity, discussed why countertransference should be important to the therapist:

> I think it’s really, really important to be aware of transference and countertransference issues…you can’t not have it, it’s gonna be in the therapy. And it’s grist for the mill, there’s lots of uh, of learning that, that can happen (Conor)
Sometimes successful management of countertransference cannot be done within the therapy session or with particular clients. Several of the participants acknowledged that some clients may be too difficult or could evoke reactivity too strongly and in those cases they would refer the client to another therapist. In summary, all of the participants have experienced countertransference and at least some are aware of the potential consequences, which can be successfully managed by a variety of strategies.

Impact of Personal Woundedness

This master theme discusses how the participants’ felt their personal histories of psychological distress have positively or negatively impacted both their professional and personal lives.

*Positive benefits of personal woundedness*

Most of the participants shared specific ways in which their individual experiences of personal distress have benefitted or enhanced their work with clients and these are summarized in Table 3. They felt that their experiences were necessary in order to be able to relate more to clients and to understand more about themselves as therapists. The most common benefit described by several of the participants was the ability to personally identify with a client and familiarity with the patient’s perspective. Since many of the participants have been therapy clients themselves, they have a much greater understanding of what it is like to be in the vulnerable position of a client and what it is like to go through the recovery process. This generates more patience and empathy for the client’s position and can enhance the ability to establish a connection between client
and therapist. Drawing from his personal struggles with depression and being a patient was considered by Gavin to be an important tool in therapy:

I draw from it in several ways, one is I draw from it, from, you know, really understanding what it can be like and what it was like for me to be at that point where, you know, you’re helpless and um, or you feel hopeless and where even the smallest task can seem, is overwhelming, you know…And also understanding that what seems really clear to us as clinicians doesn’t always, isn’t always clear when you’re living it. (Gavin)

The participants’ histories also greatly influenced their knowledge of psychological struggles. These participants have experiential knowledge outside of reading books or of being a therapist since they are informed by their own psychological difficulties. As a result they are more sensitive to the need for normalizing the client’s psychological distress and make it less stigmatizing.

Several participants also acknowledged that their personal histories were “so necessary” (Aaron) for them to achieve a great deal of self-awareness and understanding about themselves as therapists. Awareness of their own wounds helped some participants distinguish between adaptive and non-adaptive ways of coping with those wounds. Conor described how his own recovery from substance abuse allowed him to be more honest with himself:

I’ve had different experiences and um, you know, learning to um, to become more self-aware, um, just learning about my, my blind spots, um, my limitations…I mean I’ve come to realize that, this is an ongoing, it’s a dynamic process that um, you know I can learn a lot about myself but like, it never really ends. (Conor)

Other participants also reported becoming more aware of their limitations and learning to accept the imperfections in themselves as a person and as a therapist. Participants also
gained knowledge of their emotional needs and learned how to meet them. The ability to meet their own needs also enhanced their ability to meet their clients’ needs.

Personal experiences with treatment and therapy have also influenced a few of the participants’ approaches to therapy with their clients. Some have adopted a particular framework or theoretical approach that they themselves had positive experiences with in therapy. For example, with his own clients Aaron prefers the dynamic and humanistic approach that he experienced with one of his therapists. Gretchen uses her own experience with antidepressants to help clients understand the effects of medication:

I strongly support the model of chemical imbalance [for depression] and that. I generally explain it like in, in terms of more, um, you know, use the medical type things. Like being diabetic or having high blood pressure and the fact that, you know, this helps your body work better. And um, some people don’t need it forever but for some people that’s just what their body needs to stay healthy. (Gretchen)

The participants’ own struggles have also impacted the types of clients that they are committed to working with. Both Stacey and Debra shared that their own histories of personal woundedness have inspired or motivated them to work with people who are wounded or have problems similar to their own. Stacey, who became deaf as a result of meningitis, has worked for many years with individuals who are deaf and has assumed a leadership role in facilitating services for this population. Debra is passionate about tailoring clinical interventions to better meet the needs of American Indians. Struggling with their own psychological distress and experiencing recovery has given them a passion to help those in their identified communities who are also struggling to achieve recovery.

Difficult Consequences of personal woundedness
In contrast to the benefits many of the participants have experienced as a result of their wounds, several of the participants also discussed how the same wounds have negatively affected their role as a therapist. These consequences of personal woundedness are listed in Table 4. Several of the participants described feeling an increased awareness and concern about the stigma towards psychological distress and its treatment, whether it is taking a leave of absence, going to therapy, or using medication. While they may not necessarily feel stigmatized themselves, these participants are still aware that others may discriminate against psychological distress and question their ability to be therapists. Aaron, whose leave of absence to seek treatment caused his graduate department to question his competence as a therapist, shared his view of stigma:

Because I don’t think there’s a shame to [the experience of treatment], there shouldn’t be a stigma to it, and too often I think there is or there can be. (Aaron)

Although a few participants did not specifically mention feeling stigmatized, they did report an unwillingness to disclose their personal histories with others. They claimed that very few of the people around them were aware of or knew the details of their struggles with psychological distress because they were uncomfortable making that disclosure.

The participants also suggested that they continue to feel the negative effects of their woundedness. Some have had or still have difficulty relating to others. Gavin described his cycle of social isolation in which, if left unchecked, he makes new friends and then withdraws from and loses them. Aaron is working on overcoming his limited emotional range, which he says is “not as great as it could be” and can affect his emotional response towards clients. Other participants reported difficulties in taking care of themselves and their own needs as a result of their struggles, specifically substance
abuse. Conor admitted his alcohol abuse at one time prevented self-care and Stacey suggested that her history of multiple wounds continues to impact her ability to take care of herself and contributes significantly to her overeating and problem with weight:

So when everybody says oh my gosh, you’re so well adjusting, uh for people who knew my, my life story you know there’s very few people, I always kind of just laugh uh because one of the ways I dealt with it obviously is eating and you know comfort. (Stacey)

One of the most severe consequences of personal woundedness for some of the participants was becoming an impaired professional for a limited period of time. Their psychological distress occurred while they were practicing or were in training and interfered with their ability to function in a professional environment. Aaron needed to take a leave of absence from graduate school training because he could no longer handle his academic and client responsibilities in conjunction with his panic and distress. Gavin described how his worst episode of depression significantly impaired his ability to do what was required of him as a therapist:

You know at its most severe I’ve literally had like months where I wasn’t able to complete a progress note…it was a pretty significant problem for me…I mean it was at the point where I was on probation, you know, for that, for those, those issues, not for the depression but for the impairment or the impact that it had. (Gavin)

Other participants shared that due to their own struggles, they have concerns about whether or not they can truly be an effective therapist for clients who have similar problems.

In summary, a majority of the participants have found their own experiences with psychological distress and treatment to be helpful within the professional setting but at
the same time they are aware that their histories can negatively impact their professional and personal lives.

Self-Care

This master theme discusses the importance of self-care to the participants and their strategies for promoting self-care within their professional and personal lives.

All of the participants recognized the value of self-care practices for themselves and for their clients. For the therapist, however, this practice is particularly important because it prevents burn-out and increases the ability of the participants to be effective therapists. Many of the participants acknowledged that their work with clients can be frustrating, depressing, and depleting; the administrative demands alone are exhausting. Conor, who works with victims of torture and war trauma shared why self-care is important to him as a therapist:

I think I just learned early on that, um, that I really need to um take good care of myself, to, to really be as helpful to [clients] as I could be. Um and that’s just gotten reinforced over the life of my career (Conor)

Many of the self-care strategies that the participants shared were very similar throughout the interviews. The primary component to good self-care was taking care of one’s physical needs and staying healthy. This included eating well, getting enough sleep, and regular exercise. Yoga was the most popular form of exercise listed by the participants and many considered it to be a good source of personal renewal as well as physical exercise. Mental and emotional health was also considered a priority and many of the participants mentioned personal therapy as a strategy promoting their self-care. Leisure activities such as pleasure reading, playing music, and baking were also common. Several of the participants stressed the importance of keeping their professional lives separate
from their personal lives. Spending time with family was extremely important to many participants so they could remove themselves from the daily stressors that come with being a therapist.

In addition to social support from friends and family, colleague and peer support was also frequently noted as necessary for self-care. Several participants have experienced a great deal of professional support through case consultations, being part of a program team, and peer supervision. Having a sense of that support system has been important for their professional well-being. Kari described how her current organization encourages peer support, an improvement over her previous jobs where support was lacking:

Here has a much better system umm they have what they call consult meeting and you’re required to, to attend certain ones, and you bring cases and its other professionals in there…it’s, it’s really much more helpful actually…oh I’ve been happy with that here, even though I’m, you know, still getting comfortable here, that piece clinically and just emotional support wise they’re good at saying, wow that’s a tough case. They’re really good at validating umm and that’s been lovely (Kari)

Although most of the participants have effective strategies for self-care, not all of them are able to put the strategies into practice. In the words of Stacey, a doctoral intern who is also a mother of five and has teaching and administrative duties on top of her degree work:

I need to lose weight, that’s the problem, that’s my big issue, I need to lose. That’s what’s not getting done is me and uh I’ll tell you, uh, I, I really need to do that, yeah absolutely need to do that, it’s not good for me…and I always tell my clients you can always make time to exercise but I honestly, right now, I don’t have the time (Stacey)

Self-care doesn’t come easily and many of the participants acknowledged that the process to obtain these self-care skills is something they have learned over time. It takes
determination and effort to stick to these strategies in order to prevent things like burn-out or professional impairment.

In summary, all of the participants recognize the necessity of self-care even if they cannot all engage in self-care strategies. Self-care may be difficult to practice but there are a broad range of strategies the participants have adopted in order to maintain their physical, mental, and emotional health.

Discussion

The study achieved its primary aim of describing the subjective experiences of therapists who have struggled with psychological distress and how this has impacted their work with clients. The procedure of an individualized interview allowed the researchers to be responsive and flexible towards each participant’s personal context and unique life experiences. The interviews were also conducted in a naturalistic setting that was rich with contextual detail and complemented the participants’ interpretations of their personal experience of the phenomena of the wounded healer. This inductive, interpretive approach allowed the researchers to focus on the following question: how does a psychotherapist’s personal experience with psychological distress facilitate or impede work with clients in therapy? The analysis of the participants’ experiences revealed that the answer to this question was complex and it relied on the relationship between the experiences of woundedness, awareness and management of countertransference, and sufficient understanding and containment of their own distress in order to be an effective therapist. Their different struggles with psychological distress affected how they individually dealt with recovery and countertransference issues. Furthermore, a history of
personal woundedness often resulted in both positive benefits and difficult consequences for the participants and their experiences could not be restricted to simply facilitating or impeding work with clients.

All of the participants pursued some sort of treatment to facilitate their recovery. Overall, the majority of the participants described psychotherapy as a positive experience that was crucial to helping them learn more about themselves and improve their mental and emotional health. This is consistent with previous studies that reported on psychotherapists’ experiences of therapy (Gilroy et al., 2001; Norcross et al., 1988; Orlinsky et al., 2005; Stout, 1993). Due to the different natures of the three types of psychological problems studied, the participants’ experiences of treatment and recovery were also different. The participants with histories of substance abuse were more likely to have completely resolved their substance abuse issues than the participants with depression who continue to use medication in order to manage their ongoing symptoms. In other words, participants were in different stages of recovery and this influenced their experiences with reactivity to client material. The participants who had achieved more distance from and resolution of their wounds reported that they had experienced more countertransference issues earlier in their careers, when those wounds were more raw. On the other hand, some participants are currently still undergoing treatment for their psychological distress and are more likely to experience more consequences due to reactivity. One exception to the generally positive experiences with therapy for most participants was Stacey’s negative inpatient substance abuse treatment experience. She described this treatment as horrible, painful, and confrontational. Her report is similar to
prior research reports from other therapists who also experienced negative treatments characterized by a lack of warmth, empathy, patience, and tolerance and the presence of distant, rigid therapists (Orlinsky et al., 2005). Although Stacey’s negative treatment experience was in the past, the harmful nature of the treatment might have impacted complete resolution of her addictive behaviors. Of interest, Stacey also reported that she continues to struggle with a different type of addiction, an addiction to food. Her painful experiences in this treatment setting might also impact countertransference issues for her later on when working with clients in inpatient substance abuse treatment settings.

In addition to pursuing personal treatment, participants discussed other factors that influenced their recovery. Consistent with previous literature, professional support through supervision and social support through friends or family are important to the distressed therapist’s recovery (Deutsch, 1985; Orlinsky & Rønnestad, 2005). Although much of the literature warns against therapists using clients to meet their own needs (Guy, 1987; Sussman, 1992), several of the participants reported that working with clients had promoted their recovery. They felt that conducting therapy with clients who shared similar wounds helped their own healing process in a sense and was a cathartic experience. It is important to note that they recognize the necessity of maintaining focus on the client and his or her needs. Being able to come to terms with their own struggles by working with clients in order to promote healing is part of what it means to be a wounded healer (Groesbeck, 1975; Guggenbühl-Craig, 1979; Miller & Baldwin, 2000). These participants demonstrated that recovery does not always happen within treatment
programs or personal psychotherapy but the experience of interacting with others as a therapist can be healing in and of itself.

Throughout the analysis, it was apparent how important personal treatment and working through their struggles has been to the participants’ issues with countertransference. Every participant has experienced countertransference related to his or her own wounds and overall their experiences follow the model of Hayes and Gelso (2001), containing origins, triggers, manifestations, consequences, and management. Consistent with the literature, the origins of the participants’ reactivity were based in their unresolved conflicts surrounding their respective psychological distress. They were triggered by clients or situations that reminded them of their own personal woundedness and their reactivity included affective, behavioral, and cognitive manifestations (Cain, 2000; Hayes & Gelso, 2001; Hayes et al., 1998). When countertransference is not successfully managed, it can negatively impact the therapy session. The manifestations of countertransference, especially a biased perception of the client and avoidance behaviors, can affect the progression of therapy and cause the therapist to be unable to objectively respond to the client and give accurate diagnoses. Similar consequences were reported by therapists whose psychopathology and reactivity clouded their judgment and perception of the therapy session (Gilroy, Carroll, & Murra, 2001; Guy, 1987).

For the most part, however, the participants were able to successfully manage their countertransference issues through a variety of strategies. These strategies, found also in the literature, include self-awareness or self-insight and management of symptoms or distress through personal therapy (Hayes & Gelso, 2001; Hayes et al., 1998). Although
they cannot avoid being activated by clients, many of the participants have resolved their issues enough that they experienced minimal reactivity and are able to separate their own issues and needs from those of the client. Several of the participants considered countertransference to be a valuable opportunity for therapists to learn about themselves, their triggers, and how they react to clients. Other research on therapists with psychological distress reports that many therapists take advantage of countertransference as a learning opportunity (Cain, 2000).

Successful management of triggers and manifestations of countertransference allowed the participants to use their own experiences to benefit therapy. The participants felt that their histories of personal woundedness helped them connect better to clients by being able to understand the experience of psychological distress and the vulnerability of being a patient. These benefits have previously been cited in the literature on therapists who have struggled with their own issues (Gilroy et al. 2001; Norcross et al. 1988; Park, 1992; Sussman, 1992; Stout 1993). The self awareness they achieved through recovery made them acknowledge their limitations in order to become more effective therapists. Consistent with reports of therapists who have personally undergone psychotherapy (Barnett, 2007; Orlinsky et al., 2005), the participants also reported that their professional development has been positively influenced by their histories of woundedness. Specifically, it has influenced their theoretical approach, beliefs regarding medication, and the types of clients they treat.

A history of struggling with psychological distress is not without its consequences. Much of the literature on the stigma of mental illness suggests that
professionals who suffer from psychological distress are more aware of this stigma in society (Arbodela-Florez, 2003; Barney, Griffiths, Jorm, & Christensen, 2006; Corrigan, Watson, & Barr, 2006; Watson et al., 2007). Although several participants reported an increased awareness of perceived stigma, from their report the stigma affected their relationships with supervisors and peers more than with clients. A few participants discussed their unwillingness to disclose their personal histories to others. According to the stigma research, this is most likely because they are afraid of experiencing discrimination as a result of stigma and feared that clients would question their competence and/or credibility (Cain, 2000; Hinshaw & Stier, 2008; Jamison, 2006). What did impact the participants’ relationships with clients was not dealing adequately with their own wounds. Two therapists indicated that at one point they became impaired as mental health professionals and needed to take a leave. Due to significant distress, at certain points in their careers, they became incapable of doing the work necessary to be an effective therapist. This parallels the concept of the impaired professional (Forrest et al., 1999; Laliotis & Grayson, 1985; Sherman, 1996). While none of the participants in the sample currently identify as an impaired professional, their experiences underline the necessity of dealing with one’s own issues before trying to do therapy with others, an idea frequently stressed throughout the wounded healer literature (Kirmayer, 2003; Groesbeck, 1975; Park, 1992; Sedgwick, 1994; Stout, 1993; Sussman, 1992).

In addition to managing their psychological distress and resolving underlying issues, all of the participants recognized the necessity for self-care in order to remain effective as therapists. The participants reported that self-care has been important in
maintaining physical, mental, and emotional health. This finding is consistent with recent research that stresses self-care as absolutely imperative for mental health professionals (Barnett, Baker, Elman, & Schoener, 2007). Self-care strategies are necessary in order to prevent daily stressors and psychological distress from resulting in impairment. Since mental health professionals with histories of personal woundedness are more likely to become impaired, these precautions are necessary (Pooler et al., 2008; Sherman, 1996).

Through the analysis of the participants’ experiences, the present study has suggested that many factors influence the ability to function successfully as a wounded healer. In order to be a wounded healer, a therapist must be able to resolve their issues as well as their psychological distress. The healing of the self allows the therapist to better understand and connect with the client and in turn influence the client’s healing (Groesbeck, 1975; Guggenbühl-Craig, 1979; Miller & Baldwin, 2000). However, when a therapist is not fully healed of his or her wounds, the issues can spill over into work with clients and often disrupt the ability to focus on the clients’ needs. At this point the therapist is no longer a wounded healer but an impaired professional (Forrest et al., 1999; Laliotis & Grayson, 1985; Sherman, 1996). Therapy is an interaction between the therapist and the client and a history of personal woundedness within the therapist can significantly impact the therapeutic process. In order to effectively promote healing within the client, the therapist must navigate his or her own wounds, recovery, countertransference, and self-care.

The limitations of the present study are based in the nature of qualitative research. The findings cannot be extended to a wider population with the same degree of certainty
that could be done with a quantitative analysis with a representative sample. Also, due to the use of case examples, the findings might not be replicable and might be unique to the relatively few people included in the study. The participants of the study self-selected and the analysis relied on the participants’ self-report of their experiences. Although precautions were taken to ensure confidentiality of the participants’ identities, participants may not have been willing to discuss the full extent of their personal woundedness. This could be a result of perceived stigma and the fear that they could be discriminated against or judged harshly if they fully disclosed. In addition, there is no way of verifying whether the participants are still experiencing problems with their psychological distress or if they are impaired or not. As a result, the connections made between the factors of personal woundedness, countertransference, impairment, and self-care may not be accurate.

Also, the nature of IPA leads to a complicated, subjective analysis and the conclusions reached by the researchers may only be one way to interpret the data. Researcher bias was built into the study by the nature of the interpretive process and it was unavoidable. The researcher is not objectively separated from the subject matter but contributes to the creation of meaning. Although the results can be more easily influenced by the researcher’s personal biases and idiosyncrasies, this subjective interpretation allows for a rich description of a phenomenon that has been little-studied by previous research. In addition, there were two coders and one auditor for the coding of every interview so the analysis was co-constructed and achieved some objective consensus about the interpretation.
There are several avenues for future research on the wounded healer. Considering the large percentage of therapists who deal with issues of personal woundedness, researchers should explore the distinction between the concepts of the wounded healer and the impaired professional. While the impaired professional’s underlying issues typically impede his or her professional performance, the wounded healer can potentially use his or her struggles to enhance the therapeutic relationship. In order to counteract the stigma towards mental illness in mental health professionals, future research should focus on examining how the experience of psychological distress can be beneficial to therapists. In addition to continued qualitative research on therapists’ own experiences, quantitative research would be better able to establish connections between therapists’ histories of distress and the impact it has on work with clients. Empirical support for the benefits and consequences of the wounded healer could provide the objective evidence that is missing from the current literature.

The present study carries several implications for the mental health profession. It suggests that therapists who have personally struggled with psychological distress do use that experience to relate better to clients. If a therapist has resolved his or her issues and can successfully manage countertransference, the experience of personal woundedness can become a valuable tool in therapy. However, the results suggest that self-awareness is crucial for therapists at any stage of recovery in order to recognize when their underlying issues are becoming problematic. Psychological distress within the therapist does not always result in impairment or incompetence. Stigma towards mental illness and seeking treatment could be reduced if the mental health profession understood more about the
wounded healer. Since such a large number of therapists have struggled with psychological distress, the potential for clients to benefit from the therapist’s experience of healing and recovery is great. This study demonstrates that the advantages gained from reduced stigma and greater acceptance of the wounded healer could impact both sides of the therapeutic alliance and continued research on the wounded healer phenomenon would contribute to a greater level of understanding within the profession.
References


Sherman, M. D. (1996). Distress and Professional Impairment Due to Mental Health


## Appendix

### Table 1: Participant demographics and details of personal woundedness

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age, Gender, Ethnicity, Marital Status</th>
<th>Position/Job, Degree</th>
<th>Details of Personal Woundedness</th>
</tr>
</thead>
</table>
| Stacey      | 40 year old, Female, Caucasian, married | • Clinical Psychology Internship  
• director of institute providing services for the deaf  
• MBA; MA | • Cocaine abuse in college  
• Meningitis induced deafness  
• Past incident of sexual assault |
| Gavin       | 50 year old, Male, Caucasian, married | • Clinical Psychologist at VA  
• PhD | • History of social anxiety – related to childhood trauma  
• History of major depressive episodes, beginning in teens |
| Jerry       | 63 year old, Male, Caucasian, married | • Therapist at VA  
• MSW Social Work | • Delayed PTSD reaction to Vietnam war – related to severe ongoing survivor guilt |
| Aaron       | 28 year old, Male, Caucasian single | • Clinical psychology graduate student  
• MA Psychology (working towards PhD) | • Severe panic symptoms and panic attacks – related to anxiety over feelings of inauthenticity and isolation |
| Kari        | 50 year old, Female, Caucasian, single | • Clinical Psychologist at community care center  
• PsyD | • History of major depressive episodes, beginning in teens  
• Accidental death of sibling and partner suicide |
| Gretchen    | 53 year old, Female, Caucasian, married | • Social worker for child foster care  
• MA Psychology;  
• BA Special Education | • History of depression, long and on-going  
• Suffered from an eating-disorder as a young adult |
| Conor       | 63 year old, Male, Caucasian, married | • Social worker for refugee torture victims  
• MSW Social Work | • History of alcohol abuse during his 20s and 30s  
• Emotionally abusive father |
| Debra       | 54 year old, Female, American Indian, married | • Counselor for grief and trauma; work with American Indians  
• MSE Counseling Education; working on Ed.D | • History of substance abuse – alcohol addiction  
• Significant family history of alcohol addiction  
• Personal history of childhood abuse |
Table 2: Examples of Countertransference Related to Personal Woundedness

<table>
<thead>
<tr>
<th>Origins</th>
<th>Triggers</th>
<th>Manifestations and Consequences</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stacey</td>
<td>Working in addictions setting during internship rotation; first time re-exposed to inpatient clients with substance abuse issues</td>
<td>Re-emergence of anger, frustration, and embarrassment related to her own past treatment; addictive thinking and behavior reactivated; concerns around disclosure</td>
<td>Acknowledging limitations; processing her past treatment history with supervisor and discussing the need for caution about disclosing unprocessed issues within the treatment setting</td>
</tr>
<tr>
<td>Gavin</td>
<td>Clients with depression (more so early in career)</td>
<td>Over-identification with clients’ struggle</td>
<td>Works at keeping client and therapist experiences separate; maintains the focus on the client and does not assume his experience of depression is similar; has pursued his own personal treatment for depressive episodes; can refer clients who are too triggering</td>
</tr>
<tr>
<td>Jerry</td>
<td>Vietnam vets experiences in the field; Intentional and delusional fabrication of experience in military for PTSD diagnosis and/or financial gain</td>
<td>Experiences guilt when hearing stories from the field; anger could influence whether he makes a diagnosis</td>
<td>Healing process – doing his own work; keeping client and therapist experiences separate</td>
</tr>
<tr>
<td>Aaron</td>
<td>Needy clients</td>
<td>Influences how he fulfills clients’ need for compassion; can respond by either withholding validation or by becoming depleted by giving too much; It can be difficult for him to say no or set limits</td>
<td>Pursued personal therapy and took a leave of absence; learned to acknowledge limitations and boundaries; learned to process internal reactions to clients; developed a balance between conflicting pulls; seeks</td>
</tr>
<tr>
<td>Name</td>
<td>Experiences with loss of relatives and partner through death or suicide</td>
<td>Clients who have experienced similar losses and deaths</td>
<td>Concerns about ability to effectively treat clients with similar loss issues, especially when this death has been recent</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------------------------------------------------------</td>
<td>-----------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Kari</td>
<td>Family of origin dysfunction and her own personal struggles with depression and an eating disorder</td>
<td>Parents who see their children as bad, push them too hard, are overly punitive and ignore the child’s positive characteristics</td>
<td>Becoming too close to clients to be objective; early in career, vulnerable to idealization by clients; reactivity can be related to her realization that families can change but it is difficult to break a destructive cycle</td>
</tr>
<tr>
<td>Gretchen</td>
<td>Lived with an emotionally abusive father and emotionally reactive mother</td>
<td>Working with emotionally abusive clients</td>
<td>Cognitively aware when clients are relating to him in an abusive way; confronts client, tries to change atmosphere or removes himself from situation</td>
</tr>
<tr>
<td>Conor</td>
<td>Historical traumas in American Indian community, current experiences of child abuse, loss, death, and substance abuse in family and community</td>
<td>Clients crying; clients with child abuse history and multiple traumas</td>
<td>Can over-identify with client’s tears and engage in over-caretaking; issues around abuse and loss trigger her own issues; can become too impacted by work; strong “abuse radar”</td>
</tr>
<tr>
<td>Debra</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 3: Benefits of Having Struggled with Psychological Difficulties

Increased ability to personally identify with the client experience

1. Increased ability to connect with and understand the client’s experience
2. Created empathy and humility about being in the client position
3. Enhanced understanding of the recovery process and the transformation that needs to occur for therapy to be successful

Self-awareness about limitations and needs

1. Promoted self-awareness of one’s own limitations, blind spots, and needs
2. Heightened understanding of oneself as a therapist
3. Heightened awareness of adaptive and non-adaptive ways of coping with woundedness
4. Resulted in greater compassion for the self, which led to greater client compassion
5. Led to an acceptance of imperfection in life

Influenced theoretical technique and approach to therapy

1. Informed both theoretical orientation and techniques used in therapy
2. Impacted one’s own philosophy of healing
3. Increased understanding of the utility of medication from personal experience with it and impacted how one talked to clients about the pros and cons of medication
4. Created passion for work with people who are wounded
5. Inspired motivation to work with specific types of clients and problems

Knowledge of issues surrounding psychological struggles

1. Helped to bridge the disconnect between book knowledge and experiential knowledge
2. Led to awareness of stigma and the importance of normalizing and depathologizing psychological struggles
3. Enhanced patience for clients’ struggles and ability to work with “more needy” clients
Table 4: Consequences of Having Struggled with Psychological Difficulties

Increased awareness of and concern about stigma

1. Hesitates to disclose personal history to colleagues and friends
2. Awareness of stigma attached to therapy as well as taking a leave of absence
3. Competence as a therapist was questioned by the DCT of graduate program
4. Uncomfortable discussing history of personal woundedness with others
5. Awareness of stigma surrounding medication use

Experiencing a continued negative impact

1. Scars on wrist a reminder of suicide attempt during substance abuse treatment
2. Experiences cycle of social isolation as a result of depression
3. Limited emotional range
4. Concerned about ability to effectively treat clients with similar experiences

Difficulties taking care of own needs

1. Inability to be a good resource for the self, to acknowledge emotional needs
2. Substance abuse impeded ability for self care
3. Appears well-adjusted but uses over-eating for comfort and to deal with issues

Becoming an impaired professional

1. Worst depressive episode severely impacted professional work; was put on probation
2. Forced to take a one year leave of absence during graduate school training