The Dilemma of the Wounded Healer

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The wounded healer is an archetype that suggests that a healer's own wounds can carry curative power for clients. This article reviews past research regarding the construct of the wounded healer. The unique benefits that a psychotherapist's personal struggles might have on work with clients are explored, as well as the potential vulnerability of some wounded healers with respect to stability of recovery, difficulty managing countertransference, compassion fatigue, and/or professional impairment. The review also explores psychologists' perceptions of and responses to wounded healers and examines factors relating to social stigma and self-stigma that may influence wounded healers' comfort in disclosing their wounds. We propose that the relative absence of dialogue in the field regarding wounded healers encourages secrecy and shame among the wounded, thereby preventing access to support and guidance and discouraging timely intervention when needed. We explore the complexities of navigating disclosure of wounds, given the atmosphere of silence and stigma. We suggest that the mental health field move toward an approach of greater openness and support regarding the wounded healer, and provide recommendations for cultivating the safety necessary to promote resilience and posttraumatic growth.

Keywords: wounded healer, recovery, resilience, posttraumatic growth, stigma

The wounded healer is an archetype that suggests that healing power emerges from the healer's own woundedness (Guggenbuhl-Craig, 1971; Nouwen, 1972; Sedgwick, 1994), and that the wounded healer embodies transformative qualities relevant to understanding recovery processes (Briere, 1992; Miller & Baldwin, 2000). In this review, we explore what it means to be a wounded healer, particularly, in terms of how this intersects with one's professional identity. In one sense, all therapists have had painful experiences, have confronted adversity, or have experienced physical or emotional suffering, and therefore have some degree of woundedness. The wounded healer paradigm suggests that *wounded* and *healer* can be represented as a duality rather than a dichotomy. Woundedness lies on a continuum, and the wounded healer paradigm focuses not on the degree of woundedness but on the ability to draw on woundedness in the service of healing. Goethe wrote that our own suffering prepares us to appreciate the suffering of others (cited in Jackson, 2001). The therapist's own past or present wounds can facilitate empathic connection with clients and the positive use of countertransference in therapy (Gelso & Hayes, 2007). The paradigm of the wounded healer suggests that it is the activation of the wounded-healer duality for *both* the therapist and the patient that constructively informs the healing process (Guggenbuhl-Craig, 1971; Miller & Baldwin, 2000; Sedgwick, 2001). As Gelso and Hayes (2007) explain: "Therapists who deny their own conflicts and vulnerabilities are at

risk of projecting onto patients the persona of 'the wounded one' and seeing themselves as 'the one who is healed' (p. 107). If such a dichotomous perception becomes entrenched in the therapy relationship, therapists can have difficulty accessing their own experiences of suffering and vulnerability to empathize with the client. Such splitting can also result in a lack of acknowledgment and encouragement of the client's own healing powers, fostering dependency (Gelso & Hayes, 2007). Importantly, being wounded in itself does not produce the potential to heal; rather, healing potential is generated through the process of recovery. Thus, the more healers can understand their own wounds and journey of recovery, the better position they are in to guide others through such a process, while recognizing that each person's journey is unique.

It is important to differentiate between the wounded healer and the impaired professional. The latter refers to therapists who are wounded and whose personal distress adversely impacts their clinical work (Jackson, 2001). Thus, it is critical that a therapist's wounds are mostly healed, or at least understood and processed sufficiently, to prevent them from interfering with therapy and the therapeutic relationship (Gelso & Hayes, 2007). However, there has been very limited prior research addressing how therapists' own recovery processes influence the work they do with clients and how therapists know that they have healed sufficiently to practice responsibly. The ambiguity regarding the degree to which the therapists' own wounds have healed presents a dilemma for both the wounded healer and other professionals. Psychologists' ethical responsibility to notice, address, and monitor impairment in colleagues (i.e., gatekeeping responsibilities) complicates the issue of engaging in open dialogue about how a colleague's or supervisee's wounds positively influence or interfere with their work. The wounded healers' concerns often pertain to potential stigma if the nature of the wound is disclosed and judgment by colleagues regarding their competence to practice. These concerns can result

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in secrecy, self-stigma, and shame. Thus, there has been a relative silence around the topic of wounded healers.

A central aim of this review is to raise concern over the absence of dialogue regarding the wounded healer, emphasizing the importance of developing the safety needed for the wounded healer to bring concerns to supervisors and consultants. Using such resources for support is critical to assessing, containing, and processing aspects of woundedness relevant to clinical work (Smith & Moss, 2009). By synthesizing the limited available literature in this area and highlighting areas to explore further, we hope to invite psychologists to engage in further discussion of wounded healers and the inherent related dilemmas. In Part 1, we provide an historical overview of the wounded healer construct and present a framework for understanding healer woundedness, delineating characteristics of wounds and how these factors can impact a wounded healer's recovery trajectory and clinical work. We explore corresponding professional perceptions of stigma and/or support, and ethical issues pertaining to gatekeeping responsibilities. In Part 2, we discuss implications for training and practice. We review various types of disclosure and highlight the costs inherent in stigmatizing disclosure, given the potential need for the wounded healer to seek consultation/supervision to clarify issues, access support, and, in some cases, address impairment. We address the incongruence between psychotherapists' responses to healer woundedness and our profession's espoused values and ideals, and provide recommendations for improving professional responses to wounded healers.

Part 1: Dialogue and Silence About Wounded Healers Within Psychology

The construct of the wounded healer has existed for over 2500 years and has its origins in Greek mythology and shamanistic traditions (Groesbeck, 1975; Kirmayer, 2003). Images of the wounded healer permeate religion, philosophy, and art, but also have a place in psychotherapy, counseling, and medicine, denoting a powerful duality of woundedness and healing within the therapeutic relationship. Jung was the first psychotherapist to reference the archetype of the wounded healer, drawing from Greek mythology and exploring applications to psychology (Jackson, 2001; Kirmayer, 2003). In his early writings, Jung described therapists' personal struggles as a contamination that must be eliminated, using the metaphor of a surgeon's clean hands, yet later in his career, his conceptualization shifted, and he wrote that "only the wounded physician heals" (Jung, 1963, p. 134).

The wounded healer construct has often been misunderstood, discounted, or romanticized, and has received minimal academic attention. However, it has been well documented that many psychotherapists arrive at their profession of choice through a journey that involves a history of pain or suffering (Barnett, 2007; Farber, Manevich, Metzger, & Saypol, 2005). Childhood experiences of woundedness have been cited as a primary motivation for becoming a therapist (Barnett, 2007; Sussman, 2007). Not surprisingly, a high percentage of therapists (75%–87%, in contrast to 25% of the general population) have also participated in therapy, some to meet required training needs, but many to seek help for psychological, interpersonal, or substance abuse problems (Norcross & Conner, 2005; Orlinsky, Schofield, Schroder, & Kazantzis, 2011).

Although for the most part there has not been a great deal of academic attention paid to the construct of the wounded healer, there have been a number of references to it in prior research. The most common mention of the wounded healer is in the form of a passing comment about the personal experiences that drew the therapist to this particular career (Barnett, 2007; Farber et al., 2005; Williams & Sommer, 1995). At times, the wounded healer's recovery is discussed in parenthetical comments that refer to unresolved or unprocessed material, or to "hopefully" resolved or processed material, revealing that psychologists are uncertain and cautious about whether, in fact, recovery has occurred. For example, Chu (1998) writes in his book on trauma:

> Why, then, do we do this work? Undoubtedly, some reasons are personal. Many of us have had our own painful experiences of feeling lost, victimized, or disenfranchised. We identify with our patients (*hopefully not too strongly*) and we use our own experiences (*hopefully not too prominently*) in our work (p. 207, italics added).

Similarly, Gil (1988) says that wounded healers are "familiar with the difficulties that survivors face, having experienced these difficulties themselves and (*one hopes*) having worked through them" (p. 275, italics added). These comments poignantly reveal the challenge of establishing certainty about the extent to which wounded healers are able to draw from wounds appropriately in therapy. Indeed, there have been surprisingly few detailed reports about what it *means* for a therapist to process, resolve, or recover from a wound in such a way that it might enhance, rather than interfere with, providing effective psychotherapy. Psychologists are often wary about the recovery status of the wounded healer—at worst, we judge, and at best, we worry.

In some areas of mental health treatment, the wounded healer is recognized for playing a distinctive role as a provider. In alcohol and substance abuse treatment, it is common—perhaps even preferred—for the counselor to have struggled with and overcome addiction (Jackson, 2001). It is said that those who have "been there" are the ones who truly know what recovery involves. Based on their personal experiences, they are often thought to have higher credibility regarding the recovery process and to have deeper empathic connections with their clients (White, 2000). Similarly, in the field of eating disorders, there has been recent attention to the possible benefits and challenges that arise when therapists who have personally recovered from eating disorders disclose to this client group (Bloomgarden & Mennuti, 2009a; Costin & Johnson, 2002).

The limited prior research that has examined these issues has explored the potential for positive and negative effects of woundedness on clinical work (Briere, 1992; Gil, 1988; Sedgwick, 1994). Commonly cited positive effects include a greater ability to empathize with clients, a deeper understanding of painful experiences, heightened appreciation for how difficult therapy can be, more patience and tolerance when progress is slow, and greater faith in the therapeutic process (Gelso & Hayes, 2007; Gilroy, Carroll, & Murra, 2001). Although the therapist's own wounds may be activated during psychotherapy sessions, they can potentially be used to promote self-healing within the client (Miller & Baldwin, 2000; Sedgwick, 2001). Research indicates that the wounded healer's countertransference can have a positive influence on therapy (Fauth, 2006; Gelso & Hayes, 2007; Sedgwick, 1994). Briere (1992) emphasizes that sufficiently recovered

wounded healers may make uniquely talented therapists. Commonly noted negative effects include decreased ability to be emotionally present, poorly managed countertransference, overidentification, projection, and having a personal agenda regarding the therapy process (Briere, 1992; Gil, 1988). The greatest concern pertains to boundary confusion or violation (Briere, 1992). In addition, some literature has examined disclosure to clients, in terms of positive and negative effects, which is discussed later in this review. Finally, researchers have consistently noted in studies of compassion fatigue that wounded healers are more vulnerable than other therapists to being traumatized by the clinical work itself (Pearlman, 1995; Salston & Figley, 2003).

However, psychological literature has most often not examined the topic of the wounded healer in depth; it is often only alluded to, or given a brief mention that pales in comparison to the depth that other topics have received. For instance, in her 301-page book on treating adult survivors of childhood abuse, Gil (1988) does have a chapter (at the end of the book) on the therapist survivor, but this chapter is actually only 2½ pages. Reference to the wounded healer is often set apart structurally from other material, appearing in the epilogue or afterword (e.g., Chu, 1998; Freyd, 1996), although some authors do make their woundedness an integral part of their message (e.g., Frankl, 1959; Westerlund, 1992). Given this brief coverage, many unaddressed issues remain. For instance, it appears that early in therapists' careers, and particularly during training, it feels riskier to disclose woundedness (Bloomgarden & Mennuti, 2009a; Sawyer, 2011; Stratton, Kellaway, & Rottini, 2007). The influence of career phase was evident in Jung's work: his early writings describe therapists' personal struggles as contamination to eliminate, whereas later his conceptualization shifted dramatically to highlight the importance of the healer's own wounds for fostering healing in the client (Sedgwick, 1994). Sadly, early in psychologists' careers may be the most important time for dialogue about this topic, but the perceived risk of an adverse professional consequence may appear greatest at this time.

Factors Preventing Dialogue and Contributing to Wariness Regarding Wounded Healers

Psychologists do not respond to all wounded healers consistently, making it challenging for wounded healers to navigate decisions about speaking openly about their wounds. We propose that perceptions of the significance of a healer's woundedness may vary on the basis of two dimensions: (1) characteristics of the wound itself (i.e., relevant stigma, social taboos) and (2) the scar that the healer bears (i.e., how marked the healer is by the wound and how fully recovered the healer is). Both aspects are critical to understanding psychologists' varied response to wounded healers. By developing a framework that articulates these factors, we hope to improve psychologists' ability to acknowledge and dialogue about perceptions of and responses to the wounded healer. We use the analogy of a physical wound to guide the development of our framework, using the scar to represent what is left after the wound heals—the sequelae of the wound and the degree of markedness left behind by the wound. This may encompass how a person handles feeling wounded, copes with distress, responds to triggers, or how visibly emotional struggles manifest. The treatment of a physical wound has clear procedures: it is important to care for the wounds, to clean them, and check on them. This involves keeping

wounds covered when there is danger of infection, but allowing them enough air that they may heal. Danieli (1994) speaks of therapists processing their own traumas as cleaning pus from their wounds. Even after a wound has healed, there is usually a scar (i.e., a lasting mark of woundedness) that lingers behind. Although the wound is no longer raw, open, and vulnerable to infection, a scar may still be a painful reminder of the wound. We speculate that when psychologists approach the wounded healer with wariness or doubt, there is an implied assumption that the wound has not truly healed, or that if it has, the scar is still only a scab, vulnerable to reopening.

Social and self stigma associated with characteristics of the wound. Past research on wounded healers has rarely discussed specific characteristics of the wound that might provide a framework for understanding divergent responses of stigma versus support. Wounding experiences differ on the basis of the nature, severity, and chronicity of the wound (e.g., time limited or ongoing struggles, a physical or psychological problem, a guarded or benign prognosis). In addition, the stigma associated with particular types of wounds is likely to have a significant effect on both the degree of comfort wounded healers experience regarding disclosure of their wounds and the response they receive from other professionals when they do disclose.

There has been a great deal of prior research examining the qualities represented in mental and physical health problems that appear to be related to stigma. Past research suggests that the social stigma of mental health problems is related to the following factors: visibility, dangerousness, treatability, and extent to which relationships are disrupted (Day, Edgren, & Eshleman, 2007). In general, people prefer to distance themselves from individuals with mental health problems on the basis of perceptions of dangerousness, personal responsibility/blame, but interestingly, not severity (Feldman & Crandall, 2007). For individuals whose wounds are related to physical health, degree of contagion is also a source of stigma and can lead to others distancing themselves (Bishop, Alva, Cantu, & Rittiman, 1991). Consequently, awareness of the stigma associated with one's condition, both generally in the culture and specifically within the profession, is associated with humiliation, shame, and disgrace (Hinshaw & Stier, 2008). This can lead to efforts to conceal the wound, as well as social isolation, negative mood, lower self-esteem, and self-consciousness (Pachankis, 2007). The stigma of mental illness, broadly perceived throughout society, has a strong effect on individuals' willingness to seek treatment for mental illness due to feelings of anxiety, fear and shame (Dinos, Stevens, Serfaty, Weich, & King, 2004; Hinshaw & Stier, 2008). Individuals who receive stigmatized treatment may internalize the negative stereotypes (self-stigma) that they perceive in their environment (Watson, Corrigan, Larson, & Sells, 2007). This can result in a perceived need to hide one's wounds in order to avoid stigma, a reluctance to speak openly when one struggles, and finally, a concern about the stigmatizing effects of seeking treatment. For therapists struggling with ongoing wounds, the risk of disclosure to other professionals may appear too great, particularly if the therapist has internalized self-stigma associated with his or her wound and/or perceives that colleagues hold stigmatizing beliefs.

It is important to recognize that psychologists are embedded within a larger social context and are influenced by widely held social beliefs (Schulze, 2007). We suggest that despite the fact that

psychologists may not espouse the public's views on mental health issues when approaching their *clients*' struggles, they might approach their own and their colleagues' wounds in a manner more consistent with social stigma. We propose that when psychologists move from a guiding role, typically associated with the stance of a therapist (e.g., accepting, supporting, validating), to a gatekeeping role (e.g., acting as representatives of the profession, protecting clients, and screening out those who may potentially do harm; Falender, Collins, & Shafranske, 2009), the impact of the social stigma of specific wounds may increase.

Psychologists' varying responses of stigma and support may be best understood as reflecting social stigma related to specific characteristics of the wound. Perceptions of dangerousness influence wariness, as carrying a diagnosis of schizophrenia is perceived differently from panic disorder, given the association between psychosis and dangerousness. The visibility of the wound depends on whether symptoms are overt or covert, and whether or not the wounded healer makes disclosures regarding wounds that can be concealed. With regard to treatability, colleagues might respond quite differently to a therapist's disclosure of depression in contrast to a disclosure of a personality disorder diagnosis, which carries a poorer prognosis for recovery. Finally, the issue of personal responsibility/blame is important, because people often harshly judge and/or condemn individuals who have engaged in acts that horrify them. As such, when a therapist has caused harm to another person (e.g., accidentally causing a death; Anonymous, 2007) or seems to be responsible for his or her own fate (e.g., staying in a domestic violence relationship), the degree of stigma associated with the wound may be even higher. The social stigma and the self-stigma associated with some wounds can serve to alienate and silence the wounded healer, making trainees and professionals feel that only secrecy protects them from stigma or judgment.

Another important factor that impacts a wounded healer's comfort in disclosing his or her woundedness is the existence of relevant social *conspiracies of silence*, which maintain that certain types of wounds are taboo (e.g., being a victim of incest; Butler, 1978; Herman, 1992) or disgraceful (e.g., harming another person; Anonymous, 2007). These types of woundedness, which fall within the realm of "unspeakables" or "unmentionables," are relegated to the social domain of "some things are better left unsaid" (Zerubavel, 2006, p. 76). Conspiracies of silence convey to a wounded healer who bears a "taboo" wound that privacy and silence are the wisest approaches with colleagues. Conspiracies of silence have also been identified in the absence of discussion regarding countertransference to trauma (Danieli, 1994) and compassion fatigue (Figley, 2002). Therapists might fear criticism and judgment from colleagues if they openly discuss wounds or struggles that are "unmentionables." Consequently, they may be more apt to maintain cultural imperatives, such as participating in the conspiracy of silence around these issues. The influence of stigma and conspiracies of silence clarifies the lack of discussion regarding wounded healers. Research on these social influences provides support for the two factors we hypothesized as influencing the tendency toward wariness regarding the wounded healer: (1) social stigma associated with characteristics of the wound, and (2) perceptions of the scar the healer currently bears (e.g., concern regarding fragility or continuing symptoms), highlighting uncertainty regarding the present and/or future functioning of the wounded healer.

Recovery trajectories: The uncertain stability of the wounded healer's recovery. Recovery is not necessarily linear or, when achieved, permanent, contributing to the complexity of assessing a wounded healer's recovery status. While psychologists can assess the wounded healer's history of functioning, there is, inevitably, uncertainty about the wounded healer's future trajectory. We propose four different types of future trajectories that might characterize therapists who have struggled with a significant wound: (1) a trajectory anticipating recovery over time; (2) a trajectory characterized by posttraumatic growth; (3) a relapse trajectory, anticipating fluctuations and setbacks; and (4) a chronic dysfunction trajectory anticipating continuous symptom-related struggles (see Figure 1). It should be noted that these four trajectories are presented to illustrate the variability that is possible in recovery trajectories and are only some of the many trajectories of recovery that might occur. Because recovery processes are dynamic and include various trajectories, there is inherent uncertainty regarding an individual's future psychological functioning (Howard, 2006). Articulating this ambiguity helps to clarify the wariness and suspicion that wounded healers often encounter professionally. The uncertainty regarding wounded healers' future functioning provides a framework for understanding the challenges faced by supervisors/consultants in responding to them. We suggest that professional wariness toward wounded healers is based on concern for relapse and regarding chronic dysfunction. The key issue for wounded healers, and for other professionals, is whether or not the manifestations of the wound interfere with or enhance their ability to provide effective and appropriate therapy.

Chronic dysfunction and relapse trajectories: The dilemma of gatekeeping. It is critical to understand the tension inherent in the uncertainty of recovery trajectories (Howard, 2006), and how this might impact the stigma or support a wounded healer receives from other professionals. Uncertainty regarding the wounded healers' future functioning elicits doubt: we do not know how fully recovered a person is when we meet him or her, nor do we know where he or she will be in the future. The problematic question evoked by this uncertainty is whether recovery is permanent/stable, temporary/fragile, or not achieved at all (Howard, 2006). If perceptions of the healer's wounds and the nature of recovery lead to a fear that the wounds could easily become active again (e.g., a recurring depressive episode or an addiction relapse), concern regarding the stability of recovery is foremost. For those therapists who struggle with chronic and enduring symptoms (e.g., dysthymia), concerns relate to the degree to which the symptoms interfere with optimal clinical functioning and currently impact energy, concentration, judgment, and empathy. Some wounded healers might have a chronic condition with continuous symptoms that do not interfere with therapy. For example, an individual who is struggling with a continuing physical health problem may find that it does not interfere with clinical work. We emphasize that the uncertainty of the wounded healer's recovery is threatening for both the wounded healer and other psychologists, raising issues pertaining to competence in clinical practice.

Recovery and posttraumatic growth trajectories: Benefits of the healer's woundedness. Significantly, woundedness is not only a risk factor—when wounds are properly tended and appropriately treated, some healers may derive benefit from their
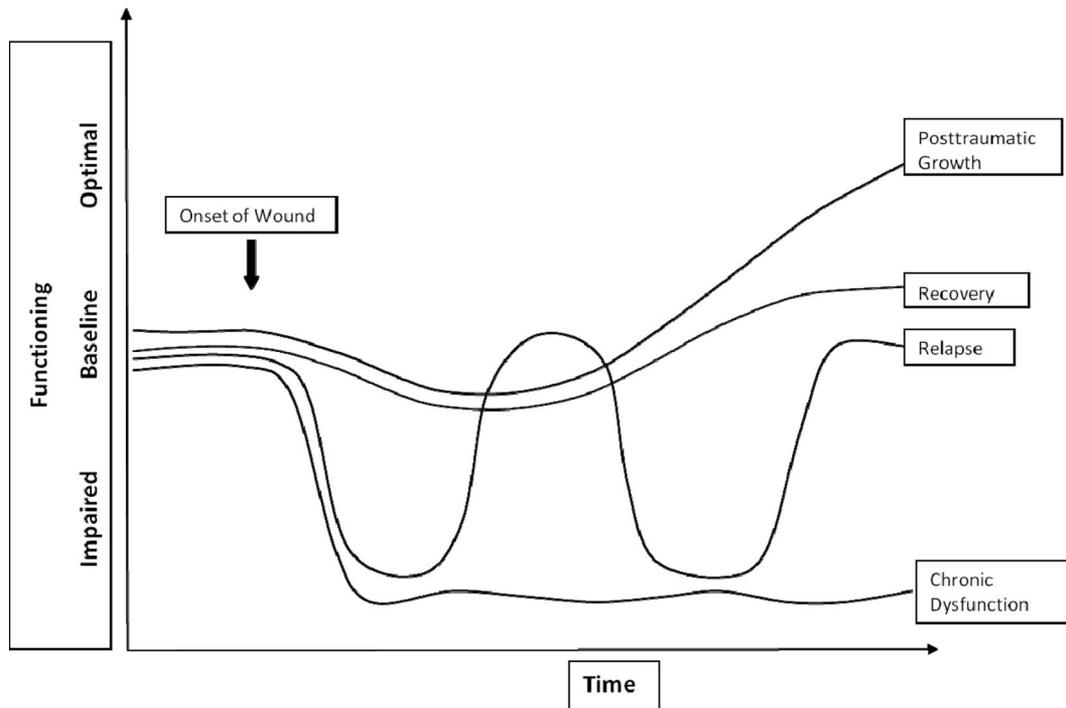
Figure 1. Variability in recovery trajectories over time following the experience of a wound. Note: The trajectories shown here represent one possible manifestation of each trajectory. The figure is meant to illustrate the variability of trajectories rather than to depict a static image of each particular trajectory.

woundedness (Briere, 1992). In accordance with the archetypal notion of healing through the wound, some therapists use their woundedness to promote recovery in their clients. The wounded healer's concurrent forces of woundedness and healing become a catalyst for healing within the client (Groesbeck, 1975; Sedgwick, 1994), as well as vice versa (Miller & Baldwin, 2000). Sedgwick (1994) suggests that in the therapist's working through of countertransference, therapeutic gains can occur for both therapist and client, even when the countertransference reaction is not shared with the client. The healer's woundedness can be beneficial as an internal reference point for understanding a client's pain (Hayes, 2002). If the therapist uses self-disclosure appropriately, the wounded healer's resilience may also instill hope of healing and recovery (Kirmayer, 2003; Miller & Baldwin, 2000). Finally, for many therapists, the work of therapy itself can be healing and restorative.

Many wounded healers view their difficult experiences as having been transformative, leading to profound growth personally and professionally. Calhoun and Tedeschi (2006) have captured this possibility in their exploration of the posttraumatic growth that can occur as a result of coping effectively with traumatic experiences. They describe five domains in which growth or positive transformation are often reported following successful engagement with traumatic experiences: (1) viewing the self as simultaneously vulnerable and strong; (2) discovering new potential; (3) reporting an enhanced appreciation for life; (4) developing a deeper sense of purpose and meaning; and (5) having deeper interpersonal connections and greater empathy. Growth in these domains can foster within the wounded healer a deeper insight regarding the nature of

the client's struggles and optimism regarding the client's ultimate outcome. However, it is especially critical for the wounded healer to guard against overidentification with the client and to remain aware that no journey of recovery is the same as another (Gelso & Hayes, 2007).

Clinical Psychology's Predicament: The Gatekeeper's Role

From the perspective of our professional gatekeeping responsibilities, psychologists may choose to err toward wariness regarding the woundedness of colleagues, and may be especially concerned when wounds are disclosed by trainees. It is likely that more established psychotherapists, who have observable track records of competent functioning, can more readily risk being open about their wounds. They do not have to work as hard to convince the members of their profession of their recovery status. This allows therapists with many years of experience to feel greater safety identifying as wounded. However, given the importance of dialogue about how one's wounds are affecting one's work as a therapist, waiting until late in therapists' careers to explore these issues seems very problematic. Trainees may be in particular need of support and guidance regarding these issues in order to provide appropriate treatment to clients.

Concerns about the wounded healer often focus on poorly managed countertransference and professional impairment (Gelso & Hayes, 2007; Sherman, 1996; Smith & Moss, 2009). Supervisors and peers have historically been reluctant to inquire about and intervene when they have concerns regarding a colleague's or

trainee's possible distress or impairment (Smith & Moss, 2009). Many factors exacerbate this reluctance, including lack of knowledge about how to appropriately inquire about and respond to concerns, uncertainty about one's professional responsibility to do so, reluctance to intrude, belief that intervention might result in a negative outcome for the colleague or trainee (e.g., termination, loss of license), and/or fear of personal risk to the self (e.g., litigation, loss of friends; Floyd, Myszka, & Orr, 1998; Smith & Moss, 2009). The line between "distress" and "impairment" is also difficult to determine, which creates uncertainty about whether or when to intervene, strengthening potentially detrimental avoidance of the issue. Furthermore, throughout training and in professional practice, there is little encouragement to express concerns about oneself or to acknowledge areas in which one is struggling in clinical work. Ironically, psychotherapists have often displayed an unfortunate tendency to neglect their own needs and their own wellness (American Psychological Association, 2000; Smith & Moss, 2009).

It is critical to acknowledge that, over the course of one's life, each of us is vulnerable to personal distress, burnout, or difficulty functioning at work (American Psychological Association, 2000). Supervisors and consultants are encouraged to create space for discussion of psychological difficulties and work-related stressors, providing recommendations for addressing burnout or impairment as necessary (Ladany, Friedlander, & Nelson, 2005). When supervision or consultation promotes silence and secret distress, an opportunity to dialogue about struggles and promote healing is lost. Psychological theories regarding recovery support approaching wounds with care, diligent tending, and a belief in the ability of wounds to heal. If the wounded healer's most important needs are to be addressed through professional support (e.g., supervision regarding countertransference, personal therapy), then it is an important ethical consideration that psychologists provide a safe space that invites seeking support. It is important to remember that even when a wounded healer is in great distress, the transactional and dynamic nature of resilience allows for profound shifts to occur on the basis of the response that is given to him/her, as well as the person's own active engagement with the unresolved issues (Lepore & Revenson, 2006; Masten & Wright, 2010). Avoidance, silence, secrecy, and shame are leading contributors to relapse, chronic dysfunction, and failure to recover from a variety of traumatic events and mental health difficulties (Chaudoir & Fisher, 2010; Courtois, 2010; Hinshaw & Stier, 2008).

Part 2: Implications for Training and Practice

Risks and Benefits of Disclosing Woundedness

For a wounded healer to access support or consult about issues related to practicing as a wounded healer, some degree of disclosure to another professional (e.g., personal therapist, supervisor, and/or colleague) may be necessary. The decision to disclose woundedness is complicated to navigate and may be motivated by a variety of factors (see Chaudoir & Fisher, 2010). We do not advocate disclosure; rather, we emphasize the fundamental importance of having disclosure as a viable option for wounded healers in need of support. We believe that it is problematic if our profession has developed an atmosphere in which it is stigmatizing to acknowledge vulnerability or woundedness. Such a milieu puts

wounded healers at greater risk of unaddressed impairment by precluding opportunities to assess the impact of woundedness and to suggest intervention when needed. Those who have studied impaired functioning and distress among psychotherapists have stressed the importance of destigmatizing seeking outside support in the form of supervision, consultation, or personal therapy (Deutsch, 1985; Sherman, 1996; Smith & Moss, 2009; Zur, 2009). Wounded healers may disclose to varying degrees and in multiple contexts: personal life (e.g., friends, family), professional context (e.g., colleagues, professors, supervisors, clients), and the general public. We focus here on disclosure in professional and public spheres.

Disclosure to clients. The topic of disclosure to clients has recently received some attention after many years of neglect (Baldwin, 2000; Bloomgarden & Mennuti, 2009b; Zur, 2009) and guidelines have been developed regarding making disclosures to clients (Bloomgarden & Mennuti, 2009a; Geller, 2003; Knox & Hill, 2003). Before making a disclosure to a client, therapists need to examine their motivations, making sure that the disclosure is made for the benefit of the client, rather than to meet the therapist's own needs. Therapists can start with small disclosures (e.g., vacation plans), noting the client's response to receiving personal information (Geller, 2003). Guidelines recommend that the therapist seek supervision or consultation before making a disclosure of the therapist's own prior struggles, but this assumes that the therapist feels safe taking such a risk. Finally, it is suggested that disclosures only be made to clients if the issue is resolved and processed. Of course, this raises the elusive question of what "resolved" means.

A therapist may discuss woundedness in a nonspecific manner, making reference to a journey of recovery through "difficult times" or "times of great suffering." In contrast, the decision to make a more specific disclosure to a client involves sensitive considerations. The effect of a disclosure on a client may be positive or negative. On the positive side, disclosure of the healer's woundedness invites clients to access their own inner healers (Hayes, 2002), connecting woundedness and healing (Miller & Baldwin, 2000). In fact, clients' "own healing resources may be evoked by their recognition of the healer's vulnerability" (Kirmayer, 2003, p. 251). When the client observes the wounded healer duality in the therapist, recovery may seem more possible. A disclosure may redistribute power in therapy, as both therapist and client have shared with one another in an authentic manner (Kirmayer, 2003; Knox & Hill, 2003). A disclosure also demonstrates the therapist's willingness to engage with difficult material, giving the client permission to share more. On the other hand, disclosure may have a negative effect on a client. The client may prefer not to have personal information about the therapist, or the disclosure may focus attention inappropriately on the therapist (Gil, 1988).

Bloomgarden and Mennuti (2009a) discuss the importance of not sharing with clients any information that one does not want known within the professional context (e.g., among colleagues, supervisors). Bloomgarden gives the example of choosing not to share with clients her own history of an eating disorder until she was comfortable disclosing this in the work setting, noting that while therapists are bound by confidentiality, clients are not, and should never be put in the position of keeping a therapist's secret.

Intriguingly, a qualitative study and a number of personal accounts from wounded healers revealed that therapists report feeling more comfortable sharing their own woundedness with clients rather than with colleagues and peers (Bloomgarden & Mennuti, 2009b; Wright, Seltmann, Telepak, & Matusek, 2012), presenting a predicament around seeking consultation or supervision before disclosure to a client.

Disclosure to other professionals. In contrast with the detailed guidelines available for disclosure to clients, there is a notable absence of discussion or research on navigating decisions about disclosure to other professionals or "going public" about woundedness. There appears to be implicit agreement within Psychology that it is risky to disclose woundedness—those who disclose risk stigma, judgment, or overt hostility from other professionals. Descriptions of such negative consequences have been detailed in a variety of courageous first person narratives (e.g., Bassman, 2007; Freyd, 1996; Jamison, 1995; Rippere & Williams, 1985). The stigma of disclosing woundedness may prevent psychotherapists from seeking help for their distress (Deutsch, 1985), the very thing that might help (Danieli, 1994; Schoener, 2005). A common fear is that woundedness will be misconstrued as impairment (Sherman, 1996). Receiving official evaluations of clinical competency complicates the risks associated with a disclosure of woundedness for trainees and early career psychologists. Supervisees who are receiving middle-of-the-road or negative evaluations may find it too risky to make disclosures. In fact, these therapists may be the most in need of guidance around how to handle clinically relevant manifestations of wounds. In contrast to personal woundedness, vicarious traumatization is not rare for psychologists to disclose. Figley (2006) compiled the autobiographies of pioneer trauma scholars, asking how they became drawn to study trauma. Some reported personal histories of trauma; many more reported being affected by the suffering of others. Perhaps, it is safer or less stigmatizing to identify as having been impacted by the traumatic experiences of others.

Disclosure in the public sphere. Some wounded healers take on roles as educators or advocates through disclosure in the public sphere (e.g., Bloomgarden & Mennuti, 2009b; Carey, 2011; Frankl, 1959; Freyd, 1996; Jamison, 1995; Sawyer, 2011; Westerlund, 1992). In these forums, disclosures may be made to the general public, including the professional realm in the greater public domain. For example, Linehan's recent identification as a wounded healer appeared on the front page of *The New York Times*, such that therapists read about her disclosure along with other members of the public (Carey, 2011). Wounded healers may use their uniquely informed perspectives to become advocates and/or activists (Adame, 2009; Bassman, 2007; Westerlund, 1992). The wounded healer's public retention of these multiple identities may allow those who are wounded to envision the potential healer within themselves (Miller & Baldwin, 2000), thus providing inspiration. Disclosure in the public sphere changes the nature of the revelation. When this information is public, valuable information is available to clients in therapist selection (Gil, 1988). While the relevance of woundedness to the relationship may unfold and change throughout the duration of therapy, the disclosure itself does not have to be negotiated.

Recommendations for Fostering Resilience and Cultivating Support

Our profession has not yet resolved the tendency to reject, silence, or stigmatize the wounded healer. It is curious that psychotherapists, who choose a life of bearing witness, at times have great discomfort with another therapist's woundedness. Psychologists' cautious focus on the potential for impairment seems to hinder the very foundational responses that we champion with clients (Cushway, 1996). With wounded clients, we normalize the struggles and guide them through a process of growth, recovery, or healing. We encourage the unshrouding of silence and offer responses of empathy and support. Yet, we do not approach our wounded colleagues with the same warmth and support. Instead, our profession seems to promote silence around a healer's woundedness, perhaps to protect against stigma or doubt regarding professional competence (Bloomgarden & Mennuti, 2009a; Rippere & Williams, 1985; Sussman, 2007).

This silence must be broken in order to support the wounded healer in navigating issues of recovery, management of countertransference, and seeking help when necessary. This includes questioning the incongruence between how our profession regards woundedness in its clients and its practitioners. This is relevant any time that a wounded healer confides in a mentor, advisor, supervisor, or consultant. Psychotherapists are especially well positioned to be political advocates for the wounded and to improve the way that our society views mental health struggles (Adame, 2009; Bassman, 2007; Feldman & Crandall, 2007; Schulze, 2007) by clarifying misperceptions about mental illness, educating about stigma, and speaking about healing and recovery. This type of advocacy is congruent with the values of our profession, yet the wounded healer often does not receive such support. We propose that the discrepancy between our values about client woundedness and our responses to the healer's woundedness comes from social stigma and wariness due to uncertainty regarding the stability of the wounded healer's recovery.

We can create environments that are conducive to promoting resilience for wounded healers. Fostered in contexts of openness and support, rather than secrecy and avoidance, dialogue and exploration are the most effective approaches to assessing and reducing impairment (Sherman, 1996). By being aware of and curious about our internal responses of blame, fear, or concern for relapse, we become less apt to stereotype or stigmatize the wounded healer and more able to respond in a caring and supportive manner, while also cleaning and checking wounds.

To perform gatekeeping responsibilities properly, supervisors and consultants must be able to differentiate between a current problem that has led to impairment and a disclosure of a personal struggle or wound that is not adversely impacting the psychotherapist's professional role. Thus, disclosures may require an assessment of the wounded healer's current functioning and clinical work. To do this, the supervisor or colleague must be able to identify when and if the therapist is exhibiting impaired functioning that has resulted in ineffective or harmful services or has crossed boundaries inappropriately. The supervisor or colleague can also invite discussion of what steps have been taken to foster recovery and how the person has been able to draw positively from the wound. In assessing the degree of resolution or recovery, visibility of a scar does not necessarily indicate impairment. It may

be evident, for instance during disclosure to a supervisor, that there is still pain associated with the wound. The presence of an emotional reaction does not indicate lack of resolution, although containment of affect is required to consider disclosure to clients. It is important that the therapist has confidence about his or her ability to modulate emotional reactions and has learned to cope effectively with cognitive and affective responses to triggers. The supervisor or consultant might ask questions such as: *What do you experience when a client brings up something related to this issue? What do you typically do in a session to manage your personal reactions? Have your reactions produced any adverse effects on the therapy relationship? When has this occurred and how did you cope with this?*

Training programs and clinical workplaces can improve the status quo by cultivating supportive responses to wounded healers and differentiating between disclosure of woundedness and need for intervention or requests for help. This requires that distressed professionals who experience difficulty functioning are not "demonized," and that these topics are discussed openly "in a compassionate, nonpunitive manner" (Smith & Moss, 2009, p. 12). Workplaces can train with an assumption of healer woundedness, normalizing that this may be from personal history or from the work itself, conceptualizing vicarious traumatization as an "occupational hazard" rather than a result of therapist "inadequacy" (Pearlman, 1995, p. 52). Therapist supervision or consultation groups focused on processing countertransference can facilitate identifying, containing, and coping with countertransference reactions (Danieli, 1994). Continuing education may also provide a forum for exploring issues related to woundedness (Smith & Moss, 2009). Wounded healers have reported that professional support can come in a variety of ways: being part of a clinical team that included ongoing interpersonal process work, participating in weekly peer consultation groups, continuing education opportunities relevant to one's domain of practice, and engaging in ongoing or periodic personal therapy (Wright et al., 2012). However, many also noted that it was sometimes a struggle to find a truly supportive, helpful, and safe supervision group.

In training, didactic coursework and clinical supervision provide opportunities for dialogue about countertransference and impaired functioning (Gelso & Hayes, 2007; Sherman, 1996). Creating safety allows wounded healers to broach and explore issues, and supervisors will then be better able to assess whether woundedness is negatively impacting clinical work. Supervisors are in an optimal position to distinguish between woundedness and impairment, as they see supervisees' behavior across contexts (e.g., with clients, colleagues, and in supervision; Ladany et al., 2005). Personal therapy or other interventions can be encouraged as needed. Training programs can develop environments that facilitate thoughtful discussion of disclosures, stressing the importance of knowing when and whom to ask for help, identifying impairment, and articulating need for support. Ideally, training is a context in which personal awareness and self-exploration are encouraged, struggles are supported, and myths of therapist invulnerability are debunked (Cushway, 1996). Wounded healers are more likely to cultivate trajectories of recovery within models that normalize therapist stressors and countertransference issues, encourage seeking consultation and/or personal therapy, and integrate attention to compassion fatigue, therapist well-being, and self-care (Cushway, 1996; Pearlman, 1995).

Attention to self-care and one's own well-being (e.g., regular exercise, yoga, eating well and getting enough sleep, spending time with friends, establishing boundaries between one's personal and professional life, and making time for fun activities) are critical to the wounded healer's psychological health (Figley, 2002; Pearlman, 1995; Wright et al., 2012). In a qualitative study, wounded healers all recognized the value of self-care practices in preventing a reemergence of psychological distress or burnout (Wright et al., 2012). However, they also acknowledged that self-care did not come easily; it took time to accomplish these goals, and incorporating these activities into a busy professional life was, for many, an ongoing struggle.

Conclusion

We hope that the framework we have laid out here facilitates dialogue about the wounded healer. We encourage an approach to wounded healers in which we lead with openness, curiosity, and exploration, assuming possibilities of resilience, while also considering and responding to concerns of relapse or chronic difficulty. It is important that psychologists acknowledge that recovery takes time and is an ongoing process and support wounded healers in taking the time they need to recover when setbacks occur. We can cultivate this openness by learning from wounded healers about their recovery thus far, as well as how fragile or stable they perceive it to be. Rather than distancing or silencing wounded healers with our wariness, if we can tolerate the uncertainty of recovery trajectories, we are more apt to promote recovery stability. It is critical that we convey sensitivity, compassion, and concern for wounded healers, and offer them support and guidance if needed. We believe that the issues raised are applicable to a broad definition of woundedness, including physical and mental health problems, family of origin dysfunction, traumatic life experiences, the microaggressions and overt discrimination faced by psychotherapists who have a marginalized identity (e.g., racial/ethnic/religious/sexual minority group membership), and many other types of woundedness. We hope further research addresses professional issues specific to a variety of types of wounds.

We advocate for willingness to acknowledge woundedness and tend to wounds through open dialogue, providing support in accessing consultation and personal therapy when needed. To that end, it is critical to have an environment that is not experienced as shaming or stigmatizing; rather, the focus needs to be on identification of resources needed to promote the psychological well-being of wounded healers. We can cultivate an environment of greater safety by addressing woundedness in a balanced manner, not only as a risk, but also a potential benefit for therapists. The wounded healer represents not only pain and suffering, but also the possibility of resilience, posttraumatic growth, and the ability to use the knowledge acquired through one's own suffering in the service of clients' recovery. Ultimately, the goal of psychotherapy is to heal the wounded. The paradigm of the wounded healer may offer a unique and valuable perspective for clients, clinical training, and our field, if we are indeed willing to explore it.

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