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Wounded healer therapists: A legacy of developmental trauma

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Abstract: My research asks, 'what impact might a personal history of complex developmental trauma have on a counsellor's experience of, and work with, traumatised clients?' Semi-structured interviews were conducted with 6 experienced therapists who had self-identified as having been traumatised as children. A seventh contribution is a reflective narrative of my own story. Three of the themes which emerged in a phenomenologically orientated qualitative bricolage were: help-seeking, trauma treatments, and survival strategies. The analysis uncovered considerable diversity of both narrative and meaning-making, even in this small sample of participants and this was reflected in the participants' diverse beliefs about what constitutes effective practice in trauma therapy. Their experience challenges the espousal of standard treatment protocols seen in some primary care and substance abuse services and calls for greater flexibility in both practice and research strategy. Discussion is offered around diversity, research approaches, and the use of personal experience in the therapy room which have implications for therapist training, therapist self-care, therapeutic strategies, and further research.

Keywords: Wounded healer, developmental trauma, narrative, therapeutic relationship

Lewis (2004, p.22) says "a family history of helping and a history of personal difficulties that contribute to the development of empathy for others" are the major pathways to a career in counselling. I asked myself if it was also true that the ways in which we work in the therapy room, or relationships with colleagues and clients, are more tied to our complex individual stories than we might at first realise.

In my own personal therapy, post-qualification, I began to realise that emotional difficulties with which I had struggled

had traumatic origins. I noticed a change in my counselling practice, in which I became more attuned to the possible traumatic roots of clients' experiences, and this made me curious as to whether this might be true of other mental health professionals who have a trauma history. This curiosity led to my research my question. My hope was that more awareness of our own traumatic processes as therapists may help to catch that of our clients. I have myself seen clients who had sadly fallen through the net of some services (Bond, 2019) simply because their troubles were not recognised as having traumatic origins and therefore who were not given appropriate help.

The idea of the wounded healer can be found throughout history and in diverse cultures, from the Greek myth of Chiron, through to modern concepts (Benziman, Kannai, & Ahmad, 2012). Modern Western concepts follow Jung's notion of a 'wounded physician' (Jung 1954). Until the latter part of the 20th century, few publications had been comfortable with the idea that mental health professionals might be wounded healers, and the stigma attached to mental ill health inhibited disclosure (Fisher, 1994; Frese & Davis, 1997; Cain, 2000). There is now somewhat increased acceptance, with more autobiographic material seeing print (e.g. Orlans, 1993; Tamas, 2008; Adams, 2014). A wealth of research, both qualitative and quantitative, on trauma and its treatment has been carried out. However, there is still little which addresses the type of therapist-client connection where a therapist carries similar wounds to those of their client. My research hopes to contribute some findings to widen the exploration.

Methodology

I have not followed a standard methodology. Instead, my method of analysis emerged organically, intuitively and creatively as a 'bricolage' with an interpretive phenomenological orientation. Embracing Richardson's (2000) 'writing as a method of inquiry' and a creative dialogical approach, my end result was a combination of narrative and themes. I found that I needed a methodology which would enable me to explore both objective (the abuse, the fire, the bullet, the neurological and chemical responses) and subjective (the feeling of fear, the legacy of depression, the memories) experiences of childhood trauma and how these impacted on subsequent therapy practice. I was influenced strongly by the 'experience near' ideas of Bondi & Fewell (2016), the focus on context in Flyvbjerg's (2001) understanding of Aristotle's *phronesis* (Metaphysics, VI.1) or 'practical wisdom', and by Denzin and Lincoln's (2018) call for more qualitative researchers to be bricoleurs.

Participants

Six participants self-selected following an approach to organisations which employed therapists who were unlikely to be known by me. This was designed to minimise undue interpersonal contamination of data or a change in relationship with colleagues who might otherwise have offered to take part. They fitted the inclusion criteria of being experienced therapists who had been traumatised in

childhood and had worked on that trauma in their own therapy. They were all working therapists, British, had trained and were resident in either Scotland or England.

As I also fitted the inclusion criteria, I included myself as a seventh participant. My purpose was to engage reflexively in the process and make my part as researcher transparent. I hoped in that way to glean insights through the interactions with the participants.

Data collection

Open semi-structured interviews were employed to collect data while my own contribution was a reflective written autobiographical narrative.

Interview prompts covering their personal history of trauma, therapy, training, work with traumatised clients, traumatic dissociation, and views on the term 'wounded healer' had been prepared in advance. In practice, these were only referred to if a topic was not raised spontaneously.

Ethics

The relational ethics of the project follow closely to BACP's ethical framework for both research and practice (2004, 2018), and Andrew's (2017) ethics of autoethnography, and were approved by the University of Edinburgh's School of Health in Social Science Research Ethics Committee. Austin (2008) sums up the core of relational ethics succinctly:

Ethics is about our interdependency as well as our freedom, our emotions as well as our reason, our unique situations as well as our commonalities ... we need to be sensitive to the whole of a given situation, to be inclusive in our dialogue about it, and to be aware of the effect of our contributions on it. (2008, p.748)

The information given in the selection process, and the subsequent interviews (Bond, 2018), were carried out with an acute awareness of the sensitivity of interpersonal trauma research. Project information sheets anticipated concerns about unwelcome re-emergence of memories, anonymity, and security and use of data. I made it clear to participants at the start of the interviews that it was not essential to my research for them to give details of their initial trauma, so they were free to choose how much or little they wanted to share. Aware of the risks of triggering traumatic memories, I continued with an emotionally neutral question about how the interviewee had come to be a therapist.

As a therapist myself, I drew on my sensitivity, listening and attuning skills as part of my duty of care, doing my best to monitor their comfort in what they chose to disclose. All consented formally to my using material from the interviews in future publications, were given a right to withdraw consent for up to six months following interview, offered sight of the transcripts and to delete inadvertent identifiers. Only one chose to have a copy and that was for her own reflective practice.

In order to minimise unintended damage to the participants or others, person-identifiable details were removed from the transcripts and five of the six interviewees chose pseudonyms. The sixth had the possible implications of not doing so explained to her but chose nonetheless to retain her own forename. The people involved in my own story are either deceased or unidentifiable.

Analysis

Analysis of the transcripts began with initial coding (Braun & Clarke, 2006). Fifteen codes, and many more sub-codes were identified. These were arranged into six more general groups, four of which (trauma, therapy, training, practice) came from the narratives of the participants, and the other two were responses to discrete questions (definitions of trauma, and reflections on the term 'wounded healer').

Rather than proceeding with analysis at this point, the diversity within them was so apparent as to demand particular attention. To capture this, I wrote imaginary post-interview discussions between myself and each interviewee in which as many as possible of the transcribed words of the original interview were used. Having immersed myself in the transcript data I began with short 'ghost-written' biographies of each participant, which were sent to them to read and approve.

I then divided the transcript into 'feelings' and 'reflections' before creating the post-interview conversations. It was through this process that themes emerged, and my part in the conversations brought in my own suggested interpretations or sought to clarify the meanings of the participants' words. The inspiration for this unusual approach was Laurel Richardson's (2000) "writing as a method of inquiry" together with my desire to capture individuals' idiographic phenomenological experiences (Ashworth & Greasley, 2009). Having by this time immersed myself in the data (Moustakas, 1994) I was better able to honour participants' words and meanings and suggest rather than impose my own assumptions.

Findings: Participants' stories

A brief vignette of each participant's story is offered below followed by an analysis of some key emergent themes. Six participants answered the opening question about becoming a counsellor with a life narrative. Only Paul did not, as he had no personal memory of his trauma, which he had learned about later from third parties.

Helen works as a senior counsellor in occupational health. Her training was integrative, but she is committed to a person-centred approach, though open to using eye movement desensitization and reintegration (EMDR) when indicated. Her father had been severely disabled due to neurological trauma all her life until her adulthood, and her mother was focussed on his troubles. She became her mother's 'counsellor' early in her life and developed global anxiety around possible disability and death of those around her. She sought psychological help for this as a young adult, something she found more or less useful.

Jane is a second-generation holocaust survivor. Such was the secrecy around the trauma in her family that she was a teenager before she discovered her mother was Jewish and had been evacuated on the Kindertransport. Her mother's trauma was never explicitly acknowledged when Jane was a child though she was diagnosed as having bipolar disorder. Her father had major depression. Jane "brought [herself] up", seeking solace in academic achievement. Anxiety and insomnia as a young adult led to receiving helpful person-centred counselling. She subsequently trained as an integrative counsellor and worked for 11 years as a telephone counsellor in an agency providing psychological first aid and debriefing for those involved in major trauma incidents. She is currently a face-to-face counsellor in another organisation and does not specialise in trauma work.

Morag is head of an organisation providing counselling for victims of sexual trauma, and a trainer. "Bizarre" memories indicating childhood trauma were reactivated by an assault when she was a young adult and led to lengthy stays in a psychiatric hospital. Much personal therapy after that time led eventually to good health and to training. She has worked in several settings, and she now focusses on trauma work.

Fran works with teenagers who have suffered sexual trauma. She was raised in a family where her father was alcoholic and

a misogynist. Mother also drank excessively. Home life was "terrifying". Attending a private school, Fran was sexually molested by the school doctor, but not believed when she reported this and was reprimanded for being a troublemaker. Rebellion, where it was safe to rebel, followed for some years until she saw a film which featured a psychologist. This introduced her to a whole new world of ideas. Memories of seeing a variety of therapists (person-centred, psychodynamic, hypnotherapy) were almost all negative, but her 'discovery' of psychology through this film eventually led to more education, a psychology degree, work as a psychologist, re-training as a counsellor and then as a counselling psychologist, and to her current post.

Paul is a psychodynamic counsellor working in short-term primary care. His episodic memory of trauma as a very young child is absent, but gaps have been filled in by third parties. He describes his teenage self as "hitting rock bottom" and describes some failed, if well-meaning, attempts by his general practitioner (GP) to get him appropriate counselling help (person centred, and cognitive behavioural). He turned to self-help in the form of reading, and then later entered training.

Lizzie's story is one of parental neglect, in which their religious work took precedence over her and her two siblings. All the children were sent at very young ages to boarding schools, and sometimes farmed out to relatives in the holidays. She rebelled, but remained committed to an understanding of faith, but one which left her very vulnerable to spiritual abuse. Untrained 'help' led to a psychotic breakdown which in time resulted in helpful psychotherapy and psychiatric out-patient care. She trained in gestalt therapy and later sensorimotor psychotherapy and developed a private psychotherapy practice in which she has a particular interest in trauma.

Pat had a loving if somewhat dysfunctional family, whose care was exemplary. At age 2 years she contracted tuberculosis and was hospitalised for much of the next 2 years. Late in her teens, following two more hospitalisations for surgery, she developed dissociative and other symptoms of posttraumatic stress, misdiagnosed at the time. A family script of 'just get on with it' enabled a career in science which was followed, close to retirement from her clinical scientist post, by one in therapy. Only her last therapist (psychosynthesis), once she was already in practice, recognised the traumatic aetiology of her dissociation, which cleared up almost immediately. She currently works in private practice, and has a keen interest in trauma, working integratively.

Findings: Thematic Analysis

I focus here on three of the themes identified from the participants' narratives and reflections – initial help-seeking, their own personal therapy and its influence on their practice, and trauma survival strategies.

Help Seeking: "I thought at the time that I wasn't right in the head. ... I took myself off to the GP" (Helen)

The seven participants all had very different experiences and motivations in help-seeking, initially and subsequently. Jane and Pat sought help because friends had found therapy helpful. Helen and Paul's sense that something was wrong with them first consulted their GPs, with different outcomes. Helen was referred to psychiatry, which was a negative experience, and Paul was referred to therapists within the healthcare system, but these were people to whom he could not relate at that time:

The first person that I met was very young, female, attractive, and that to me was everything that I didn't want to be around because I felt that what I carried inside was so black, so damaged, and wouldn't think that sitting in the company of somebody who'd had a positive experience of being a human being, someone who'd done well at school, gone to university from school ... so I didn't want to contaminate this person with anything negative that was inside me. (Paul)

Paul and Fran had negative initial experiences of therapy, which steered them down the self-help route. Both chose personal study, and in Paul's case therapy training, as the way they might understand their own issues. Fran had also experimented with "less legal ways of coping". Early adult single incident trauma had triggered a serious breakdown in Morag, which led to sectioning under the Mental Health Act (Department of Health, 1983). Lizzie's first experience of therapy was with an unqualified and abusive person within her religious tradition. Only later did a psychotic breakdown lead to referral to helpful psychotherapy and outpatient psychiatric care.

Six of the seven participants spoke about their trauma history in considerable detail, although one, Morag, spoke more about the details of being re-traumatised as an adult and her experiences in hospital. Paul and Morag, who had little, if any, episodic memory of childhood trauma referred to being

tongue-tied when asked about their feelings in therapy. Other factors such as Helen's memory of needing to have her thoughts marshalled before voicing them, were cited by the other participants when they had found it difficult to engage in therapy.

Good and Bad Memories of Being a Client: Influence on practice

Morag's help had been initially imposed on her when she was sectioned under the Mental Health Act, and her perception, at the time, that it was irrelevant has stayed with her and profoundly influenced her passion to find relevant ways of helping her clients: "if I believe I have something to offer it has to be relevant to the person I'm offering it to". Her abiding passion for therapeutic interventions to be relevant to the client is reflected by the other participants' descriptions of both positive and negative experiences of therapy.

Paul sought therapy as a last resort and remembers enough of that feeling to recognise it easily in clients. He sees the establishing of psychological contact as of prime importance in his practice. He is also very aware that they may be suffering from the confusion and existential fear which had been his experience as a young man: "I use that ... from my own experiences of remembering what that's like". He also described the influence on his practice of his un-remembered early trauma. He is acutely aware of the hidden story, known or unknown, which might be trapped inside any client he sees. Even in the non-ideal setting of short-term therapy he is determined to let them tell their story, or as much of it as they are able, so that the pressure that story exerts on their psyche could be reduced.

Other participants remembered experiences of their own therapy also use that awareness in thoughtful ways when relating to their clients. This allows them to avoid the pitfall of unhelpful projection of those experiences on to their clients. An example is Lizzie's first experience of 'therapy'. It has led her to develop a high sensitivity to any emerging feelings in herself which could harm a client. She recognises them as triggers from her own past and takes them to supervision: "Sometimes I get, my own stuff gets triggered. You know, I, I find myself self, sort of seeing flashbacks of what I used to be". Also, the emotional harm done to her by that counsellor convinced her of the devastating effects of abuse by any therapist and warns her supervisees clearly about it.

Fran was an angry young woman when she first sought therapy. Predictably she reacted angrily to some of her early therapists, and even in hindsight blames them rather than herself, now recognising that they failed miserably to relate to her in ways

that held any meaning for her. She easily recognises the pain in the anger of her clients. As well as having suffered sexual abuse by a school doctor, she had an ambivalent relationship with her very angry misogynistic father. She has brought relief to some of her young clients by her ready understanding that they might both love and hate their abusers. She both loved and hated her father.

Jane made a brief comment about a counsellor's disclosure which had been helpful to her and believes that it can have a place in her practice.

Pat remembers the relief of being given a plausible explanation of the dissociative experiences which had previously been frightening and shaming and does not shy away from psychoeducation with many of her clients.

Lizzie uses her helpful therapist's practice of murmuring softly to maintain reassuring contact when a client is in a paroxysm of distress.

Few comments were made by participants about the impact of their basic training on their work with traumatised clients. Those that were made tended to indicate that the training had not equipped them well for working with trauma. Paul was the most positive and he values the attachment focus of his psychodynamic training. However, most said they had gone on to more specific post-qualification trauma training which had generally been helpful. Their experiences of personal therapy had often had a more direct impact on their practice. Lizzie and I apart, those who had received treatment in medical settings, admittedly some years ago, made rather negative reflections on their experiences. Fran, Lizzie, and Paul, especially, said that they had learned from negative experiences as clients how not to do it.

One common factor was apparent in the participant group. All had undergone therapy, cumulatively spanning years. None had found a 'quick fix', and there was no agreement on which modality of therapy they had found the most helpful. Helen, Paul and Pat are specific in their concern about the lack of affordable appropriate long-term trauma care available to clients. Paul manages the restrictions of short-term work by offering high quality connection with his clients in which he gives opportunity for them to tell their stories rather than have them locked in their heads. Although EMDR is now one of the therapies recommended by the National Institute for Care and Clinical Excellence (NICE, 2005), none of the participants said that they sought it as clients. However, Helen and Morag had undertaken training in it and use it sparingly when relationships with clients has been sufficiently established. Aware of the range of different needs of their clients, similar flexibility in modality is apparent in all the participants.

Survival Strategies: “I think it’s [anger] helped me hugely with my resilience” (Fran)

Therapists are often awed by stories of survival in clients who went through childhood trauma. Many children seem to have unexpected resilience and find ways of coping with what life throws at them by adopting strategies which work for them. These differ from child to child and context to context. Anger and rebelliousness in childhood are described by Fran, Pat and Lizzie. Anxiety and hypervigilance are highlighted by Helen and Jane. An example of Helen’s hypervigilance was delay in starting her family: “I didn’t have children till I was in my early 30s because it wasn’t until then that I knew I could risk having children.” Dissociation was Paul’s way of coping with his trauma, as was seemingly Morag’s, until feeling memories were reactivated by adult trauma. Distraction through striving for academic achievement at school were amongst Jane’s and Pat’s strategies.

As therapists, survival strategies in the context of listening to many trauma stories, are also diverse. However, good supervision is valued; Helen, Pat, Lizzie and Fran explicitly note this. Pat, Jane, Fran and Lizzie believed it is especially helpful for their supervisor to know about their traumatic past, and to be able to remind them of how that could still be influencing their responses to clients. Whilst noting that supervision should be different from therapy, Wheeler (2007) recommends supervisors are familiar with the wounded healer paradigm as it may be operating in relationships between a therapist and their client. Jane, Helen and Lizzie indicated they have learned actively to measure their capacity and assess when to stop working with certain clients. Such learning, and the development of a good ‘internal supervisor’ (Casement, 1973, 1985), is seen as of major importance by all the participants. Some voice criticism of therapists who are unwilling to “do their own [inner] work” (Lizzie).

Paul pays special attention to bodily self-care, Lizzie uses reflection, prayer and calming measures. Examples of the awareness of their own processes while counselling traumatised clients are given by Helen, Jane and Lizzie who all report some incidents where client material had triggered vicarious posttraumatic responses in themselves. Pat has learned not to react negatively to the colour mauve, which was worn by nurses who frightened her when a toddler. Jane, over her 11 years of telephone work, complained of the effect of having trauma stories entering her head directly through the earpiece. “There’s no space to withdraw especially on the phone with somebody. They’re right inside your head”. She was aware that she sometimes “didn’t really want to listen to this” and remembers exhibiting signs of stress back home after work, which she mitigated by stress-relieving activities.

Discussion and Conclusion

The diverse experience of these wounded healer therapists-participants underlines the point that one size does not fit all. I choose to let these findings speak largely for themselves but now, in this section, I broaden the discussion about how this research might inform trauma work in terms of:

1. **Diversity** - Careful consideration of diversity of meaning-making by both therapists and clients is of crucial importance in trauma therapy.
2. **Research** - A wide-ranging research strategy can capture otherwise hidden aspects of trauma experience.
3. **Practice** - Choices of trauma therapy strategies are often influenced by therapists’ own experiences of surviving developmental trauma, and what has been helpful to them. This can be beneficial but there needs to be flexibility and responsiveness. This can be beneficial but there needs to be flexibility and responsiveness to clients’ own presentations.

Diversity

The history of trauma studies is fascinating in its evolution (Weisæth, 2002). When contemplating trauma today, I am struck by the continuing difficulty of defining psychological trauma. There are differences between acute, single incident, and the complex trauma which normally (but not always) originates in childhood (Heitzler & Soth, 2018; Herman, 1992), quite apart from popular linguistic uses which include a bad day in the office, and the embarrassment of dealing with a toddler’s tantrum in a supermarket.

My focus on developmental trauma using an idiographic lens, show widely different experiences even in a small sample. The contexts of each participant are unique to them, and their early responses within those contexts are far from uniform. We see rebellion (Fran, Lizzie and Pat); we see dissociation (Paul); we see self-sufficiency (Helen and Jane); we see compliance alternating with rebellion (Lizzie and Fran); we see a pull towards caring professions (Helen and Lizzie had initially qualified as nurses) and a striving for academic achievement (Jane and Pat); and we also see differences in memory, in spontaneity in both therapy and training situations, in attraction to practice modality, in vulnerabilities to triggering, and so on. Each participant had, over time, consciously or unconsciously, made meaning of their trauma in organic, and different ways. It is reasonable to conclude that our clients will

exhibit the same diversity in their experiences, meaning-making, and resulting behaviours. This puts an onus on their therapists to avoid the pitfalls inherent in some treatment protocols which follow more fixed understandings of trauma.

Research

There is a wealth of high quality quantitative and qualitative trauma research published, but designs have often necessitated inclusion criteria which are relatively narrow and do not therefore capture the diversity seen in this study, or indeed the experience of many working therapists.

The 'science wars' (Kovel, 1996; Ross, 1996) in which qualitative research found opposition and publication was resisted, were at their peak 25 years ago. Since then there has been, at least in the United Kingdom (UK), increasing pressure to manualise psychological therapy on the basis of evidence, where evidence is too often embedded in positivist thinking, and economic constraints. By attempting to gain some phenomenological insights into what is actually experienced by this group of therapists, I argue for a broadening of outlook which can lead to more relevant treatment for numbers of traumatised clients. While valuing the scholarship around trauma study, Rothschild (2000) repeatedly underlines the need to recognise that one therapeutic size does not fit all, a point which is not always implemented in healthcare organisations.

NICE (2005) guidelines, based largely on positivist empirical evidence ('the medical model') have been very influential in treatment of emotional distress in the UK but are not accepted uncritically by practitioners who prefer to draw on a wider evidence base than those used by NICE (see e.g. Clark, 2011). Parry (2000) reviews the arguments for and against (empirical) evidence-based psychotherapy and suggests that arguments against fall into two camps. One camp recommends total rejection, and the other "does not reject it so fundamentally but sees it as fraught with difficulties and dangers". Clark (2011, p.59) says, more moderately, "professional wisdom understands that evidence-based practice can never provide all the practical answers that we need". This is the position that would be held by the participants in this study (including myself), given the diversity of experiences they describe of both helpful and unhelpful therapy for their own developmental trauma. The participants also find, on the basis of their clients' presentations, that being willing to step aside from their preferred therapeutic modality is crucial for good outcomes.

Addiction services often focus primarily on behaviour modification interventions. Though understandable because of addictions' devastating immediate effects on addicts and

society, avoiding addressing underlying causes may account for quite high relapse rates. The National Association for Alcoholism and Drug Abuse Counselors (NAADAC, 2009) makes only one mention of trauma in their basic guide for addictions counsellors, and NICE guidelines (NICE, 2007, 2011; Pilling, Strang, & Gerada, 2007) similarly concentrate on harm reduction. Again, the NHS Choices website does not include trauma as one of the possible causes of addiction (NHS Choices, 2015). Experienced addictions therapists (T.Halford, pers. comm.) are acutely aware of the traumatic backgrounds of most of their clients and believe that the trauma, not just the resulting behaviours, needs to be treated.

Van Os, Guloksuz, Vijn, Hafkenscheid, and Delespaul (2019) question strategies used by followers of more positivist research which tend to prioritise symptom reduction and lose sight of the individual. While this provides relief in the short term, longer term effects are harder to identify. Few follow up studies extend for more than a year (e.g. Stalker, Palmer, Wright, & Gebotys, 2005) and Bradley, Greene, Russ, Dutra and Westen (2005) specifically note this and recommend longer study. In complex posttraumatic stress disorder (CPTSD) the apparent limited time efficacy of some interventions for symptom reduction or behavioural modification offered by some treatments may be explained by Fisher's (2000, p.1) point that "adult survivors of trauma become ... remarkably adept at inventing *compensatory strategies aimed at self-regulation* [her emphasis] long before they enter the doors of our offices, hospitals, and clinics." Without evidence to the contrary, clients may simply be returning to their default strategies over time. Treatment strategies rely on research, so it is vital that research encompasses wider-ranging experiences of clients and therapists alike. Bricolage, the term's origin being the creation of a crafted object with whatever diverse material is available, can be applied to understanding complex subjects like trauma. Different theoretical, methodological, narrative, interpretive and political ideas are allowed to play their part. This present study has used elements of bricolage but there is a good argument, which has been made elsewhere, for more studies by bricoleurs (Denzin & Lincoln, 2018; Kincheloe, 2001, 2005). Such studies may go some way towards a more holistic understanding of the complexities of trauma and give pointers to treatments which are more individually tailored.

Practice: Wounded healers in the therapy room

The findings highlighted in this paper include: 1) the ways in which the participants first recognised that not all was well, and sought help; 2) memories of being a client; and 3) the survival strategies which they had individually employed as children. Whilst recognising that there were others, these were selected because they can illustrate how therapeutic

practice can be shaped by our past, just as was our choice of career. Digging a little deeper into the behaviours and memories sketched in the findings we find other themes which play their part in the wounded healer's practice.

The first is a **sense of self**. The experience of trauma, especially childhood trauma, is well recognised as having significant effects on people's sense of self (Herman, 1992; Ozturk & Sar, 2016; Rave, 2000; Saakvitne, Tennen, & Affleck, 1998; Ulman & Brothers, 2009; Van der Hart, Nijenhuis, & Steele, 2006). Even over 70 years ago, Buchenholz and Frank (1948) wrote of the implications of trauma on the concept of self, so it would not be surprising to find that the 'self' of the therapist who is a trauma survivor can influence their practice in some way.

Pearlman and Saakvitne (1995, p.18) say "the therapist's self is elemental in the unfolding therapeutic relationship". That relationship is one between two selves that have been shaped by trauma. Survivors of trauma, especially complex trauma, often have augmented problems with trust (Herman, 1992), so trust is a particular issue that can make or break a trauma therapy relationship. An early focus on creating a strong therapeutic relationship is something emphasised by the participants. Both Paul and Fran gave their therapists' focus on technique rather than relationship as the reason for their withdrawal from therapy and their choice of self-help.

Specific research data on clients' sense of trust in their therapist seems sparse in relation to drop-out rates. Many studies on discontinuation (e.g. Swift & Greenberg, 2012) focus on client demographics, therapeutic modality, diagnosis and clinic setting. Samstag, Batchelder, Muran, Safran, and Winston (1998) are some of the few to focus on relationship and found that therapist friendliness (not necessarily synonymous with trust of course) was positively correlated with continuation. Complex trauma usually exhibits some level of structural dissociation (Van der Hart, Nijenhuis, & Steele, 2006) and this can sometime explain withdrawal. The 'flight' activated part could be seen to be operating in Morag, who 'zoned out' rather than engage with her psychiatric treatment, and the 'fight' activated part took over when Fran abandoned therapy. She reports thinking, "you're useless, so f... you!"

A second theme is that of **identification**. Paul describes a safe use identification when he talks of using the memory of his feelings in his early therapy. This is discussed by Cain (2000) who contrasts ways in which countertransference can cause either unhelpful over-identification with clients or, alternatively, greater empathy. I think it important to notice references to identification, and to vulnerability to secondary or vicarious trauma, in this group of therapists.

Mearns and Cooper (2005) give an extended account of a counsellor 'Lesley' who draws on her own experiences to help her empathise with clients. Paul's memory of sensing his "black

hole" led to his work at relational depth and is akin to Mearns and Cooper's illustration. Lizzie's awful memories of being an abused client have sensitised her to emerging feelings in herself which could harm a client. Out of fear of rejection Pat's rebellion against authority figures in her past sometimes makes her project those feelings on to clients and inhibits her use of appropriate challenge in therapy.

What is noticeable, in all the participants, is their acute awareness of the effects of their early trauma, and that they are using that awareness to help their clients, either immediately, or later through guidance from their supervisors. All are explicit in their passionate belief that wounded therapists need to work on their own trauma, and none are in sympathy with the objective stance encouraged by some modalities, seeing it as a form of unhealthy avoidance.

Identification can manifest itself in physical ways. Even when someone's trauma has been emotional rather than physical, the body does indeed remember (Rothschild, 2000, van der Kolk, 2015) and therapists' own memories can be triggered physically by their clients' stories, non-verbal communications or appearance. It is beyond the scope of this paper to discuss the increasing interest and scholarship in this field, but some participants reported experiencing physical effects of their trauma work.

At another less conscious level, identification can take place in vicarious (McCann & Pearlman, 1990) or secondary (Figley, 1983) trauma. Helen described extreme stress on hearing of a serious brain injury sustained by a friend: "My reaction was just so extreme what I was experiencing and feeling... I was absolutely distraught. The nightmares, the imaginings, the flashbacks." This left her in no doubt about the possible severity of vicarious trauma. At some level she was identifying and re-experiencing unrecognised fears of her many years of living with her neurologically disabled father. McCann and Pearlman (1990) describe vicarious trauma as a special kind of countertransference, and the question arises as to whether wounded healers are more or less prone to Helen's kind of negative countertransference reaction. A number of researchers (Kassam-Adams, 1995; Follette, Polusny, & Milbeck, 1994; Van Deusen & Way, 2006; Barker, 2016; Benatar, 2000) have investigated this issue, but have come to different conclusions. Follette et al mention that "other factors" may hold the key to the differences between therapists, and this could add weight to my argument for taking diversity very seriously.

A third theme to emerge was that of the participants' **attitudes to therapy** for complex posttraumatic stress disorder (CPTSD). All the participants had undergone lengthy periods of therapy before reaching the level of competence in trauma therapy which they now show. There is general acceptance that CPTSD therapy normally takes longer than the 9-12 weeks which can

bring about substantial improvement in PTSD symptoms (Cloitre et al., 2011). In the same survey of expert clinicians in the field, Cloitre and colleagues found that there was no consensus about duration of therapy for CPTSD other than that it was normally longer than this. Courtois and Ford (2009) believe trauma therapy is "rarely ... meaningful if completed in less than 10-20 sessions" and may take decades. Ringrose (2012) recommends long initial commitments by therapists treating people with Dissociative Identity Disorder – probably the most extreme trauma-related pathology. This is consistent with Kluft's (1984) work on the disorder which emphasises the length of treatment needed. The 6-session model of brief therapy in many primary care settings falls short of even these minima for classical PTSD, let alone CPTSD and, as I have written elsewhere (Bond, 2019), there is a real risk that clients in many of the UK's Improving Access to Psychological Therapies (IAPT) programmes fall through the net simply because their trauma history is not recognised. Like Khan (1997), Paul accepts the organisational limitations pragmatically and prepares clients well for accepting that more work might be needed in future. He finds, however, that for now the crisis which brought them to him has found some measure of soothing. The participants' own experiences of therapy demonstrate that we should not anticipate that brief therapy alone would be appropriate for most clients with CPTSD.

Some therapy practices which the participants adopted from their own therapists were of the opposite script type ("I wouldn't do it that way with any of my clients"). Others took positive lessons from their therapists. Lizzie uses her therapist's practice of murmuring softly to maintain reassuring contact when a client is very distressed, communicating empathy through the social engagement system (Porges, 2003). Jane's positive experience of a counsellor's self-disclosure contradicts the view that self-disclosure is to be avoided in therapy and believes that when handled appropriately it can be helpful (Hanson, 2005; Knox & Hill, 2003; 2016 and others in that 2016 special edition of *Counselling Psychology Quarterly*). The most enduring lesson I have learned from my last therapist was the relief I felt at her total acceptance and lack of shock or criticism when I had enough courage to disclose previously well-guarded secrets. Fran's appreciation of a "brilliant" "brutal" hypnotherapist she had seen had not resulted in her borrowing his style, but it could have contributed, along with her rebellious spirit, to her "maverick tendencies" (Orlans & Van Scoyoc, 2009), which her supervisor helps her to keep "in check". Morag's experience of hospitalisation has left her with a passion for therapy to be perceived to be relevant by the individual client, and this view is echoed by all.

All the participants, even those who have preferred modalities, are open-minded about other approaches. 'Messy', but frequently effective, mixing of positivist medical insights with

postmodern experiential ones was evident in many of the participants' presentations of their practice. There is however a cross-modality unifying characteristic – the valuing of relationship. In practice, as in human science research as Law (2004) argues, there is a need to accept 'mess' as part of the package. Without that recognition empiricism can lead to a danger of side-lining the 'expert' experience of wounded healers. It is of note that one of the organisations dedicated to support and training around Dissociative Identity Disorder speaks frequently of "experts-by-experience" (First Person Plural, 2020), meaning those who have been diagnosed with the disorder, and who seek to share their insights more widely. Jane's experience of the stress of hearing trauma stories getting right into her head through the earpiece in telephone therapy, is perhaps pertinent in the contemporary situation during the Covid-19 pandemic when so much therapy cannot be carried out face-to-face. Telephone therapists cannot balance visual perceptions in the way that face-to-face therapists can. Ceconi and Urdang (Ceconi & Urdang, 1994) describe the effect on therapists who are visually impaired:

Although she [Ceconi] has a good adaptation to her blindness it is nevertheless 'an ongoing trauma ... a perpetual state of being ... you have to protect yourself from an onslaught of stuff ... if you didn't have defenses you'd be a basket case ... I can readily see defenses that abused children, like [her client], have erected. (1994, p.189).

I suggest that wounded healers who undertake telephone work need to be especially alert to this danger that impacted negatively on Jane and take steps to mitigate it.

Fourthly, the part played by survival responses is well understood by the participants. A question that is worth asking regarding therapists' own experiences is whether they use those experiences to enhance empathy or to project those experiences on to clients. The utility of helping their clients to be curious about the strategies which they have employed to survive their own trauma is one of the lessons that has emerged from the participants' experiences of their own historic ways of processing their personal traumas. Often there are quite marked links between those survival strategies, and the habituated coping strategies that clients find are not working well for them in the present day. This is consistent with Fisher's work on trauma and dissociation which utilises both the structural dissociation model of trauma (Fisher, 2017; Steele, Van der Hart, & Nijenhuis, 2005; Van der Hart Nijenhuis & Steele, 2006) and Internal Family Systems (Schwartz, 2001; Sweezy & Ziskend, 2013). Fisher (2017) describes the former thus:

Structural dissociation facilitates negotiating unsafe attachment relationships: if the wish for closeness is held by an attach part, the ability to appease by a submit part,

the need for distance by flight, the fear of attack by freeze, and the imperative to control the situation is instinctive for the fight part, then the individual has all the 'ingredients' necessary to manage in a dangerous world (p133)

Internal Family Systems is a model not restricted to trauma, but in which 'parts' within the client are encouraged to understand each other to help reduce inner conflict.

Anger (a product of the 'fight' part) is a well-recognised response in trauma (American Psychiatric Association, 2013; Dyer et al., 2009; Herman, 1992) and was expressed more or less overtly by Fran, Pat and Lizzie in childhood, manifesting itself later in life as rebellion. Unfortunate issues can arise where the traumatic origins of anger are unrecognised, and aggression is seen only as a behavioural problem rather than someone's principal survival strategy. If underlying trauma is not detected and addressed the result can be burn-out (Freudenberger, 1975; Lemberg, 1984), power games (Heller & LaPierre, 2012), and even criminality (Stinson, Quinn, & Levenson, 2016). Anxiety is also common, and in Helen and Jane hypervigilance and avoidance were major parts of their survival strategies. Attempts to make up deficits in childhood care by seeking affirmation by academic achievement were the paths chosen by Jane and Pat, and amnesia through dissociation was Paul's way of survival. The traumatic origins of dissociative symptoms can also be overlooked and the more severe conditions such derealisation and depersonalisation disorders have been reportedly under-diagnosed (Gentile, Snyder, & Marie Gillig, 2014).

All these strategies worked well for the participants in childhood but became less effective as adults. Any working therapist will have had developmentally traumatised clients deny that anything significantly negative had happened to them as children, simply because their inherent and unconscious survival strategies had shielded them from too much awareness of pain. The little boy who runs to the garden shed to be out of earshot when his parents are hurling abuse at each other genuinely believes that all parents have rows like that, so 'it's normal'. That same boy as an adult is miserable at work because his way of dealing with the office bully is to hide in the toilet. Helping him in therapy to make the connection can be a powerful way of increasing resilience and open up new, adult, strategies. Fran's transformation of her anger is impressive. From such an angry young person, she has clearly recognised and tamed that beast so that she derives energy from it and finds creative, cutting edge, safe ways of helping her traumatised young clients. Jane and Pat have turned their academic interest to new learning in psychotherapy. Helen has reflected deeply on her default anxiety and it no longer controls her. Wounded healers' recognition of their own specific survival methods can enable them to move on and justifies Morag's passion for relevance in therapy.

We come back, full circle, to the issue of diversity, and the need to take context extremely seriously – something that needs to inform our research and our practice alike.

Final Reflections

This small idiographic project never aimed for generalisability, but rather sought to gather experiential evidence to add to that found by other researchers in the field. In the long run such evidence may help to improve therapeutic practice in trauma therapy. The findings allowed me to discuss issues more broadly around diversity, research approaches, and the use of personal experience in the therapy room which have implications for therapist training, therapist self-care, clinical assessment, therapeutic strategies, and further research.

Opting for a novel research methodology is risky. Such attempts can be criticised as displaying an 'anything goes' mentality, and care needs to be taken to be rigorous enough, without losing the exciting prospect of perhaps opening up a debate about what might be missing in more standard approaches. While there are still occasional skirmishes at the tail end of the science wars, much benefit to our clients has accrued when the findings of both qualitative and empirical trauma studies have been combined. Perhaps the next stage in detente will be to embrace bricolage more wholeheartedly and take it much further than I have done here. Bricolage (e.g. Kincheloe, 2001, 2005; Rogers, 2012) accepts complexities of ontological and epistemological approaches in life as it is actually lived. A full-blooded bricolage would include, for example, cultural contexts. All the participants in this sample were white British, so that cross-cultural perspectives on trauma were not explored. Using imaginative re-construction of original transcripts has the advantage of including much more of the participants' verbal material than would otherwise have been the case. There is also, however, the risk of my own unconscious interpretive bias, which could be mitigated in designing more collaborative writing in a future project.

Any experiential account can only begin to capture the actual lived experience and any account is always partial, selective, and incomplete. Lived experience is always more complexly layered than any written description can possibly capture (Denzin & Lincoln, 2018). The problem of trauma, especially in these days of more than usual political turmoil around the world, calls for innovative approaches which may or may not stand the test of time. However, a more thorough-going form of narrative research or existential phenomenology would go beyond my more explicit idiographic analysis but would have lost some of the advantages of the bricolage. An in-depth lifeworld analysis of the embodied experience of being a wounded healer would be a useful extension of this research.

Whilst acknowledging the weaknesses inherent in my methodology the main advantage is that some freedom from a standard 'method' allowed me to capture my participants' experience, meanings and stories in a lively way, in imitation of the use of 'storying' by some of the world's most influential teachers in history. In her work on metaphor and stories TeSelle (1975, p.66) says "the parable appears to be more and other than any interpretation." The idea that stories are not merely illustrations but actually give more than their abstract commentary is a key point. Maintaining a phenomenological orientation helped me to keep close to the participants' stories and attuned to their frames of reference and resist the temptation of slipping into assumptions of my own.

A major aspect of trauma therapy is that the therapist is frequently living, consciously or unconsciously, at the interface of the client's and their own reality. In the messiness and thickness of human experience we derive some sense of what both we and our clients bring to the therapy room when we meet. As therapists we are there primarily in the service of our clients and any wounds of our own, in that moment, are only of value in as much as they might have transformed us into wounded healers. The analysis here suggests strongly that to become a wounded healer, therapists who have themselves been traumatised as children need to have engaged to a high degree in self-reflection, usually with the help of other therapists, trainers and supervisors, to be able to be reflexive in their practice, and to attend well to self-care strategies. These will enable them to establish meaningful empathic contact, uncontaminated by vicarious trauma, triggered reactions, or unhealthy over-identification with clients, and engage in therapeutic strategies that are relevant to individuals.

The evidence of this study points to wounded therapists having a particular qualitative *potential* to empathise with wounded clients that they might not otherwise have had. Even in encounters with the awfulness of trauma in our clients, therapists who are themselves survivors can perhaps celebrate their woundedness (Martin, 2011) and give the greatest gift of all – a living demonstration of hope.

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About the Author

Pat Bond is an integrative counsellor and supervisor in private practice in the North East of England. She had a long career in science, including research and diagnostic posts in tropical medicine and the molecular genetics of cancer. She qualified in humanistic counselling in 2006 not long before retiring from her NHS post as a Clinical Scientist. Her special counselling interests are trauma, cross-cultural issues and spirituality. Much of her CPD has been trauma-related, culminating in 2018 with a PhD from the University of Edinburgh. Much of her formal counselling work is with clergy, and informally she has a passionate interest in supporting asylum seekers and refugees.