Integrating Therapist Subjectivity in Therapeutic Practice

by

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Contents

Abstract

This capstone explores the longstanding opinion within the field of counselling psychology that the therapist ought not to bring much of their own subjectivity to their counselling practice. The exploration begins with a literature review of the current research, beginning with an examination of the history and efficacy of the therapeutic alliance, followed by a contextualization of the philosophical importance of the therapist's own 'way of being'. Subsequently, the opportunities and risks presented by the 'wounded healer' therapist are considered, including issues such as their proclivity within the field and their potential for vicarious trauma. Following this, ethical considerations are explored, such as navigating countertransference, adherence to ethical codes of conduct, and the limitations of self-care. The literature review concludes with a consideration of the legitimacy of mutual aid and peer support as they pertain to healing, and the advent of consumer survivors within the counselling field. Current research findings demonstrate that the field of counselling psychology values the lived-experience of the wounded healer, while continuing to stigmatize them. Consumer survivor counsellors express feeling dissuaded from self-disclosure, concerned with the limits of 'professionalism', worried that their lived-experience delegitimizes their expertise, and find incorporating subjectivity into their practice to be discouraged. This project suggests that therapists ought to embrace their lived-experience, woundedness, and subjectivity, and be encouraged to incorporate it into their practice. This project concludes that rather than risking centering the therapist over the client, this practice functions as a means of strengthening the therapeutic alliance, humanizing the therapist, and empowering the client. Finally, recommendations are made for future therapist education and training, in order to accommodate for these findings.

Keywords: therapeutic alliance, self-disclosure, lived-experience, wounded healer, therapist subjectivity, consumer survivor.

Chapter One: Introduction

Purpose Statement

The intention of this paper is to explore the relationship between therapists' utilization of their subjective lived experience in the therapeutic process. Therapy is itself an inherently relational process, in which the therapist and client work together on the common goal of supporting the client in their process of change (Orlinsky et al., 2005). Second only to the client's willingness to change, the therapeutic relationship between client and counsellor has been found to be of significant importance in producing positive therapeutic outcomes (Stubbe, 2018). It is widely accepted that the ability of the therapist to attune to their client, empathize effectively, and fully conceptualize their client's suffering is of utmost importance in the establishment of an effective therapeutic relationship (Miller & Baldwin, 2013).

The questions that generated the scope of this project include: (1) Does it stand to reason that a therapist's personal experience of suffering or woundedness might increase their capacity to establish an effective therapeutic alliance? (2) Is it necessary for a therapist to self-disclose their experience(s) in order to instil their client's trust in their level of shared understanding? (3) When is the process of a therapist's lived experience and subsequent self-disclosure detrimental to the client? (4) What are the ethical considerations that a therapist must attend to in determining whether to self-disclose? (5) Does the consideration of therapist subjectivity reach beyond the confines of any specific model of therapy? (6) Should therapists not receive better training on how to utilize their uniquely subjective skills and experience in practice?

This paper seeks to unpack the aforementioned concepts with the intention of considering their complex dynamics, explore the multifarious effects of a therapist's lived experiences of their clients' therapeutic outcomes, and offer some solutions to how to move

forward with the understanding that therapist subjectivity is, in fact, a skill to be utilized across all modalities.

Key Terms Defined

Lived experience

From an experiential-humanistic philosophical point of view, which includes therapeutic modalities such as Emotion Focused Therapy (EFT), Rogerian Therapy, and Narrative Therapy among others, a person's lived experience encompasses the personal knowledge they have gained through direct involvement in everyday events (Orlinsky et al., 2005). Lived experience is understood as being knowledge that is acquired experientially, rather than knowledge gained through a technical understanding or through standard description (Orlinsky et al., 2005). From this perspective, lived experience is understood as providing individuals with a rich and more useful type of knowledge and understanding, than a purely technical or academic conceptualization. For the purposes of this paper, we will be discussing the lived experiences of therapists' mental health, from the perspective that their lived experience has the capacity to sensitize the therapist to the attitudes and feelings of their clients.

Therapeutic Alliance

As mentioned above, the therapeutic alliance is viewed as being the second most significant factor in producing positive therapeutic outcomes for the client. So how do we quantify the therapeutic alliance? While there are differing definitions, most theoretical definitions of the therapeutic alliance have three common themes: the collaborative nature of the relationship, the affective bond between client and therapist, and the ability of both parties to agree on treatment goals (Stubbe, 2018). The therapeutic alliance is widely understood to be a measure of the therapist's and client's mutual engagement in the work of therapy, and

represents a key factor in achieving treatment success regardless of the specific modality and/or treatment methods employed (Stubbe, 2018).

For the purposes of this paper, the therapeutic alliance is understood as a dynamic that is co-constructed between client and therapist. In Chapter Two this paper will examine the current research on the effects of therapists' lived experience on the establishment and efficacy of the therapeutic alliance as well as its potential for damage.

Self-disclosure

As is outlined by Bray (2019), therapists' self-disclosure is often defined in two different ways: immediate and nonimmediate self-disclosure. Immediate self-disclosure refers to when the therapist chooses to express their feelings about the relationship with their client, whereas nonimmediate self-disclosure refers to when a therapist discloses information about their personal experiences to the client (Bray, 2019). For the purposes of this paper when using the term self-disclosure we will be referring to nonimmediate self-disclosure.

It is widely understood within the field of psychology that, when done professionally, and used sparingly, counsellor self-disclosure can build trust, foster empathy and strengthen the therapeutic alliance between therapist and client. That being said, as will be discussed in a future section, there are ethical considerations a therapist must take into account when utilizing self-disclosure -- namely, that it must only be utilized when it will be of benefit to the client. This is of course a difficult outcome to predict, hence the ethical conundrum. Therapist self-disclosure is also widely understood as having the potential to derail progress, and shift the focus from the client to the therapist in an unhelpful or even harmful way. In order to prevent undue harm to the client, it is suggested that therapists undergo training, experience, and supervision so as to best equip them to utilize self-disclosure effectively (Bray, 2019).

For the purposes of this paper, self-disclosure is understood as a tool to be utilized to convey the wisdom of therapists' lived experiences in order to support their clients' own progress. Chapter Two will discuss both the benefits and limitations found in recent literature of utilizing self-disclosure in the therapeutic setting.

Contextualizing the Issue

In order to begin examining the current research on the impact of therapists' utilizing their lived experiences in their practice it is important that we position ourselves within the context of the relevant philosophies of knowledge, therapeutic modalities, and systems of change.

The Wounded Healer Archetype

It is worth taking some time here to discuss the concept of the wounded healer, as it is central to the conceit of this paper. The wounded healer is a relational dynamic concept that was coined by Carl Jung to describe a phenomenon that takes place between the analyst and the analyzed (Benziman et al., 2012). In one of his later works, Jung suggested that sometimes a disease was the best training for a physician, and that only a wounded physician could treat effectively. This concept has been extended to all mental health professionals, and is widely accepted in the field of counselling psychology.

It is not a stretch to argue that all therapists have had painful experiences, as have all human beings. Therapists may have confronted adversity, or have experienced physical or emotional suffering, and would 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. It posits that the degree of woundedness is not important but moreover that the degree to which the therapist can draw upon their experiences in service of healing their client is what matters (Zerubavel & Wright, 2012).

It is important to acknowledge that being wounded in itself does not ensure a therapist's potential to heal, but rather that healing potential is generated throughout and within their own process of recovery (Zerubavel & Wright, 2012). Therefore, it stands to reason that the more therapists can work to understand their own woundedness through the process of recovery, whether that be through their own personal therapy or otherwise, the greater success they will have in meeting their clients' where they are at and support them effectively.

Many psychoanalysts have surmised that the success of the wounded healer paradigm relies on the activation of the wounded-healer duality for *both* the therapist and the patient, as they work in conjunction to co-construct their mutual healing process (Kramer, 2013; Sedgwick, 2001). As Gelso and Hayes (2013) 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 a therapist believes that they themselves are unwounded they may have difficulty accessing their own experiences in order to empathize with their client. Even worse, by positioning themselves as the healer, and the client as the wounded, therapists run the risk of fostering dependency in their client rather than emphasizing their capacity to heal themselves (Gelso & Hayes, 2013).

Additional Framing

In addition to Jung's wounded healer archetype, this project works from a Relational Therapeutic lens, in which the relationship between client and therapist is central to the therapeutic growth and change experienced by the client. This project also argues for the integration of therapist lived experience in modalities that aren't exclusively relational. It also argues from an Existential-Humanistic lens for the value in considering a therapist's 'way of being' as foundational to therapeutic practice. This project also operates from within a post-

Structuralist therapeutic model, in which there is no one subjective truth, but a myriad of potential versions of subjective reality that provide opportunities for generative growth.

Reflectivity and Positionality Statement

My interest in this topic is very personal. In 2015 I experienced a "rock bottom" of sorts, in which my mental health was at an all-time low. I had been struggling with disordered eating and alcoholism for over a decade by then, and it was no longer something I could ignore. I was spending my days in a cycle of eating disorder symptoms and substance misuse. Soon I was isolated from loved ones, unable to work, and fearful of losing my life. It was at this time that I moved home to my mother's basement at age 27 and entered into treatment for my mental health conditions.

Through the support I received in tertiary and community-level care, I was able to learn that my maladaptive coping strategies came as a result of my experience with childhood neglect and trauma, and were resisting change due to the shame and internalized stigma I carried with me. It was this experience that directly led me to believe in my own capacity to change and grow, and infer that all humans have capacity for growth and change if given the opportunity, time, access to resources, and connection. I believe that every therapist has a moment like this, a formative experience that drives them to pursue a career in counselling. While not all formative experiences are related to woundedness, I believe that it is precisely these types of experiences that inform and show up in therapists' practice whether they are aware of them or not. Furthermore, it is namely their uniqueness that makes counsellors most useful to their clients.

I believe that therapists ought to lean into their subjectivity, rather than away from it, in order to most effectively select, connect with, and support their clients. This has led me to want to work to destigmatize the therapist's use of self in therapy. It is my hope that the following chapters outline the clinical relevance for adopting such a stance.

Outline of Capstone Chapters

Chapter one introduces the topic of therapist subjectivity in the context of therapeutic practice. It also outlines the conceptual framework(s) informing this project, defines key terms, and positions the author within the context of this work. Chapter two is a literature review of selected works intended to explore some of the current literature related to the therapist's use of self in their practice. Topics explored in chapter two include: history and efficacy of the therapeutic alliance, the philosophical relevance of the therapist's 'way of being', conceptual origins and implications of the wounded healer archetype in practice, utilizing transformative countertransference, the effects of vicarious trauma and post-traumatic growth on practitioners, ethical considerations for utilizing subjectivity in practice, the limitations to and commodification of self-care, spiritual pain versus burnout, the impetus for collective caring, and the justification for integration of peer support and consumer survivors in therapeutic practice. Chapter three includes an exploration of the intended audience for this research, an overview of the evidence in support of integrating therapist subjectivity into practice, and some of the current barriers to integrating subjectivity in practice including: stigma, "professionalism", and gaps in education. It concludes with suggestions for next steps within the field, namely, increasing education around therapist subjectivity and offering new therapists the opportunity to practice incorporating their experiences in practice.

Chapter Two: Literature Review

Therapeutic Alliance

Historical Origins

Historically, the alliance concept dates back to the middle period of Freud's writings (Fluckiger et al., 2018). Freud recognized the importance of the client's conscious attachment to the therapist, stating that "...even the most brilliant results were liable to be suddenly wiped away if my personal relation with the patient was disturbed." And that "...the personal emotional relation between doctor and client was after all stronger than the whole cathartic process" (Freud, 1961, p. 27). In addition to the concept of an effective alliance, Freud also posited that transference, the unconscious projection of significant past unresolved relationships, was at the core of the therapeutic process (Freud, 1961). Freud believed that changes in the psyche were conditional on the establishment of a therapist's relationship with a client in which the client could re-enact their unconscious projections in order to bring them into consciousness.

Following Freud's inception, the concept of alliance was subsequently taken up and expanded upon by numerous other psychoanalysts (Fluckiger et al., 2018). Psychoanalyst Elizabeth Zetzel (1956) was the first to coin the term *therapeutic alliance,* which she referred to as the client's ability to utilize the healthy part of their ego in order to join the analyst in the accomplishment of therapeutic tasks. Subsequently, M.D Ralph Greenson (1956) established a distinction between a client's capacity to align with the tasks of the analysis, or *working alliance,* and the capacity of the therapist and client to form a personal bond with one another, or *therapeutic alliance* (Horvath & Luborsky, 1993).

Following these developments came the work of Carl Rogers and his offerings of the facilitative conditions a therapist ought to portray in order to influence change, such as unconditional positive regard, empathy, and genuineness (Rogers, 1951). Rogers' works

subsequently resulted in a more rigorous investigation of the impact of relational variables on therapeutic outcomes.

Following Rogers (1951), Dr. Lester Luborsky (1976) proposed that the therapeutic alliance developed in two phases: Type I alliance involves the client believing the therapist to be a source of assistance through their portrayal of a warm, supportive, and caring relationship; and Type II alliance involves the client's investment and belief in the process of therapy itself, as well as a willingness to invest in their shared ownership of the process (Fluckiger et al., 2018). Luborsky's definition of the therapeutic alliance highlights the shift in perspective at this time from believing the alliance to be founded solely on unconscious processes to a more conscious process taking place between the therapist and client as they collaborate and work together.

Psychologist Edward Bordin (1976) proposed a version of the alliance with the intention of its widespread applicability across theories, called the *working alliance*. Derived yet distinct from Greenson's aforementioned concept, Bordin defined working alliance as a collaborative therapeutic stance in which (1) the client and therapist agree on the therapeutic goals, (2) the client and therapist agree on the tasks that make up therapy itself, and (3) the client and therapist establish and develop their bond (Fluckiger et al., 2018). Bordin recognized that therapists practicing from differing modalities would both value and challenge different aspects of the relationship and therefore the ideal working alliance would differ across orientations.

Subsequent research from varying theoretical orientations would go on to adapt and expand upon Bordin and Luborsky's perspectives, resulting in numerous understandings of the therapeutic alliance that we have today. Some of the current approaches include those valuing the *psychometric definitions* of the alliance. This is to say that these approaches assert that the alliance is composed of independent components and are interested in determining

which components may be prioritized over others at any given time (Falkenström et al., 2015; Webb et al., 2011).

Other approaches are interested in the stability, or lack thereof, of the therapeutic alliance over time. These approaches focus on the *longitudinal unfolding* of the alliance; with some viewing the alliance as relatively stable over the course of treatment (Crits-Christoph et al., 2011), and others focused on the measurable changes in the alliance between sessions (Falkenström et al., 2013; Rubel et al., 2017; Zilcha-Mano et al., 2016).

Some research approaches to the therapeutic alliance focus on the various *participant perspectives* of the experience. These approaches are interested in the simultaneous and interdependent evaluations of the alliance from the perspective of the therapist, client, as well as other observers such as partners and group members (Fluckiger et al., 2018). Each of these participant perspectives represent a particular view of the alliance, all of which are considered worthy of exploration and extrapolation (Atzil-Slonim et al., 2015; Hartmann et al., 2015; Kivlighan et al., 2016).

Finally, modern research on the therapeutic alliance is often focused on *alliance-outcome associations*. These researchers often look to the nested levels of data held within the structure of the alliance, with the aim of identifying which variable(s) at any given level contributes most to the overall variability of treatment outcomes (Baldwin & Imel, 2013; Dinger et al., 2007).

These and other varieties of approaches to defining and assessing the therapeutic alliance allows for a wide variety of practitioners from numerous theoretical perspectives to adopt and apply the term within their existing frameworks (Fluckiger et al., 2018). Conversely, the lack of consensus on a definition has also made for difficulties in the development of research literature insofar as there are infrequently agreed upon consistent points of reference from which to base findings (Fluckiger et al., 2018).

Current Research on Efficacy

Despite a lack of consensus on the definition of therapeutic alliance, current growing research focusing on the efficacy of the alliance-outcome associations show that the quality of the therapeutic alliance is linked to the success of treatment across a broad section of clients, treatments, and identified problems. (Fluckiger, 2012). While the relationship between alliance and outcome is seemingly modest, with approximately 7% of the variance, this outcome has proven to be greater than the relation reported between other treatment variables such as therapist adherence to treatment modality, and therapist competence with outcome (Webb et al., 2013). There have been four meta-analyses conducted over the past 20 years (Horvath & Bedi, 2002; Horvath et al., 2011; Horvath & Symonds,1991; Martin et al., 2000) demonstrating the consistent correlational link between therapeutic alliance and outcome at a rate of 7% (Fluckiger et al., 2012).

Despite the research findings there continues to be a debate within the field around the relative efficacy and importance of the therapeutic alliance, particularly for proponents of treatments that are based on randomized clinical trial (RCT) testing outcomes (Crits-Christoph et al., 2005; DeRubeis et al., 2005; Strunk et al., 2010). Advocates for this position believe that in order to obtain consistently effective treatment outcomes therapy ought to involve empirically supported treatments and close adherence to manualization under RCT guidelines (Clark, et al., 2008; Siev et al., 2009). Conversely, others believe that the therapeutic alliance is a direct representation of the collaboration and mutual investment in the work of therapy regardless of the specific modality, approach, or content, and is integral to achieving treatment success (Hatcher & Barends, 2006; Horvath & Luborsky, 1993).

Fluckiger et al. (2012) presented a longitudinal meta-analysis to test the nature of the alliance-outcome relationship in the context of RCTs. Their findings do not support the argument that the alliance–outcome relationship is substantially less relevant or influential in

standardized evidence-based treatments, such as CBT, for specific disorders, and/or in the context of randomized clinical trials (Carroll et al., 1997; Krupnick et al., 1996; Siev et al., 2009). The findings from this study suggest that all therapists, even those working from heavily manualized approaches, such as CBT, ought to focus on the quality of the therapeutic alliance particularly in the early stages of treatment (Fluckiger et al., 2012). The authors of this study go on to suggest that manualized models could be strengthened further by being explicit about contextual factors such as a therapists' characteristics, and addressing institutional metacommunication (Fluckiger et al., 2012.)

A Meta-Models Approach

With current research failing to demonstrate that any one single model of therapy is consistently more effective than another (Shadish & Baldwin, 2009), common factors research suggests that elements common to all therapeutic approaches, such as the therapeutic alliance and client motivation, are more responsible for change than the unique contributions of any model (Fife et al., 2014). In this view, therapeutic modalities become the vehicle through which common factors are delivered (Davis, et al., 2012; Sprenkle & Blow, 2004).

Some of the current research's proposed common factors of effective therapy include hope and expectancy, the therapeutic alliance, motivation, and therapist confidence. (Fife et al., 2014). While much of the current research on common factors focuses on them independently, Fife et al. (2014) argue that this fails to recognize the potential interdependence between factors in practice. Indeed, Hatcher and Barends (2006) make the connection between alliance and technique, arguing that therapeutic alliance is actualized when technique engages clients in purposive work. While others make the connection between alliance and clients' perception of the therapist's techniques as being relevant and resonant (Davis & Piercy, 2007; Simon, 2012).

Researchers Fife et al. (2014) posit further that if common factors in therapy cannot be understood independently, how then should therapy-assisted change be conceptualized, practiced, and researched? They point to the possible solution of adopting an understanding of meta-models or "models of models" (Davis & Piercy, 2007; Fraser et al., 2012). A meta-model in this context focuses on how common factors interact to produce change in effective therapy regardless of the therapeutic modality applied (Fife et al., 2014).

Fife et al. (2014) emphasize that their suggestion of a meta-model approach seeks to describe the relationship between two specific common factors - the therapeutic alliance and techniques, as well as a third common factor which they call the therapist's way of being. This third common factor the researchers claim is both oft overlooked, as well as foundational to most if not all aspects of effective therapy. Through the application of a meta-model approach Fife et al. (2014) seek to define the ways in which therapeutic alliance, therapeutic techniques, and the therapist's way of being interact in order to produce therapeutic change regardless of the modality applied.

Way of Being - Working from an "I-Thou" Perspective

Way of being is understood as the attitude that a therapist has towards the client in the moment and is foundational to the therapeutic alliance (Fife et al., 2014). The therapist's way of being can be one in which the client is perceived as human and dynamic, or wherein the client is perceived as an object and static. The way of being of the therapist is considered a foundational common factor as it greatly influences how clients experience the therapist, and subsequently their attitude towards therapy (Fife et al., 2014).

Other research on the therapist's way of being has shown that clients typically respond to the way their therapist feels about them (Boyce, 1995). More significant than the importance of therapist knowledge, skill, or education seems to be the client's response to "the quality of our hearts" (Boyce, 1995, p.31). Anderson (2006) defined the therapist's way

of being as the way in which a therapist conveys their understanding of the client as a unique human being worthy of being seen and heard, rather than seeking to assess and categorize an individual into a larger system. It has been argued that therapists hiding behind a veil of professionalism will ultimately keep their clients hidden and out of reach from connection (Corey, 2005). Connection is viewed as an integral component of the therapeutic process as therapy is an inherently human endeavour, therefore requiring an authentic human relationship that necessitates the authentic humanity of the therapist as well as the client (Corey, 2005).

The therapist's way of being facilitating connection with the client is a concept that can be traced back to the philosophical work of Martin Buber (1965) who suggested that it is only in relation to another person that the "true self" is manifested, and therefore it is in relationship with others that our way of being is found. Buber describes two types of relationship stances: I-Thou and I-It, the former allowing for the full awareness of the humanness of the other, and the latter viewing the other as object (Buber, 1958).

The significance of the therapist's way of being has been referred to indirectly by the likes of Carl Rogers (1957) and Virginia Satir (1988) who advocated for unconditional positive regard and the valuation and appreciation of clients' strengths respectively. Way of being has also been emphasized from a constructivist approach through the attention paid to establishing a collaborative rather than hierarchical attitude in therapy (Freedman & Combs, 1996). With therapists embodying an inherent position of power within the therapeutic relationship they are at risk of perceiving their own perspectives as correct and devaluing the reality of their clients (Whiting et al., 2012); through the embodiment of an I-Thou perspective therapists are encouraged to consciously choose to put the humanity of their clients first (Buber, 1999). While it is unrealistic for therapists to remain in an I-Thou way of being at all times it is considered important for therapists to increase their awareness of their

own way of being in order to effectively and ethically engage in their clinical work (Fife et al., 2014).

In situating therapists' way of being as a foundational common factor in effective therapeutic change authors Fife et al. (2014) reject the conclusion that a therapist need only be compassionate and accepting in order to be successful. Moreover, they suggest that a therapist must attend to alliance, way of being, and techniques equally in order to provide effective therapy, and that applying this meta-model approach from an I-Thou perspective will ensure a responsiveness to the client's needs regardless of modality (Fife et al., 2014).

Wounded Healer Archetype

Conceptual Origins

In "Fundamental Questions of Psychotherapy" Carl Jung (1979) first attributed the concept of the wounded healer in therapeutic practice to describe a facet of a therapist's relationship with their clients. Jung emphasized that it was therapist's (or analyst in Jung's words) own woundedness that afforded them the transformative capacity to heal their clients. Guggenbuhl-Craig (2005) expanded upon Jung's theory of the wounded healer by emphasizing the clients' own inner capacity for change through their own inner healer. Guggenbuhl-Craig (2005) posited that once a client's own inner healer has been activated, they have the capacity to assist in their own healing, and even heal others by extension. Both the therapist and clients' own woundedness therefore is understood as having a mutually beneficial impact on the other when healing is activated; this builds on Jung's belief that the client often provides the analyst with the exact tending their own wounds are in need of (Benziman et al., 2012).

The presupposition that a therapist's own woundedness provides a catalyst for change within the client might be interpreted as suggesting that in order to enhance their efficacy, all mental health practitioners ought to have vulnerabilities that they are prepared to expose and

utilize in the pursuit of supporting their clients (Benziman et al., 2012). This notion is highly contested within the field of counselling psychology with many scholars arguing on either side. Some, like Barnett (2007), argue that a predisposition to painful experience is part of becoming a therapist, and that the art of counselling isn't something that can be learned without it. Conversely, those such as Biering (1998) argue that the basic assumptions of Western psychiatry are in direct contradiction with the concept of the wounded healer, stating that psychiatry does not expect woundedness to promote growth, let alone cultivate transformative healing potential (Benziman et al., 2012).

Cultural Considerations

It is worth acknowledging that Jung was not the first to conceptualize the wounded healer archetype, but merely the first Caucasian male within the field who is most frequently credited. Considering wounded healer narratives from across a diversity of cultures can help enrich our understanding of the importance of empathy and mutuality in therapeutic practice (Benziman et al., 2012). Historical cross-cultural examples of the wounded healer archetype functioning to enhance the physician-patient relationship include examples such as the Greek myth of Chiron, African Shamanistic traditions, and the ideas of the medieval Muslem physician Al-Razi to name a few (Benziman et al., 2012).

To illustrate further, take the example of Ramphele (2008), a South African medical doctor, known primarily for her work as an anti-apartheid activist. Ramphele addressed her country's psychology practitioners in an article advocating for the development of a common language that would enable South Africans to speak about their psychological needs and mental health issues (Conchar & Repper, 2014). Ramphele (2008) emphasized that in order to assist South Africans in conceptualizing the validity of mental health, it ought to be remembered that illness in African culture is conceived of as a visitation from one's ancestors. Those who fall ill are then conceived of as wounded healers whose capacity for

healing comes from the acknowledgment of their weakness itself, and the empathy they develop for fellow sufferers (Ramphele, 2008).

Another illustrative example of the wounded healer archetype cross-culturally can be seen in the example of pastoral counselling, originating from the early writings of the Dutch Priest Henry Nouwen (1972) (Conchar & Repper, 2014). Nouwen asserted that a pastor ought to make his own wounds available to his constituents as a source of healing, as they can serve as an empathetic bridge between pastor and member, facilitated by the perception of authentic suffering (Nouwen, 1972).

The frequency with which the wounded healer archetype occurs cross-culturally can help illustrate that "woundedness" is only one of an individual's many identities, which when embraced within the whole can transform the individual and their approach as healers.

Serving Others or Self-Serving?

An emergent area of research interest is the examination of the motivations behind "wounded" mental health practitioners entering the field. The most common reason cited in a recent meta-analysis of literature on the subject was the practitioner's interest in their own self-healing (Conchar & Repper, 2014).

MacCulloch & Shattell (2009), for example, depict the experience of a psychiatric nurse entering the field without a full understanding of her woundedness, but who recognized on some level the need for her own healing and was therefore drawn to a profession which could offer her this possibility through her work in healing others.

Multiple research reviews identify that a primary influencing factor contributing to an individual's decision to become a counsellor is a desire to resolve issues emergent during early childhood (Cushway, 1996; Farber et al., 2005; Barnett, 2007; Graves, 2008). Wolgien & Coady (1997) conclude that therapists entering the field having had difficult early life

experiences is a common phenomenon, and one that often provides said therapists with a prized source of strength and learning.

Transformative Countertransference

Jung believed that for the wounded healer a therapeutic encounter ought to be regarded as a dialectical process in which both the therapist and client participate in equal measure (Jung, 1951). The psychotherapist, in his view, ought to have an understanding of their own personal wounds as well as a willingness to examine them (Amundson & Ross, 2016). Jung maintained that if a client's wounds were similar in nature to those of the therapist's, the therapist's wounds may be activated -- founding the basis for countertransference.

Countertransference is a term coined by Freud, referring to a therapist's emotional reaction to and entanglement with a client brought upon by the therapist's own unconscious feelings. Countertransference, according to Jung, offers the therapist the opportunity to examine their own unconscious content, which he also believed to be a precursor to effective treatment. Jung believed that self-examination was at the heart of the role of the practitioner, and that half of every therapeutic treatment ought to consist of the therapist examining themselves, for "only what he has put right in himself can he hope to put right in the patient (Jung, 1951, p.116).

The countertransference experienced by a wounded healer engaged therapy can result in a special unconscious therapeutic relationship in which the healer tries to activate the wounded patient's own healing powers (Guggenbühl-Craig, 2005), while at the same time, the patient's "inner healer" is made available to him/her unconsciously as the healer passes their conscious or unconscious awareness of their own activated wounds to the patient. As Guggenbühl-Craig (2005) states, this process initiates equality and mutuality within the healer-patient relationship, in which the suffering patient is not only cared for by a wounded physician, but also assists in the physician's own healing process. In order to engage in real

change, and avoid getting caught in a loop of mutual unconscious projections between healer and client seeking to meet their own needs, the healer must be aware of and in touch with their own wounded side, while the client must also get in touch with and receive help from their own inner healer (Groesbeck, 1975). In this view, each healer-client encounter can be transformative and creative for both parties.

Self-Reflection of Woundedness

When considering the metaphor of the wounded healer, scholars have distinguished three distinct perspectives on its implications: 1) the implications of the therapist's own predisposition towards woundedness; 2) the effect of the therapeutic relationship on the clinician; and 3) the therapist's opportunity for growth in the face of woundedness (Nolte & Dreyer, 2008). When considering a therapist's predisposition for woundedness, both the clinician's psychological strength and vulnerabilities are of equal relevance (Amundson & Ross, 2016). An appreciation of one's own vulnerabilities is a central tenet of psychoanalysis, insofar as the Socratic quest to know oneself was foundational to Freud's doctrine (Rank & Tucker, 2012). Additionally, with self-reflection being one of the foundational principles of professional psychology (Yalom, 1999) personal self-reflection is heavily incorporated in the training of aspiring therapists (Fenichel, 1972; Rudnytsky, 2002). The goal of this reflection is not only for the therapist to reflect upon qualities of their own character, but moreover on the potential impacts of their personality upon their clients, as well as the impact of the clinical work itself upon the therapist (Amundson & Ross, 2016).

One study demonstrated that 74% of practicing clinicians had suffered, directly or indirectly, significant traumatic life events that contributed to their clinical career choice, and that they presumed to affect their practice (Barr, 2006). Some of the types of experiences listed by practitioners included personal mental health concerns, family conflict, neglect, and abuse (Barr, 2006). Wounded healer scholars posit that these experiences, when thoroughly

examined, offer practitioners the opportunity to engage with their own vulnerable predispositions in order to prepare for their usefulness in clinical practice (Amundson & Ross, 2016). Groesbeck (1975) makes the point that while healers' awareness of their own woundedness is essential, the sharing of this information may neither be necessary or recommended unless it is to the benefit of the client.

Vicarious Trauma & Posttraumatic Growth

With a predisposition to woundedness also comes considerations around a therapist's vulnerability towards vicarious trauma (VT), or secondary traumatic stress (STS) from their clinical work. Considerable attention has been paid to VT and STS in recent years (Baird & Kracen, 2006; Conchar & Repper, 2014; Knight, 2013), in order to identify the conditions of their development and potential protective factors. VT and STS have been found to develop from a therapist's overexposure to clinical work that is both demanding and traumatic, with the potential to lead to attrition over time (Amundson & Ross, 2016). VT and STS have also been referred to as professional burn out, compassion fatigue, spiritual pain, and empathetic enmeshment (Amundson, 2015; Figley, 2002; Reynolds 2011).

Some of the more severe cases of VT can result in the clinician struggling with restricted affect or disinterest, increases in interpersonal conflict, and displaying failures in professional conduct such as absence from work, substance misuse, or incompetent practice (Brancu, 2013). VT can also manifest in more subtle ways such as experiencing a lower level of distress tolerance, lack of clinical interest and enthusiasm, and decreased feelings of care and compassion (Rothschild, 2006).

While demanding and traumatic clinical caseloads run the risk of exposing all counsellors to vicarious trauma and secondary traumatic stress, some scholars argue that counsellors with a predisposition to woundedness are at a greater risk of developing these symptoms, posing a liability issue to the field of counselling (Amundson & Ross, 2016).

Supervision and training have been emphasized as a means of supporting intern counsellors predisposed to woundedness, with supervisors inquiring of their trainees “can this intern sustain the demands associated with exposure to intense human emotion, day after day?” (Amundson & Ross, 2016, p116).

Gil (2015) in a study of over 100 trained professionals working with adults who had suffered childhood sexual abuse found that while these professionals experienced higher levels of secondary or VT, the degree of VT related directly to the degree of post traumatic growth (PTG). Therapists who were open and aware of the impact of the clinical work could transform the experience into personal growth and clinical empowerment. The use of clinical experience to ground, energize, regulate, or relax is reflective of transformation of VT to PTG (Bush, 2015).

Opportunities for Growth

Operating from the understanding that the personhood of the therapist themself has an impact on their clinical practice, and their treatment in turn impacts them (Bush, 2015; Means, 2002), wounded healers can be understood as presenting an opportunity both for increasingly creative and individualized client treatment (Benatar, 2004), as well as an increased capacity for transformation within the therapist themselves (Baldwin, 2000; Gil, 2015; Pietzer et al., 2015).

The opportunity for creative treatment is understood as being driven in this context by a therapist’s own creative anxiety that effective treatment can evoke (Sedgwick, 2001). This creative anxiety is thought to occur more acutely in wounded healer therapists due to their predisposition to woundedness, in turn resulting in their increased capacity for creativity in the face of varied and uniquely demanding client characteristics (Gladding, 1992).

With the perspective that uncertainty is more generative for clinical practice than operating from a position of absolutes and certainty (Amundson & Stewart, 1993), therapists

are often invited to be tolerant of the distress that comes along with not knowing (Amundson & Gill, 2001). Wounded healers are understood as having an increased willingness to remain open to wounding (Benatar, 2004), which can be seen as an increased tolerance for uncertainty and flexibility in the face of challenges (Amundson & Ross, 2016). This flexibility presents an opportunity both for creative individualized treatment, as well as an opportunity for the therapist to remain open to critically reflect on their own use of self in practice (Amundson & Ross, 2016).

With countertransference being understood as an opportunity for both clinical refinement and personal self-awareness (Wolf et al., 2013), its prevalence in wounded healers' clinical practice can be seen as useful for both the client and therapist. It is worth mentioning that this process is not guaranteed, as predisposition to woundedness can result in incompetent clinical work and burnout (Zerubavel & Wright, 2012) as mentioned above.

Proclivity within the Field

Numerous scholars within the field of counselling psychology maintain that the therapist's own woundedness presents a powerful opportunity for facilitating healing in clients (Conchar & Repper, 2014). Some scholars maintain that the very life experiences that led to their woundedness can establish the foundation from which a therapist practices and facilitates healing in their clients (Mander, 2004). Others maintain that the wounded healer can offer a sense of hopefulness and possibility for their clients in the face of suffering due to their shared lived experience (Kottsieper, 2009; Cain, 2000). Wounded healers have also been found to have a greater confidence in their client's capacity for recovery from acute mental illness than other professionals (Cain, 2000).

Still some scholars argue that lived experience, or woundedness, is not essential for efficacious treatment, and in fact all that is required is the capacity for and cultivation of empathy (Davis, 2009). With an understanding of empathy as being the skill of active

listening (Davis, 2009), this ultimately risks the therapist lacking in true understanding, which is what Jung suggests is essential for healing (Conchar & Repper, 2014).

Ethical Considerations

Effectively Managing Countertransference

Working from the assumption that countertransference is an inevitable aspect of the therapeutic process (Hanna, 1993; Winnicott, 1949), it stands to reason that a generative therapeutic alliance in part hinges on the wounded healer's capacity to effectively manage their countertransference. From a psychoanalytic perspective countertransference is at its core an ineffective measure for treating mental illness (Shorter, 1997), however from a more modern, relational perspective it has shown to be useful to therapists seeking to integrate self-awareness and objectivity in their process (Cain, 2000).

The poststructuralist trend towards therapists utilizing their countertransference in their work means that therapists have a responsibility to be aware of their countertransference and how it manifests with their clients (Ekstein & Wallerstein, 1958; Freud, 1961; Hanna, 1993), in order to ensure that it does not harm the client or hinder the treatment progress (Cain, 2000).

With the integration of countertransference often comes the use of self-disclosure in the therapeutic process. In the context of the therapeutic relationship, self-disclosure involves the therapist disclosing statements related to their personal history to the client (Anderson & Mandell, 1989). It is widely understood within the field of counselling psychology that, when done professionally and used sparingly, therapist self-disclosure can build trust, foster empathy and strengthen the therapeutic alliance between therapist and client (Miller & Baldwin, 2013). That being said, there are ethical considerations a therapist must take into account when utilizing self-disclosure -- namely, that it must only be utilized when it will be of benefit to the client (Miller & Baldwin, 2013). This is of course a difficult outcome to

predict, hence the ethical conundrum. Therapist self-disclosure is also widely understood as having the potential to derail progress, and shift the focus from the client to the therapist in an unhelpful or even harmful way (Zerubavel, 2012). In order to prevent undue harm to the client, it is suggested that therapists undergo training, experience, and supervision so as to best equip them to utilize self-disclosure effectively (Bray, 2019). In short, self-disclosure to clients raises ethical and theoretical considerations.

While the wounded healer is equipped in many ways to empathize and connect with their clients, their woundedness, or previous suffering, does not in and of itself promote healing in their clients (Gelso & Hayes, 2013). Nouwen (1972) urged wounded healers to take care to resolve the causes of their suffering so that they may be beneficial to others. The process of transforming the therapist's own life experiences into content benefitting their clients is the integral process of utilizing countertransference in therapy (Gelso & Hayes, 2013).

There is also the danger of the wounded healer falling into a pattern of over-identifying with their client if they uncover commonalities such as shared difficult life experiences (Gelso & Hayes, 2013). Wounded healers also risk falling into so-called empathic failure as a result of overidentifying with patients' experiences, and so caution is called for in walking the "use-of-self tightrope" (Gelso & Hayes, 2013).

Limitations of Countertransference

Empirical research on the notion of the wounded healer is limited, and what little data exists are mixed. Studies tend not to support the popular belief that drug and alcohol treatment is more effective when offered by therapists in recovery (Culbreth, 2000; Najavits & Weiss, 1994). In addition, sobriety does not guarantee resolution of one's internal conflicts that underlie addictive behaviour. Nonetheless, according to one qualitative study, it is not

unusual for therapists to attribute their effectiveness to the resolution of personal suffering (Wolgien & Coady, 1997).

In any event, to use themselves, including their countertransference, as therapeutic instruments, therapists must be able to see into themselves, to understand their fluctuating needs and preferences and shortcomings and longings. Self-insight is a necessary precondition for connecting one's own experiences with a patient's experience. Intentionally drawing from one's personal history in one's work with patients is demanding.

That being said, it seems important for therapists to see both themselves and patients within a wounded healer framework. 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." When this dichotomy is established, therapists cannot use their own experiences of suffering to empathize with patients, and patients' inner healing capacities are not acknowledged and utilized (Guggenbuhl-Craig, 1971; Laskowski & Pellicore, 2002). Remen et al. (1985) argue that there is no essential difference between the two people engaged in a healing relationship. They argue that both therapist and client are wounded and both are healers, and that it is the woundedness of the healer which enables them to understand the patient and which informs their wise and healing action.

It has been said that countertransference is the best of servants, but the worst of masters. The challenges in managing countertransference so that it serves rather than dominates one's work are complex and formidable. Several therapist characteristics seem to facilitate this process: self-insight, conceptualizing ability, empathy, self-integration, and anxiety management. Therapists can seek to function as wounded healers in the ideal sense by drawing from their own experiences of working through painful personal incidents to better understand, offer hope to, and work therapeutically with patients.

BCACC Code of Ethical Conduct

As stated previously, therapist self-disclosure has the potential to result in both positive and negative outcomes for the client. It is important to highlight here some of the ethical responsibilities of licenced clinical counsellors in BC, as the decision to self-disclose is ultimately a judgement call that every therapist must make for themselves.

A licenced counsellor in BC has a duty to adhere to the ethical code of conduct outlined in either the British Columbia Association of Clinical Counsellors (BCACC), or the Canadian Counselling and Psychotherapy Association (CCPA). In order to obtain a licence, counsellors in BC are required to register with either association and are expected to abide by their respective codes of ethics.

On top of their association's ethics, RCC's are expected to abide by the provincial and federal laws that pertain to their practice. It is worth noting here that there are different kinds of legal duties: legislative duties and common-law duties (Bryce, 2014). Legislative duties are established by statutes, commonly known as acts, and can take the form of either a direct prohibition, or an implied right of an individual (Bryce, 2014). Common-law duties are established when a judge in a court of law determines that a duty was owed (Bryce, 2014). A counsellor must keep in mind that just because there is no legislative statute prohibiting a specific act or behaviour, does not mean that a counsellor will not be found guilty of malpractice or negligence in a civil-court of law.

The BCACC Code of Ethical Conduct is based upon four fundamental ethical principles: (1) Respect for the Dignity of All Persons and Peoples; (2) Responsible Caring; (3) Integrity in Relationships; and (4) Responsibility to Society (BCACC, 2014). While all 4 principles should be adhered to by every therapist as much as possible, Principle 1: Respect and Dignity for All Persons and Peoples should be given the highest weight if a scenario presents itself in which two or more principles are in conflict with one another (BCACC, 2014). From this we can infer that as much as possible, therapists must put the client's needs

first in all matters related to their treatment. If a therapist's judgement were ever clouded and their ability to discern what is best for their client impaired, the likelihood of their actions being in conflict with their ethical code of conduct is high, as would be the risk of harm to their client.

Limitations to Self-Care

Another aspect of ethical concern related to the efficacy of the wounded healer is their capacity to tend to their own needs. The theme of self-care and self-help is considered integral to the success and indeed survival of the healer. A number of writers (Jones, 1991; Ungar et al., 2000; Conti-O'Hare, 2004; Dunning, 2006; MacCulloch & Shattell, 2009; Richard, 2012) focus on this area with the aim of educating individual healers and the healing profession as a whole, urging them to heed their message of the importance of tending to a counsellor's own wellness.

Some authors, such as Jones (1991) suggest that wounded healers may fail at engaging in self-care due to an attempt to protect their own woundedness as it is this quality which allows for their professional healing capacity. While others argue that wounded healers may be less likely to be aware of their triggers and more likely to fall into the cycle of overidentifying with their clients (Gelso & Hayes, 2007), Jones (1991) argues that wounded healers are likely to be very well aware of that which causes their woundedness, but rather will resist self-care in order to legitimately remain a healer. Jones (1991), who is himself a wounded healer poses the question: "can we afford to get well?", answering that for some healers the answer may be no. This poses an ethical challenge to the field as counsellors have a duty to provide responsible care to their clients, a quality which is limited by the ways in which counsellors care for themselves.

Other authors argue that wounded healers may deliberately avoid the self-reflection necessary for self-care due to their trepidation at finding an imperfection that could

negatively impact their professional practice (Emerson & Markos, 1996). Others still posit that wounded healers may struggle with a sense of denial over their woundedness as a means of self-preservation (Conti-O'Hare, 2004). For these healers it may be too painful to experience the uncovering of their wound in order to engage in self-care around it. There are also findings to suggest that pressures of societal expectation around healers needing to remain strong and devoid of weaknesses add pressure to the wounded healer to hide their perceived vulnerabilities, leading them to either deny the existence of their woundedness or engage in self-treating (Conchar & Reppar, 2014).

Carr (2008) identifies that many in healing professions are fearful of acknowledging their own experiences of mental illness for fear of losing the inherent unconscious distinction between "us and them" in regards to their clients. Carr (2008) suggests that the pressure to rise above human frailty in order to maintain a sense of professionalism leads healers to suffer in silence as they feel the need to remain stoic or else make themselves vulnerable to criticism. Bradley (2009) elaborates that this culture of denial of woundedness in healing professions can lead to a lack of attention to self-care, causing prolonged periods of absenteeism and eventual burnout.

It is important to mention the prevalence of stress and burnout amongst those employed in the field of mental health. Numerous authors have identified that burnout, stress, and anxiety are directly linked to the pressurized and often harrowing working environment of mental health professionals (Bradley, 2009; Canfield, 2005; Clarke & Singh, 2004; Guggenbuhll-Craig, 1999; Hall, 1997; Rabin et al., 2011; Sperry, 1987). Consensus among these authors maintains that in order to effectively support their clients' healers must take care to identify, know, and heal their own wounds and must take to avoid feeling superior to their client and above the experience of woundedness as it distances them from their client and frames them as "other".

Commodification of Self-Care

It is worth mentioning the ways in which "self-care" itself became the commonly maintained solution to any measure of woundedness. After getting its start in academia throughout the 1980s, the term "self-care" gained mainstream renown in the 1990s through its connotation with the ways in which a person could take supplementary responsibility for their personal health (Harris, 2017). By the 2000s "self-care" was everywhere in Westernized culture and has been reduced to a catch-all phrase used in marketing to encourage treating oneself by indulging in consumerism in order to increase professional productivity.

Active self-care, according to Foucault, was originally considered to be a type of vigilance that not only encompassed taking care of basic needs but also an effortful seeking of self-knowledge that comes from active leisure of reading, studying, and ruminating (as cited in Harris, 2017). Under capitalism self-care has become a commodified solution to a problem that it created -- instead of looking at systemic ways to support the conditions for active leisure, self-care is individualized, with people being encouraged to spend more and work harder in order to avoid burnout.

Spiritual Pain

Another way to conceptualize burnout experienced by mental health professionals was coined by Vancouver-based clinical counsellor and activist Vicky Reynolds. Reynolds has coined the term "spiritual pain" in order to contextualize the harm that helpers suffer as a collective experience rather than an individualistic failing (Reynolds, 2011). Spiritual pain is defined as the experience that healers face when they are forced to work under systems that conflict with their ethics and values (Reynolds, 2011). Reynolds' aim with the term is to broaden the focus from the social responsibility placed on the individual healer to engage in self-care in order to avoid burnout, and instead call to attention the ways in which systemic structures and limited resources are at play to challenge the generative capacity of healers.

Reynolds encourages supervisors and administrators to notice and attend to the spiritual pain of their healers; instead of attempting to smooth over the discomfort of employees experiencing burnout, Reynolds believes there is an opportunity for an ethical investigation into how to return to alignment with sustainable, collective ethics (Reynolds, 2011). The same way that there can be strength in the woundedness of a healer, Reynolds believes that spiritual pain can be utilized as a potential resource from which to learn about what feels "respectful, humane, generative, and contexts which call on us to violate the very beliefs and ethics that brought us to therapy and counselling work" (Reynolds, 2011).

Reynolds' approach to conceptualizing burnout encourages the collective responsibility of community in the face of unsustainable practice. Reynolds encourages those experiencing spiritual pain to share their experience with their colleagues, peers, and community in order to gain support in shouldering the pain, as well as invite collective accountability and the examination of collective ethics in the hopes of fostering sustainability (Reynolds, 2011).

Collective Caring

Expanding upon the concept of decentralizing the responsibility of self-care away from individualism and towards collectivism comes the idea of "collective caring". Collective caring is a concept with its origins in activist communities in which safety is defined as being both implicitly and explicitly cultivated (Coe & Ronnblom, 2018). Collective caring is a response to the prevalence of "unsafety", which is understood as a systemic, social issue that requires a coordinated and enduring response to protect those it impacts (Coe & Ronnblom, 2018).

The concept of collective caring is also in line with political theorist Lorey's (2015) concept of the "practice of caring". Lorey argues that precariousness is an existential state experienced by all humans, and that despite our efforts to create safety, it is not possible to remain constantly protected (Lorey et al., 2015). Lorey posits that all security retains

precariousness; all protection and care maintains vulnerability; and that nothing guarantees invulnerability (Lorey et al., 2015). From this logic, naming the risks and vulnerabilities associated with unsafety, spiritual pain, and woundedness, at both the individual and collective level, shoulders the burden of experience, promotes safety, and is a practice of care. Conversely, individualizing these issues and framing them as something to avoid and protect oneself from further produces the societal conditions under which a lack of care is replicated.

Peer Support and Mutual Aid

Support for the efficacy of the wounded healer archetype within the field of counselling psychology can also be found within the success and efficacy of mutual aid groups over the past 80 years, as well as the growing recognition of peer support within the medical model.

Mutual-Aid Groups and the Recovery Movement

Within the past several decades there has been a paradigmatic shift within the current model of public and mental health in which there has been a valuation placed on the lived experiences of individuals, rather than exclusively a focus on foundational therapeutic theories and modalities.

The conceptual shift in question is called the recovery movement (Kurtz, 2014). The recovery movement maintains that certain mental health issues, namely addiction, should be understood as chronic health conditions that can require many years of effort before sustained recovery is achieved (Kurtz, 2014). Previous models of treatment in the field of addiction, namely, the medical model, were typically focused on some concept of the root cause of the disorder, be it “sin”, mental illness, or criminality (Kurtz, 2014). The recovery model, conversely, does not focus on the causation of the addiction, but instead on the *experiences* of successful recovery, drawn from those with lived and living experiences with it.

The recovery model of addiction treatment has its roots in peer-led mutual-aid groups, such as Alcoholics Anonymous (A.A.), founded in 1935. Mutual-aid community support groups such as A.A. and other 12-step programs, involve members coming together to share their experiences, strength, and hope, with the purpose of staying sober and helping others to achieve sobriety (Alcoholics Anonymous World Services, 2018). There are hundreds of thousands of these mutual-aid groups worldwide, with over two million participants in recovery, as well as the ongoing substantiation of the American National Council on Alcoholism and the American Public Health Association since the 1960s (Alcoholics Anonymous World Services, 2018).

Since the proven success of the recovery model within mutual-aid groups, over the past few decades it has begun to influence mental and public health sectors worldwide in their policy development and implementation. This shift is exemplified in a myriad of ways including: the growing emphasis on client-centered approaches to therapy; the expansion of psychiatric teams to include peer support workers; public policy makers including the lived experience of the population for whom their services are catered; and even the advent of destigmatizing language used to discuss issues of mental health colloquially (Kurtz, 2014).

Alcoholics Anonymous

Alcoholics Anonymous began in the 1930s and can be understood in simplest terms as a mutual-aid support group program which focuses on its members recovering from alcohol dependency. A.A. members engage in a program consisting of "12-steps" whereby members who have completed the twelve steps are viewed as mentors who can provide empathic support and guidance to other new-to-the-program alcoholics (Alcoholics Anonymous, 2018). One need only look to the proliferation of A.A. meetings in every city around the world in order to get a sense of the program's pervasive reach. While it is difficult to obtain definitive findings on the program's efficacy due to the anonymous nature of its participants,

as well as a myriad of external factors to control for, a 2009 meta-analysis on the subject found that rates of abstinence from alcohol are approximately twice as high among alcoholics who attend A.A. meetings than among those who receive no treatment (Kurtz, 2009).

Much of the program's success is attributed to its inherently non-hierarchical structure (Conchar & Repper, 2014) in which members seek to support one another on their mutual paths to recovery, simply by speaking to and sharing their personal stories of lived experience with alcoholism. Mutual aid groups do not start and end with A.A., but rather they extend into all corners of modern society, and are accessible tools for organization, connection, activism, and healing.

Peer Support in the Medical Model

Since the advent of the recovery model, and the success of mutual-aid groups, the medical model has adapted to incorporate individuals with lived experience on their interdisciplinary teams, specifically, peer support workers. Peer support work is defined by the Mental Health Commision of Canada (Kirby & Keon, 2006) as "a supportive relationship between people who have a lived experience in common." Since 2006 the MHCC has advocated for the use of peer support workers within the medical system, as synthesized by the statement "instead of focusing on what is wrong, we are beginning to focus on what is strong" (Kirby & Keon, 2006).

A few key themes characterizing the role of peer support workers in the coordination and implementation of physical health and mental health services have been identified as follows: (1) Advocacy on clinical teams and advisory councils; (2) sharing their lived experiences both with clients and service providers; and (3) substantiating the need for continuous funding, and sustainability of peer support services (Storm et al., 2020). Incorporating peer support within the healthcare system has been shown to reduce the need

for hospitalization, reduce the emotional distress of medical patients, and help to encourage and instill patients with a sense of self-efficacy (Storm et al., 2020).

Not unlike the function of mutual-aid groups, the role of the peer support worker (PSW), as individuals who have experienced similar adversity to those they support, is to support others via a non-hierarchical relationship (Nestor & Galletly, 2008). Research has shown that the inclusion of PSWs on mental health teams has resulted not only in improved patient care, but also had a measurable positive impact on the PSWs themselves (Nestor & Galletly, 2008). PSWs were found to have increased confidence, reduced hospitalization rates, as well as increased rates of stable employment, and the social and financial benefits derived from this integration (Nestor & Galletly, 2008). Peer support is now becoming embedded in policy and practice; recognized and valued by employers as an effective way of encouraging staff with mental health issues into the workplace.

By sharing their stories of resiliency to patients experiencing suffering similar to their own, peer support workers help affirm patients' ability to shift their mindset away from hopelessness, and towards hope. The efficacy and inclusion of peer support workers in Canada's health care system is yet another example of the ways in which lived experience is being valued in the modern treatment of mental health.

Barriers to Peer Support Integration

Despite the positive effects of peer support workers on the recipients of their support, PSWs continue to face barriers to integration within the field of mental health due to their limited levels of power and authority (Conchar & Repper, 2014). Some of the barriers identified that PSWs most often faced when working on mental health teams include a lack of support from other staff members due to such fears around personal job security; the blurring of professional and personal roles and responsibilities; and the prejudice and stigma they

faced due to their status as people who have/have had mental health issues (Conchar & Repper, 2014).

Considering studies showing that 25% of the population will experience a mental health issue in any given year, a statistic which is found to be significantly higher in certain helping professions (Clarke & Singh, 2004), it stands to wonder why, outside of stigma, peer support roles are relegated to so few positions within large health authorities. Even when given employment opportunities PSWs are often paid a fraction of what other healthcare professionals earn (Storm et al., 2020), further delegitimizing the value of their work. There remains much to do to improve the experience of people with mental health issues, both those working within mental health services as well as being served by them.

Despite the multiple barriers they face, PSWs have a valuable role in the field of mental health - their capacity to instill hope, motivate, and promote self-efficacy to fellow sufferers is undeniable. In addition to their impact on patients, their inclusion on mental health teams has also been shown to help encourage employers to address organizational dilemmas such as how to support staff who become mentally ill during their employment, and how to address self-disclosure of mental health issues (Conchar & Repper, 2014).

Consumer Survivors

The impact and importance of identifying individuals working within the mental health field as consumer activists and survivors is a cause taken up by Psychiatrist Daniel B. Fisher, Executive Director of the American National Empowerment Centre (NEC). Fisher identifies himself as a consumer survivor, self-identifying as having recovered from schizophrenia (NEC, n.d.), and seeking to dispel the myth that people with psychiatric disabilities should refrain from working in the mental health system (Fisher, 1994). Fisher highlights the value that he and other consumer survivors bring to the field, stating that the process of their

recovery from psychiatric disabilities allows for their unique contribution at all levels of service provision, specifically because they were once there too (Fisher, 1994).

Fisher argues for a shift in thinking within the medical model, believing in the benefit of moving from an illness paradigm to a healing vision. This, Fisher argues, would facilitate the transition of consumer survivors from stigmatized into legitimized roles within the field (Fisher, 1994). This paradigmatic shift would help eliminate the frequency with which consumer survivors experience negative experiences within the mental health system. Adame (2011) outlines numerous stories of negative experiences faced by survivor-therapists working within the mental health field, from human rights abuses, to the devaluation of their work. The continued stigma faced by consumer survivors impedes the healing work they offer to patients, as well as the frequency with which folks entering the field readily self-disclose their struggles. There is a definite need to create a supportive environment where staff at all levels and in all professions can feel encouraged to use their own wounds to heal those of others; an environment where workers are able to be themselves at work should they choose to do so.

Implications for the Field

Research shows that the inclusion of mental health consumers in the field of mental health as professionals is supportive to both patients, professionals, and the field itself (Cain, 2000). The etiology of mental illness continues to be illuminated, with its treatment approaches ever evolving. The experiential knowledge and unique expertise of wounded healers, therefore, would do well to be considered professional assets to the field of mental health (Cain, 2000). The inclusion of wounded healers in the field helps underscore the value of collaboration within therapeutic treatment models. By including those with lived experience of mental illness in the process of forming, implementing, and evaluating mental health services, both professionals and clients alike seek to benefit from their expertise (Frese

& Davis, 1997). In short, wounded healers' capacity for empathy and belief in recovery enhance the potential for therapeutic success.

Chapter Three: Discussion

Who is This For?

The demographic of therapists for whom this research is most relevant are those practicing from a relational, post-structuralist, lens. Those practicing from a purely psychoanalytic perspective, or from a highly manualized approach, such as CBT, may not be inclined to utilize these findings in their practice. 'These findings' refers to the evidence outlined in Chapter Two in support of therapists working to embrace their humanity, even utilizing their own woundedness, when working with clients. Therapists whose primary modality does not seek to include the counsellor's own lived experience in their practice, but rather positions them as an empty vessel for which the client to project their subconscious, may not find the research outlined to be of value to them at first glance. Same for those whose modalities hinge more on therapeutic skills building and psychoeducation, rather than on the establishment of a therapeutic relationship. It is worth being clear that the research highlighted in this project is primarily geared towards therapists practicing from a relational approach - it is not expected to suit all practitioners. Despite this contingency, the following chapter seeks to make the case as to the relevancy of this material for practitioners from all modalities.

Why Does it Matter?

There is an argument to be made for practitioners outside of a primarily relational modality to incorporate a practice of embracing their woundedness in service of the therapeutic alliance. As was identified in the literature review, evidence suggests that one, the therapeutic relationship produces more measurable, positive outcomes in therapy than skills, techniques, and modality. Two, a counsellor's use of an I-Thou 'way of being' allows for an effective foundation upon which to establish a therapeutic relationship, regardless of modality or approach. Three, when counsellors deny their own woundedness it has been shown to have

adverse effects on both the therapists, as well as their clients. This can result in counsellor burnout, lack of authentic connection between client and therapist, and a lack of effectiveness of therapeutic techniques. Four, when counsellors deny their own lived experience of woundedness it can deepen the stigma associated with disclosing mental health issues, or difficult life experiences. This denial can deepen the stigmatization of therapists struggling with their own mental health and result in their clients' reluctance to share their struggles as well. Five, when therapists deny their woundedness it can also entrench the role of counsellors acting as "expert" rather than embracing the equalizing common humanity of shared experience, thereby objectifying and othering the client.

What are the Barriers to Integration?

Stigma

One of the barriers currently faced by counsellors interested in incorporating themselves in their practice is the persistent stigma associated with doing so. There is stigma within the field both around counsellor self-disclosure being perceived as bad practice, as well as more generally towards counsellors who have a history of experience with mental illness. Both of these types of stigma work to prevent therapists from adopting a holistic understanding of themselves into their practice, wherein they can bring authenticity and transparency into their work for the benefit of their client.

In a study by Cain (2000) stigma was found to be the main reason why therapists with a history of psychiatric hospitalization were hesitant to disclose their experience with their colleagues and supervisors. Many participants identified that the stigmatization and discrimination of mental illness that they had experienced within the health care system was a hinderance to their advancement in the counselling profession. One participant offered their perspective on the existence of stigma within the mental health system, stating that

Conversely, the mental health system hired some participants because of their psychiatric histories. Some participants reported that the stigma existed, but that it was "diminishing." A participant asserted an explanation for the presence of stigma:

> I think the reason for [stigma] is it's just so terrifying for some people who are working all the time and re-ally facing the kind of distress that people go through, it's so terrifying not to keep people who are going through that distress as clearly dis-tinct from oneself. It's a protective mechanism (Cain, 2000, p. 27).

Another participant shared that their experience of stigma within the field resulted in further isolation and silencing. They stressed that "As long as [consumer/professionals] are forced to remain silent, the field is really held back, not just in terms of treatment, but even in terms of understanding illness" (Cain, 2000, p. 27).

According to participants, reduced stigma could increase access to support and supervision for wounded healers, also known as consumer professionals, and ultimately increase opportunities for more of them to enter the field. Several participants identified their optimism for a future in which all consumer professionals would be free from the restraints of stigma, as they contribute valuable information to the profession and their experiences can enhance treatment for clients:

> The most important part of my recovery was sitting with someone who I knew had gone that route before....this can be one of most critical differences in recovery, because basically, the message you [usually] get is that you can't do it, and to actually see someone there who's done it [is valuable]. So, I just say that sort of is my plea to the field, that it's really important to reduce the stigma and open up this opportunity to a client (Cain, 2000, p. 27).

In short, the field of mental health and its practitioners ought to actively examine their relationship to stigma as it pertains to clinicians' experiences of mental illness. A reduction in

the amount of stigma, both experienced and anticipatory, by wounded healers would likely result in more folks with lived experience entering the field, and a subsequent improvement in the quality of client care in the field overall.

"Professionalism"

Another barrier that prevents clinicians from incorporating a holistic sense of self in their practice has been identified in modern literature as the veil of "professionalism". Stocker (2005) argues that, from a relational feminist lens, the goal of therapy is to achieve genuine mutuality that is both psychologically empowering and morally normative. Stocker (2005) posits that the key to effective therapy is the establishment of a "growth-fostering relationship", which requires authenticity and transparency on behalf of the therapist in order to encourage the same in their clients. These relationships are so important, both psychologically and morally, according to Stocker (2005) that therapists ought to examine whatever prevents their achievement, such as the facade of professionalism.

One way that professionalism can present itself as a barrier to growth-fostering relationships is through its inherent positioning of the therapist as expert; a therapist hindered by professionalism may find themselves presenting through a reliance on their training and methodology, rather than holistically. Stocker (2005) references Gilligan (1997) who states that it is common for individuals, particularly academics, to take and keep themselves out of relation through their desire to speak in the voice of an expert.

While thinking within methods and paradigms can be useful, argues Gilligan (1997), becoming reliant on methodology can result in a debilitating detachment or dissociation from the self in order to practice it. The therapist's detachment from themselves for the sake of professionalism comes at the expense of growth-fostering relationships with clients, as the therapist learns to speak in a voice other than their own (Stocker, 2005). As the recovery of the client's authentic moral voice is at the heart of relational therapy, it is paradoxical for the

therapist to speak in anything but their own voice when engaged in their work. By embracing their own authentic voices, therapists can act as profound witnesses to their clients, and encourage them to experience and share their authentic selves.

A Gap in Education

Aubrecht and La Monica (2017) argue that there is a gap in the current education system for new therapists around how to utilize their subjectivity within the therapeutic relationship. As stated in earlier sections there is a lengthy history of wariness within the field of psychoanalysis around the therapist's use of self-disclosure with their clients. That being said, there is a case to be made for the modern, relational or otherwise, therapist to increasingly incorporate their 'way of being, also known as their subjectivity or authentic self in their practice. Therapists increasing transparency around who they are and how it impacts their practice can inform clients' understanding of who they are choosing to enter into a therapeutic relationship with. Having a deeper understanding of their therapist improves a client's level of consent around the journey they are embarking upon.

If the field of counselling psychology continues to discourage therapists in training from engaging in this kind of transparency with their clients, clients will continue to be at a disadvantage, both when selecting a therapist, and during their work with them. By incorporating their subjectivity into their practice, therapists offer clients an invitation to explore the potential similarities and differences they may have, as well as how the biases and social locations of the therapist may impact their work together. This important shift within the field of counselling psychology requires that the training for new therapists incorporates how to utilize therapist subjectivity in practice.

Aubrecht & La Monica (2017) argue that disclosure ought to be thought of as a socially situated and interactional achievement. The authors liken self-disclosure to a form of autoethnography: "a valid approach to research and writing which seeks to describe and

analyze personal experience in order to understand cultural experience" (Aubrecht & La Monica, 2017 p. 4). Bochner (2013) refers to autoethnography as a searching inquiry into an experience, from which point it can be interpreted and made sense of. Bochner (2013) goes on to highlight that while facts are an important aspect of autoethnographic storytelling, the key to autoethnography is to make meaning of the experience of memory.

If therapist self-disclosure was less stigmatized within the field, and instead thought of as something closer to autoethnography, its use would provide an opportunity for both the therapist and their client to identify the process of meaning-making from reflecting on experience. Therapists sharing with their clients how they experienced something in the past, and how they experience it now could provide their clients with encouragement, hope, and insight into the process of meaning-making from their authentic experiences.

What's Next: Incorporating Lived Experience in Education

From Self-Disclosure to Subjectivity

Another path towards counsellors integrating their way of being in therapy involves a departure from the debate around self-disclosure all together, with a focus instead on developing a therapist's understanding of their subjectivity. Subjectivity in this context refers to anything to do with the therapist's unique physical, psychological, or spiritual being (Kuchuck, 2018). Kuchuck (2018) argues that rather than treating therapist subjectivity as an aside, or in the context of impasse and enactment in practice, the topic deserves to be considered in the context of a unified theory as it pertains to and affects therapeutic practice and outcomes.

Kucheck (2018) distinguishes silent-disclosure as a technique that acts as a middle ground between therapists' avoidance of the use of self-examination in the context of their sessions, and overt or deliberate therapist self-disclosure. Silent-disclosure refers to the process of a therapist conducting an internal exploration of their subjective presence and

impact while engaged in a therapy session (Kuchuck, 2018). Silent-disclosure provides the therapist with the chance to engage more intentionally with their subconscious material, rather than avoid, detach from, or ignore it. By conducting self-disclosure in session, Kuchuck argues, the therapist is given the opportunity to bring forward the intersubjective material taking place between the client and therapist. This process seeks to highlight subjective data and dynamics both within the therapist, and at play within the dyad, that might otherwise have gone overlooked without such an internal investigation.

By emphasizing the importance of therapist subjectivity, and the way that it stands to benefit the therapeutic relationship, Kuchuck (2018) aims to encourage therapists to consider how they can more effectively recognize and make good use of who they are in their work. Therapists are uniquely positioned to act as catalysts for their clients' growth and change, processes which are both helped and hindered by their own subjectivity. By embracing their subjectivity rather than rejecting it, and by engaging with it both internally and out loud with their patients, therapists have an opportunity to positively inform therapeutic action rather than interfere with it (Kuchuck, 2018.)

Suggested Next Steps

In order to support both current and future therapists with the integration of their way of being/subjectivity/woundedness in their practice, training and education ought to include modules related to this specific process. Currently, while therapists in training are encouraged to reflect on themselves and their biases, this content is often considered secondary to the exploration of therapeutic theory and techniques and relegated to private reflection. This author argues that training should include instruction on the relevancy of therapist subjectivity in practice, its potential impact on the therapeutic relationship, and encourage the development and exploration of silent-disclosure in practice.

Additionally, education and training should encourage therapists to examine their own personal barriers to engaging in self-disclosure, both silent/internal and verbal/deliberate. Therapists ought to have the opportunity to practice this technique the same way they do any other in their training, which is to say directly and amongst their peers. Therapists in training ought to have the opportunity to explore their own perspective on their subjectivity and how they foresee utilizing it, or not, in practice. New therapists ought to consider how their specific social locations, biases, and woundedness, among other aspects of subjectivity, informs the work they do.

New therapists should be asked by instructors to consider the ethics of withholding or sharing their subjectivity with clients. Therapists in training should have the opportunity to unpack what happens in the room when they self-disclose and when they have an urge to, but don't. Training for new therapists ought to examine the trajectory of opinions on the therapist's use of self within the field, from psychoanalysis to relational therapy and everywhere in between. Therapists should be asked to consider for themselves where they fit along said spectrum and identify how they are uniquely positioned to support their future clients.

Therapists in training ought to be supported by their instructors to get comfortable with their own woundedness. This exploration ought to be framed as a deepening of self-awareness, which precedes a therapist's capacity to recognize their potential triggers and limitations. Training should be focused on therapists' exploration without self-blame and shame. Exploration should be encouraged as an individual process, as well as in small groups among colleagues where appropriate. And lastly, institutions ought to provide funding for and access to individual counselling for therapists in training throughout their schooling.

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