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Elizabeth Davison BA Hons. PG Cert

The wounded healer: Clinical and counselling psychologists with experience of mental health problems.

SECTION A: Therapist self-disclosure: How can the wounded-healer effectively use self-disclosure in the therapeutic-relationship?

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Summary

The qualitative literature pertaining to therapist self-disclosure (TSD) was critically assessed and synthesised to infer how the findings might inform how the wounded-healer can effectively use TSD in the therapeutic-relationship. This review's findings identified that TSD involves high-level, contextual judgement taking into account multiple complex factors and processes. The qualitative literature reviewed cautiously guides clinicians to self-disclose to their clients while warning of ways in which TSD can have negative consequences. The wounded-healer is advised to use careful planning, support and feedback in decisions to self-disclose past wounds to clients, and thus harness the observed healing power of the wounded-healer.

Six clinical and four counselling psychologists who had experienced mental-health difficulties were interviewed to explore how the experience of previous mental-health problems affects their approach to practice. The results of this research showed that psychologists with a history of mental-health problems actively draw upon their experience. Analysis of the interviews highlighted five master themes: Use of the personal-self of psychologist; Ambivalence; Identity as a psychologist; Psychologists as agent of change; and Finding meaning in suffering. There appeared to be mixed findings concerning whether the participants felt that their mental-health difficulties had helped or hindered their practice.

'Section C' reflects on the process of researching the area of the wounded-healer, highlights areas for future development as well as lessons learnt, gaps in learning and what might have been done differently in retrospect.

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Elizabeth Davison

MAJOR RESEARCH PROJECT

SECTION A

Title: Therapist self-disclosure: How can the wounded-healer effectively use self-disclosure in the therapeutic-relationship?

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Abstract

Aim and Objectives: This review critically assessed and synthesised the qualitative literature pertaining to therapist self-disclosure (TSD) and inferred how the findings might inform how the wounded-healer can effectively use TSD in the therapeutic-relationship.

Method: Past qualitative research regarding TSD was sought and critically reviewed with particular focus paid to the antecedents, events and consequences of TSDs. Ways in which the wounded-healer might be informed by the findings, were extrapolated.

Results: The reader was introduced to an area of research involving numerous positive consequences of TSD along with a necessary plethora of caveats and questions. This might be due in part to the broad definitions used for TSD in the research.

Conclusion: This review's findings identified that TSD involves high-level, contextual judgement taking into account multiple complex factors and processes. Therefore the discussion offered points for consideration rather than a procedural formula. The qualitative literature reviewed cautiously guides clinicians to self-disclose to their clients while warning of ways in which TSD can have negative consequences. The wounded-healer is advised to use careful planning, support and feedback in decisions to self-disclose past wounds to clients, and thus harness the observed healing power of the wounded-healer.

Introduction

The debate surrounding therapist self-disclosure (TSD) has been extensively explored in research and literature since the late 19th century. However, the definition of TSD remains unclear and divergent. Whilst most traditional psychoanalysts warned of the dangers associated with TSD, in recent years, perspectives have changed somewhat to include what, when and to whom therapist should self-disclose. Matters are even less clear regarding disclosure of therapists' own difficulties/wounds. Groesbeck (1975) described the archetypal image of the "wounded-healer" in which he stated that it is the wounded part of the therapist which elicits the healer in the patient and vice-versa. Whitaker and Malone (1953/1981) and Groesbeck (1975) believed that the patient in the therapist was essential for the recovery of the patient. How then, does this take place without an element of TSD, whether explicit or implicit? If TSD is implied, how should it be orchestrated? This review will attempt to answer these questions in order to inform clinicians how they can harness the healing power that their wounds are proposed to hold.

This review will begin by defining and discussing the 'wounded-healer' and 'TSD' in turn. It will then turn to the qualitative literature on TSD in order to establish what guidelines can be harvested from which to inform TSD of the wounded-healer. This will be further extrapolated in the discussion.

The wounded-healer

The term "wounded-healer" derives from ancient Greek mythology and has since been incorporated into the mental-health literature. The archetype of the wounded-healer was used by Jung (1963) to describe both the positive and negative phenomena that may occur within the relationship between the analyst and analysand. For the purpose of this review, 'wounded-healer' refers to psychotherapists who have experienced mental-health problems

in the past. Jung (1963, p. 134) proposed that “only the wounded physician heals”. This positive stance on how distress can enhance the professional’s work was developed by Remen et al. (Remen, May, Young, & Berland, 1985, p. 85) who stated “it is the woundedness of the healer which enables him or her to understand the patient which informs the wise and healing action”.

The process of actively engaging with one’s wounds and vulnerabilities was considered to enhance the clinical use of empathy. Hayes (2002) explained how the professional’s personal suffering and unresolved conflict is used as a point of reference from which an understanding of the client’s suffering can be developed. Edith Stein (1970) defined empathy as the source of one’s experience of “otherness” through an empathic recognition of the pain in others as a similar pain that one has experienced. She emphasised, however, that this capacity is limited since one cannot experience the pain in the same manner as the other, and that self-awareness of own suffering and pain means a greater capacity for empathy.

The “wounded-healer” was, however, also considered to have the propensity to harm. Jung “warned of its dangers as well as its necessity” and it was acknowledged in later writings that Jung occasionally wounded those he healed (Mattoon, 1991, p. 486). While no clear example of harm exists in Jung’s writings, he acknowledged that the analyst can only go as deep with a client as they have been themselves which could prevent some areas within the client’s psyche from being explored, thereby inadvertently hindering the client’s growth (Rice, 2010). One could imagine that an over-identification or projection of one’s suffering into the client might mislead the therapist’s healing actions. As a way of mitigating this risk, Roger’s (1959, p. 226) stated:

“The state of empathy, or being empathic, is to perceive the internal frame of reference of another with accuracy and with the emotional components and

meanings which pertain thereto as if one were the person, but without ever losing the 'as if' condition (...) If this 'as if' quality is lost, then the state is one of identification."

The quotation above illustrates the crucial difference between perceiving someone else's difficulties with accuracy and assuming tacitly that the client's experiences are the same as one's own (identification).

The process of apperception (Husserl, 1990) is the cross-referencing of new experiences to old experiences to inform understanding. Our understanding of client material is therefore dependent upon our understanding of our own and our clients' past experiences combined with the ability to stand back from them to use them thoughtfully to seek to understand our clients' experiences. Kwiatek, McKenzie and Loads (2005, p. 27) aptly summarised this; "the way we view a person and his or her behaviour is linked to our underlying assumptions and attitudes". Filtering clients' experiences through the therapist's set of experiences, ("double hermeneutics") the therapist's response could say more about them than about the client. Indeed, these responses might impose something belonging to the therapist onto the client. The therapist's interpretation may in fact be a form of self-disclosure.

Therapist self-disclosure

Over 99% of clinicians report using TSD at least occasionally (Henretty & Levitt, 2010). TSD has been broadly defined as "behaviours, either verbal or nonverbal, that reveal personal information about the therapist" (Constantine & Kwan, 2003, p. 582). Pizer (1993) identified three types of TSD: inescapable TSD such as pregnancy or weight change; inadvertent TSD such as transference, countertransference, voice, tone and empathy; and deliberate TSD: indicating that TSD is not always intentional. Clothes worn by therapists, their accent, furniture, books, ornaments, race and gender involve some degree of self-disclosure. The internet (social media, online publications and search engines) allows clients to access

otherwise undisclosed information about the therapist's life (Zur, Williams, Lehavot, & Knapp, 2009).

For the purpose of this review, TSD is defined as "any instance when the counsellor shared or revealed personal information about his or her life outside of therapy" (Audet & Overall, 2003, p. 225). This definition includes both explicit or deliberate verbal TSD and that of implicit or inadvertent TSD such as countertransference and empathy.

The quantitative research examining the role of intentional TSD in psychotherapy was reviewed by Henretty and Levitt (2010). The authors established some guidelines based upon the findings which are summarised in table 1.

Roberts (2005) illustrated the deliberation that Henretty and Levitt (2010) referred to by considering the unpredictability that exists when choosing to intentionally self-disclose. The author noted that the decision to self-disclose requires a prediction of what the effects of providing the information might be. Although this uncertainty could be argued to apply to anything a therapist does or does not say, disclosing something personal can place the therapist and/or the client in a vulnerable position.

Fehr (2012), in agreement with Henretty and Levitt's (2010) findings, proposed that TSD can be normalising when disclosures by a client "reinforces [their] existential aloneness" (p. 2). Zur (2011) discussed how TSD is approached differently dependent upon the context and client-group with whom the clinician is working. Within some settings, TSD has different meanings and rationales, for example with war veterans, TSD has been cited to be clinically important (Stricker & Fisher, 1990).

Table 1: Recommendations for TSDs obtained by Henretty and Levitt (2010)

To whom	<ul style="list-style-type: none"> • To those with whom they have a strong alliance • Be avoided with those with poor boundaries
What	<ul style="list-style-type: none"> • Demographic information • Immediacy statements • Therapy mistakes • Relevant past struggles that have been successfully resolved • Similarities between therapist and client <div style="display: flex; align-items: center; margin-left: 20px;"> } <div style="border: 1px solid black; padding: 2px 5px; margin-left: 5px;">With caution</div> </div>
When	<ul style="list-style-type: none"> • Low-intimacy disclosures in beginning and increasing to more intimate disclosures • Disclosures may facilitate termination.
Why	<ul style="list-style-type: none"> • Ethical obligation • Promote client-disclosure • Foster the therapeutic-relationship • Model new behaviours to clients • Encourage clients autonomy • Facilitate client self-exploration and self-revelation • Validate reality • Normalise and promote feelings of universality • Equalise power • Repair an impasse or rupture • Correct misconceptions • Assist client in identifying and labelling emotions • Show similarities
How	<ul style="list-style-type: none"> • Infrequently • With deliberation • Worded with care • Be responsive before, during and after TSD • Return focus onto the client immediately after the disclosure

Countertransference

Unlike Henretty and Levitt's (2010) definition of TSD, Pizer's (1993) inadvertent TSD included countertransference. Freud (1957) considered countertransference to be a

hindrance to therapy. Heimann (1950), however, proposed countertransference as a mechanism for additional insight into the client's presenting difficulties.

Hayes and colleagues (Hayes et al., 1998) completed semi-structured interviews with eight "expert" therapists. They revealed that the therapists' unresolved conflicts with family, needs and values, termination of therapy, perceived performance and cultural issues were frequently the origin of countertransference. The countertransference resulted in the therapist distancing themselves from the client, identifying with or nurturing the client. These manifestations of countertransference provide an insight into the therapist's self, relating to the definitions of TSD. This study highlighted that in fact, transference and countertransference can be more about the therapist than the client. This study also illustrates how TSD is difficult to avoid despite the therapist's best efforts.

Immediacy

Henretty and Levitt (2010) included statements about immediacy in their definition of TSD. Immediacy involves processing the therapeutic-relationship (TR) in the "here-and-now" (Hill, 2004), considering parallels between external relationships and that of the TR (Mayotte-Blum et al., 2012). The TR is considered to be one of the most essential elements in most psychotherapeutic approaches (Sparks, Duncan, & Miller, 2008). Hill (2004) defined immediacy as "disclosures within therapy of how the therapist is feeling about the client, about him/herself in relation to the client, or about the therapeutic-relationship" (p. 74). Within a strong TR immediacy can facilitate the client's self-understanding, improve interpersonal functioning and decrease symptomology (Hill et al., 2008). Immediacy can also assist in reducing client defensiveness and support realistic self-estimates (Kasper et al., 2008).

In contrast Kronemyer (2010) referred to immediacy statements as "verbal ejaculations" which do not help the client. He observed that immediacy could interrupt the development of

transference, might violate boundary conditions and damage the therapeutic frame. Safran and colleagues (Safran, Muran, Samstag, & Winston, 2005) found that drawing parallels between the TR and external relationships within the context of a weak TR was perceived by clients as criticising. While reflecting Kronemyer's concerns this suggests putting primary emphasis upon development of the TR and also raises the question of judgement regarding therapeutic timing of immediacy statements or any kind of self-disclosure.

Rationale for this review

There is extensive research on TSD and adequate qualitative and anecdotal research on the wounded-healer. Little available literature integrates these to assist the wounded-healer in whether and how to self-disclose to clients. There is no review exploring how the wounded-healer could effectively use TSD in the therapeutic-relationship. This review is intended to qualitatively bridge those gaps. While quantitative research, as reviewed by Henretty and Levitt (2010), provides opportunity to focus on measureable variables within a defined context, qualitative research enables a scope, synthesis and perspective to be applied to participants' experience of situational and contextual variables that quantitative research would be less able to encompass. It also enables the meaning of disclosure to be more flexible and interpretation to be more fluid, taking in a broader range of contexts.

Methodology

Search strategy

The search engines included in the search were: ASSIA, Web of Knowledge [Web of Science], PsycINFO and Google Scholar. References from relevant articles were studied and additional articles were requested if inaccessible through available search engines. The searches took place in 2012/13 up until October 2013. Many search-terms were used in combination. The search-terms initially used were "wounded-healer", "self-disclosure", "self-involving statements" and "non-disclosure". A full list of the search-terms used can be seen

in appendix 1. Qualitative sources were sought and the reference lists of each article examined to identify articles that did not arise through manual searches. Additional database searches were then completed to build upon the framework and further explore relevant theoretical perspectives. Seventeen articles were identified and evaluated for their suitability based upon inclusion and exclusion criteria. Ten articles were then selected and reviewed.

Inclusion and exclusion criteria

The following inclusion criteria were used in selecting relevant articles for this review

- Articles researching the use of TSD with adults (over 18)
- Qualitative research (or reviewing only qualitative elements in mixed method studies)
- Published in peer reviewed journals
- Self-disclosure of historical events

Exclusion criteria were as follows;

- Analogue studies were excluded from this review since they study a simulated therapy session which decontextualizes the clinical situation and experience of the client.
- Articles solely exploring immediacy are excluded since this is not aligned with the definition used in this review.
- Anecdotal research
- Articles exploring current incidents such as loss or trauma
- Articles exploring the use of TSD of drug and alcohol or gay and lesbian counsellors where TSD holds different meanings and rationales.

Structure of the review

Through combining both clinicians' and clients' perspectives of helpful and unhelpful TSDs, this review is structured by examining articles through the framework established by Knox, Hess, Peterson and Hill (1997). This review will distil and synthesise the qualitative literature from both the clinician's and client's perspective to identify the antecedents, events and consequences of TSD. This framework was considered appropriate due to its provision of clear guidelines which highlight to the reader what, when, how and why a TSD is suitable and unsuitable.

Based on the findings of the review, ways in which the wounded-healer can effectively use TSD in the therapeutic-relationship will be inferred. A summary of key characteristics of the articles under review appears in table 2. Following this the methodologies of the research will be examined so the reader may bear in mind the strengths and limitations of the presented research while reading the review. The discussion will extrapolate and critically appraise the utility of findings for TSD and the wounded-healer, identify recommended research and present final conclusions.

Table 2: Characteristics of articles reviewed

Author/s	Research question/s	Methodology	Sampling procedure & sample	Definition of TSD
Knox et al. (1997)	The antecedents, events and consequences of helpful TSDs	Consensual qualitative research (Hill, Thompson, & Williams, 1997)	Convenience sampling. Thirteen psychotherapy clients, currently in long-term private psychotherapy	Immediacy Deliberate verbal TSD
Wells, T. L. (1994).	The effects of TSD on therapy and the TR.	Qualitative analysis not specified.	Snowball sampling approach (Anastas & MacDonald, 1994). Eight former-clients who had experienced TSD.	The therapist's sharing of training and practice information, personal life circumstances, experiences, attitudes and perceptions, statements of immediacy and admissions of clinical mistakes (Wells, 1994, p. 24).
Hanson (2005)	How TSDs and non-TSDs affect clients.	Constant Comparison method associated with grounded theory (Glaser & Strauss, 1967).	Eighteen clients currently in therapy	As above
Audet and Everall (2003)	The effects of TSD on the client	Existential-phenomenological analysis outlined by Colaizzi (1978) and Osborne (1990)	Four clients who had received individual psychotherapy.	"Any instance when the counsellor shared or revealed personal information about his or her life outside of therapy" (Audet & Everall, 2003, p. 225).
Audet and Everall (2010)	The impact of TSD on the TR.	As above	Nine clients, who had received individual psychotherapy,.	As above
Audet (2011)	The effect of TSDs on therapeutic boundaries	As above	As above	As above

Glue and O'Neill (2010)	Psychologists' experiences of TSDs.	Interpretative phenomenological Analysis (IPA; Smith, 2007).	Convenience sampling Six clinicians	The authors distinguished between statements of immediacy and personal disclosures.
Cain (2000)	The countertransference experience of exploring personal and professional experience as a wounded-healer	Constant Comparison method - grounded theory (Glaser & Strauss, 1967).	Nonprobability purposive sampling, followed by snowball sampling (Anastas & MacDonald, 1994). Ten psychotherapists with personal histories of psychiatric hospitalisation	"Statements about the personal history and experiences of the therapist." (Cain, 2000, p.23).
Gilbert and Stickley (2012)	The experience of "mental distress, self-disclosure and the potential for these experiences and disclosure to positively affect individual practice" (Gilbert & Stickley, 2012, p. 35).	Survey-design Thematic analysis.	Thirty mental-health students	Not stated explicitly.
Bottrill, Pistrang, Barker and Worrell (2010)	Trainee clinical psychologists' experience of TSDs and non-TSDs in their therapeutic work.	IPA	Fourteen trainee clinical psychologists.	"Statements through which a therapist consciously and purposefully communicates information about themselves and/or reveals reactions/responses to the client as they arise in the session." (Bottrill et al., 2010, p. 168).

Critique of the qualitative literature

The inherent limitations of qualitative research such as small sample groups, restricted transferability, vulnerability to researcher bias, idiosyncrasies and researcher skill (Anderson, 2010), as well as limitations associated with recollections of past events, will not be repeated in each critique but are assumed. The rigour and quality of the papers was assessed according to the guidelines by Yardley (2000) which include sensitivity to context; commitment and rigour; transparency and coherence; impact and importance.

All but one of the papers reviewed below used semi-structured interviews. Gilbert and Stickley (2012) conducted qualitative surveys from which the transcripts were thematically analysed. Wells (1994) did not specify which methodology was used to analyse the data, however from the description provided it also appears to be thematic analysis. While widely used in research, thematic analysis lacks a theoretical framework which limits interpretive power (Braun & Clark, 2006). The inherent flexibility in thematic analysis lends itself to an “anything goes” strategy which reduces reliability of findings. The survey design used in Gilbert and Stickley’s (2012) research also reduced the depth of exploration associated with semi-structured interviews.

Knox et al.’s (1997) research was clearly presented and provided the reader with sufficient information to support their findings. The authors transparently presented their research methodology, questions with definitions and their biases and bracketing process. Self-selection of the sample group and individual therapists who selected which of their clients obtained the research pack could result in clients who had left or had less favourable responses to TSD may be unrepresented in the data.

The broad and possibly over-inclusive definition that Wells (1994), Knox et al. (1997), Hanson (2005) and Bottrill et al. (2010) provided for TSD was consistent with other research

completed and highlights a challenge within this body of literature. They included both statements of immediacy and intentional direct TSD which reduces the readers' ability to discern at times which type of TSD was being referred to. Wells (1994) and Glue and O'Neill (2010) also admitted clinical mistakes in their definition which, while providing information, distorts the findings. Gilbert and Stickley (2012) did not explicitly state their definition of TSD.

Audet and Everall (2003; 2010), Audet (2011) and Bottrill et al. (2010) provided clear and transparent descriptions of their research including their initial hypotheses and biases. Audet and Everall (2003; 2010) and Audet's (2011) narrower definition of TSD meant that statements of immediacy were not included allowing the reader additional clarity about implications of the findings. Audet and Everall (2003) provided no limitations in their research, suggesting a lack of reflexivity that contradicts the general impression of the research.

Hanson (2005) explored how TSD and non-TSD affects clients from the perspective of 18 participants currently in therapy. This research was the only one that used triangulation (Mays & Pope, 2000) through a mixed-method approach. Although not included in this review, the quantitative findings reinforced their qualitative findings.

Audet and Everall (2010) acknowledged that they did not have their interpretations checked by the participants which they stated was recommended for their study. They noted while this opens the interpretation to subjectivity, it provided transparency to the reader. The data from Audet and Everall's (2010) research was used again for Audet's (2011) paper: while asking a different question of the data, the definition and methodology were the same. The author acknowledged the interdependent nature of boundaries, roles and professional qualities upon which the effect of TSDs is difficult to isolate. The fact that the participants had not been asked questions specifically about boundaries and professional qualities but

rather how TSDs impact upon the TR, suggests that different answers may have been obtained had the interview questions been framed differently.

Glue and O'Neill (2010) used convenience sampling of family connections and colleagues exposing this research to sampling and researcher bias with low external validity. Their paper was brief and did not include extensive review of the available literature. Cain (2000) and Wells (1994) on the other hand, used non-probability followed by snowballing sampling (Anastas & MacDonald, 1994) which increased the representativeness of samples and increased transferability of findings.

Synthesis of the qualitative literature

Antecedents of helpful TSDs

The decisions surrounding whether, when and how to use TSD as well as how to predict the way a client might respond to TSDs at a particular time can create anxiety in the clinician. Bottrill et al. (2010) identified nine themes in two domains ("the decision in the moment" and "the developing therapist") from interviews completed with a sample of trainee clinical psychologists. The trainees described anxiety they felt when faced with a decision of whether to self-disclose to a client. They reported feeling caught off-guard by a direct question from the client or described an inner struggle surrounding whether a disclosure would be appropriate or might be detrimental to the TR or client. They felt out of their comfort-zone of anonymity and professionalism when facing the choice to use TSD or not.

The decision to use TSD was generally assessed within the context of treatment (Zur et al., 2009). This sentiment was agreed upon by the psychologists interviewed by Glue and O'Neill (2010) who identified four themes from the participants' interviews; TSD should be about the TR and beneficial to the client; TSD is dependent on the type of client worked with; errors in TSD must be admitted to client; and great variety of circumstances within which

TSD arises. The psychologists spoke about their decisions to self-disclose related to the setting within which they were practicing. Psychologists working in forensic settings or with those diagnosed with personality disorders reported as least likely to use TSDs. Those clinicians in the sample with less experience used TSD less often than those with more experience. This might be due to the anxiety that Bottrill et al.'s (2010) participants referred to. Personality characteristics such as feeling comfortable with being "known" by clients, as well as decisions made in the moment of when it felt "right" to self-disclose were considered important. Wells (1994) also acknowledged that TSD that does not fit with the therapist's personal style can lead to an artificial quality in the TR. Finally, the participants in Bottrill et al.'s (2010) study emphasised their regard for the TR and primacy of benefit to the client when deciding whether or not to self-disclose.

The literature holds both recommendations and warnings, highlighting the need for clinicians to keep multiple factors in mind when choosing to use TSD. Gilbert and Stickley's (2012) research, interviewing mental-health students who were also wounded-healers, offers the reader a perspective of those who have received and now offer support to those in distress. A number of the participants had experienced the effect of TSD and non-TSD as clients and felt that their personal experiences enhanced their understanding of and empathy for their clients' experiences. They emphasised the need for adherence to boundaries and to first acknowledge the risks associated with assumptions that might be made when relating a client's difficulty to one's own. This wounded-healer perspective emphasises the difficulty that is faced when deciding whether or not to disclose past wounds. This recommendation implies a very cautious approach.

Audet and Everall (2010) recommended a consideration of the timing of the TSD and acknowledged that early TSDs can assist the formation of a connection between the therapist and client in early stages of therapy through provision of comfort and a reduction of power imbalances. Conversely, the authors also found that TSDs early in therapy were

found to have propensity to create role-confusion and uncertainty. This implies that the decision process involved in TSD is not straight-forward. Surprisingly, timing was not a factor in Wells' (1994) study whose participants' felt that the level of rapport and trust prior to the disclosure were more important regardless of the stage in therapy.

Knox et al. (1997) found that the clients whom they interviewed in their study experienced TSDs as most helpful when they followed the client's discussion of an important personal experience. This was illustrated by an example of a therapist who disclosed a similar past experience to the client pertaining to drug use in response to the client's fear that their disclosure may not be understood by the therapist or lead to judgement. It appears from this that the wounded-healer's TSD might be best timed following a disclosure from the client that in some way reflects their own experience.

Audet and Everall (2003) found, however, that the way a client might receive TSD is not only about when the TSD is delivered but also dependent upon the client's expectation of therapy. The clients' expectations in this study differed between "novice" and those who had been in therapy before. Novice clients assumed that TSD was the norm, while those with previous experience of therapy, experienced ambivalence towards the therapist upon their disclosure. It appears that an individual case-by-case assessment would be warranted following these findings. This recommendation might be best incorporated with the findings from Henretty et al.'s (2010) review which encouraged responsiveness to the client before the TSD in order to assess an intervention of this nature.

Event of TSD

How TSD should be orchestrated is often not easy to consider at length in the moment. However, the trainee clinical psychologists in Bottrill et al's (2010) research gave the sense that therapists develop a preferred way of working through experience and awareness of what complements their personality and orientation. The participants felt that competence is

achieved over time and by actively engaging in different strategies of TSD and non-TSD, reflecting individually and in supervision on the outcome, to find the right balance for therapist and client. Hanson (2005) found that when TSD was communicated with skill, the greatest positive effect was on the TR. Non-disclosure was found to invalidate clients, inhibit their disclosures and less likely to make future disclosures or avoid particular topics. Hanson (2005) concluded that skilful disclosure was more beneficial than rigid non-disclosure and is considered a useful tool within the therapeutic repertoire.

Audet and Everall (2003) found that the impact of how the therapist provided the disclosure ranged from 'harmful' to 'welcomed' depending upon the level of intimacy present in the disclosure and the strength of the TR. The 'wounded-healer's' disclosure might be considered to be more intimate. The authors recommended careful consideration and noted that a disclosure with a "good intention" would not necessarily ensure a positive experience for the client. The authors recommended low-intimacy disclosures which highlight similarity between the therapist and client within a robust TR. In line with the quantitative literature, they emphasised the need for the therapist to remain responsive to the client's reaction and be aware that the client may not feel comfortable expressing negative therapy experiences. Wells' (1994) results further support these findings and urge clinicians to consider not all clients will want or be able to cope with TSDs. Three key elements are highlighted including the intimacy of the disclosure, the TR and similarity between the client and the therapist. It seems that the wounded-healers' first focus is best placed on developing a robust TR through means other than high-intimacy TSDs.

Conversely, Knox et al. (1997) identified that helpful TSDs were of personal non-immediate information which would imply higher-intimacy. Disclosures illustrating similarity between the therapist and client were reported to strengthen the TR. Audet and Everall (2010), however, warned that haphazard comparisons between the client's and clinician's personal experiences risks the client feeling misunderstood.

Cain (2000) explored countertransference experiences of 10 psychotherapists with personal histories of psychiatric hospitalisation. The participants suggested that TSD of personal mental-health difficulties can instil hope, empower clients, reduce stigma and provide information about the process from the perspective of a consumer/survivor. The participants implied that their approach with clients showing empathy, optimism and wisdom, can be a form of implicit TSD in line with Pizer's (1993) inadvertent TSD. The participants stated that with their own experiences of TSD and non-TSD as clients, they use TSD as a helpful intervention with confidence. The unique aspect of this research is the dual-perspectives that these clinicians hold which can inform other wounded-healers' practice of TSD. Their acknowledgement that TSD may occur in their work implicitly through countertransference offers the wounded-healer another way of evaluating the need for explicit TSD.

Consequences of TSDs

Based upon the research above, it appears the consequences of TSD vary greatly with the context, timing, style, content, strength of TR and expectations of the client. One could argue that the literature relating to TSD is shrouded in contradiction and disclaimers. Knox et al. (1997) highlighted that helpful TSDs did result in the reduction of power imbalances, increased insight, normalisation and reassurance.

Disclosures illustrating similarity between the therapist and client reportedly cemented the TR, increased trust in the therapist and prompted more open and honest communication (Knox et al., 1997), while also noting not all TSDs result in positive consequences. One participant felt confused by the disclosure and questioned the therapeutic boundaries, while another client felt overwhelmed by the closeness that the disclosure invoked. This finding was in agreement with Wells' (1994) participants who at times questioned the therapist's professionalism upon their TSD. Participants reported initially feeling "stunned", "freaked-out" or even angry when their therapist self-disclosed. Six of those participants, however,

went on to describe feeling validated, understood and trusted as well. They emphasised the need for the therapist to discuss the TSD and allow the client to talk about positive and negative impacts on them and their therapy experience. This might also include clearly stating the rationale for the TSD, remaining responsive and eliciting feedback to mitigate an initial feeling of shock.

Audet and Everall (2010) identified that TSDs can assist the therapist to convey their presence as attentive and responsive. The authors also highlighted that TSDs can assist in engaging the client through encouragement of risk-taking and fostering closeness. They found that indiscriminate or incongruent TSDs, however, could hinder the TR by leaving the client feeling overwhelmed or disengaged. This again reminds the reader that infrequent TSDs illustrating similarity are indicated more often than frequent, haphazard disclosures.

Audet (2011) found mostly positive effects of TSDs on therapeutic boundaries. They identified that TSDs reduced power imbalances, empowered the client and increased their self-worth, while not generally diminishing professional credibility and competence. This finding is of particular relevance to the wounded-healer since the fear of judgement and the stigma associated with mental-health difficulties might prevent TSD. However when the boundaries of the TR extended and become perceived more like a friendship, clients were less able to focus on themselves. One participant in this study experienced a single, powerful disclosure which led them to question the therapist's competence and credibility. Glue and O'Neill (2010) found, however, that their participants' felt ruptures caused by misjudged TSDs could strengthen the TR provided they are addressed quickly and openly as soon possible after the error. This point is in line with Winnicott's (1969) idea that the function of the therapist is to fail and be 'good-enough', not perfect; the skill of being able to help the client through their responses is what matters so that new/reparative relational learning can take place.

Gilbert and Stickley 's (2012) research found participants recognised TSD's facilitative nature in terms of instilling hope and normalising of clients' difficulties but was dependent on the circumstances and needs of the client. One participant in Bottrill, et al.'s (2010) study spoke about disclosing his struggle with mental-health difficulties and noted that it provided a positive shift in the TR. This example might encourage the wounded-healer to trial TSDs with due consideration and responsiveness.

Discussion

This review's findings identified that TSD involves high-level, contextual judgement taking into account multiple complex factors and processes. Therefore discussion offers points for consideration rather than a procedural formula. The qualitative literature reviewed above cautiously guides clinicians to self-disclose to their clients while warning of ways in which TSD can have negative consequences. Certainly the results of helpful TSDs speak for themselves but also involved risks that clinicians might reasonably wish to avoid. It is hardly surprising that Bottrill et al.'s (2010) trainee clinical psychologists described discomfort towards TSD. Some reassurance can be taken however from the findings of Gilbert and Stickley (2012) and Cain (2000), which advocate judicious use of TSD from the perspective of the wounded-healer.

Before offering conclusions from this review, it is important to consider the strengths and limitations of the literature. Firstly the 'grey' literature was omitted from this review which limited access to unpublished voices of service-users and clinicians for whom the topic of TSD is important. The articles included in this review were published in peer-reviewed journals, recognised of high standard and credibility. However not all of the articles reviewed were deemed methodologically sound, which might limit the utility of the some of the findings. Nonetheless all articles apart from Glue & O'Neill, 2010 transparently provided the

reader with an overview of biases, description of methodology and critical discussion of their findings which increases their strength.

The studies exploring TSD from clients' perspectives comprised participants who had been or were currently in private psychotherapy. Data reported may differ regarding therapy experiences and expectations if participants included people who had been receiving psychotherapy free at the point of delivery such as the NHS.

Definitions used by the articles varied since they did not focus on one specific form of TSD. This makes findings difficult to extrapolate and the statements of TSD may or may not have included disclosure of therapists' wounds. Therefore specific ways in which the wounded-healer can effectively use TSD in the TR are less clear. The reader is encouraged to remain cognisant of these limitations.

While keeping in mind that the research reviewed was not focused on one specific form of TSD, the findings tentatively suggest that decisions to self-disclose therapists' past wounds, which are unavoidably of high-intimacy, should only be considered within a robust TR (Wells, 1994; Audet & Everall, 2003). This reflects findings from Henretty and Levitt's (2010) review. This is challenging as TSD is also suggested to strengthen the TR. It might be possible to offer less intimate initial disclosures and evaluate the response to guide future TSDs when the TR is more robust. Findings from this review also suggest, in line with Henretty and Levitt's (2010) quantitative study, that TSDs reflecting similarities between the therapist and client can have positive effects on the TR and client (e.g. Audet & Everall, 2003; Hanson, 2005). In these cases personal, non-immediate information is recommended, implying only wounds that are resolved and in the past should ever be considered for self-disclosure.

When determining whether a client might respond well to TSD, one could engage in a dialogue to assess their expectations of therapy as stated in Audet and Everall (2003).

Involving the client as an active agent in their therapy might enhance their self-confidence, enhance trust, strengthen the TR and reduce power imbalances between the therapist and client. Seeking feedback from the client can help gauge how best to proceed.

Clinical and ethical implications

Perspectives on the ethical implications of TSD have raised concerns surrounding the potential exploitative nature of TSD (Peterson, 2002). As one can see from the review above, the very complex nature of TSD opens the clinician and client to various risks. Zur (2004) raised concerns surrounding the isolation that exists when making decisions about adherence to boundaries, including TSD, and that it is within this isolation that exploitative practices can occur. Zur (2004) proposed that the rationale for TSDs need to be clearly documented in the client's treatment plan in combination with close supervision.

This recommendation raises an additional concern for the wounded-healer. The fear of stigma from colleagues and supervisors was extensively discussed by Cain's (2000) participants some of whom did not disclose their past wounds to colleagues or supervisors but often chose to only disclose them to their clients. This could potentially increase the risk of exploitative practices. Cain's (2000) participants discussed how reduced stigma could increase the support available for wounded-healers and encourage wounded-healers to join the mental-health profession.

Supervision can provide a space in which TSD can be discussed and managed on an individual basis that respects the complex contextual judgements involved (Bottrill et al. 2010). Celenza (1995) posited that supervision should provide a professional atmosphere of tolerance, safety and clarity as well as an appreciation for complexity and ambiguity of the therapeutic and supervisory dyad. Reflective and reflexive practice can enhance the

awareness of clients' responses to TSD. Reflective practice or personal-professional development is becoming a core competency of many healthcare professions (e.g. HCPC, 2012; and RCN, 2010).

Recommended research

Research surrounding self-disclosure has been predominantly focused on the "healthy" clinician's self-disclosures. There is a paucity of research relating to the wounded-healer's decisions to self-disclose and the subsequent impact of this on clients. Due to the inherently complex nature of TSD combined with the specific challenges the wounded-healer might face in isolation, a variety of research strategies could begin to expand understanding of this topic.

A qualitative study exploring the processes that are involved in wounded-healer's decision to self-disclose would be valuable, including the ability to access support from colleagues and supervisors in these decisions. A qualitative exploration of the impact on the client of TSD by the wounded-healer and quantitative assessment of effect on outcome would help wounded-healers understand the effects upon clients of their decisions. Research of TSDs by wounded-healers in the NHS has not been covered by existing literature and may involve qualitatively different factors to private practice (e.g. changes in power, waiting lists and free at the point of delivery).

Research into the area of wounded-healer TSD could be improved by tightening and narrowing definitions and terminology to ensure results measured are as intended and comparable. This might involve exclusion or segmentation for example regarding statements of immediacy and self-revealing statements about wounds of a historical nature.

Another useful research could qualitatively explore the impact on practice experienced by mental-health professionals who have personal experience of mental-health difficulties. Does it help or hinder their practice? Do they defend against it or do they draw on it while working with their clients? Lastly, does their experience help them to understand their clients better and in so doing, make better judgements in terms of TSD?

Conclusion

This review critically assessed and synthesised the qualitative literature pertaining to TSD and inferred how the findings might inform TSD of wounded-healers. In so doing, the reader was introduced to an area of research involving numerous positive consequences of TSD along with a necessary plethora of caveats and questions. This might be due in part to the broad definitions used for TSD in the research and could be overcome by narrowing them in future research.

From the perspective of the few wounded-healers in the research, TSDs from clinicians who had worked with them when in receipt of care had lasting positive effects. This can encourage other wounded-healers in the judicious of TSD. Careful planning, support and feedback seem crucial in decisions to self-disclose past wounds to clients, and thus harness the observed healing power of the wounded-healer.

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Elizabeth Davison

MAJOR RESEARCH PROJECT

SECTION B

Title: The wounded healer: clinical and counselling psychologists with experience of mental health problems. An IPA study.

Word count - 8000

Abstract

Objective: To explore how the experience of previous mental-health problems affects clinical and counselling psychologists' approach to practice.

Method: Semi-structured interviews were conducted with six clinical and four counselling psychologists who had experienced mental-health difficulties. Data was analysed using interpretative phenomenological analysis.

Results: Analysis of the interviews highlighted five master themes: Use of the personal-self of psychologist; Ambivalence; Identity as a psychologist; Psychologists as agent of change; and Finding meaning in suffering.

Discussion: The results of this research showed that psychologists with a history of mental-health problems actively draw upon their experience. In managing their dual identity of service-user and professional, they reported a degree of ambivalence which influenced the way that they viewed themselves and their practice. Their personal experiences seemed to be closely tied up with their professional-identity, which either conflicted with their sense of self or complemented it through highlighting how fortunate they were compared to others. The interviews frequently highlighted how psychologists' experiences can provide an impetus to speak out for patients' rights to ensure that they are treated with respect and dignity. A number of psychologists with an experience of mental-health difficulties felt that they might not have pursued their career had they not had previous mental-health difficulties. There appeared to be mixed findings concerning whether the participants felt that their mental-health difficulties had helped or hindered their practice.

Introduction

“Life is difficult. This is a great truth, one of the greatest truths” (Scott Peck, 1978, p. 15).

This well-known statement acknowledges the universality of suffering. Through life, we inevitably accumulate what some call ‘wounds’ and others call ‘opportunities for growth’. One in four adults in Britain “...experience at least one diagnosable mental-health problem in any one year, and one in six experiences this at any given time...” (Office for National Statistics, 2001, p. 26).

Health professionals are not immune to mental-health problems. The NHS reports a high incidence of sickness, staff turn-over and mental-health difficulties among their staff (Williams, Michie, & Pattani, 1998), with one study reporting 26.8% of staff with minor psychiatric disorders compared to 17.8% of the general population (Wall et al., 1997). Health professionals may hold a dichotomous view of wellness and impairment (Good, Khairallah, & Mintz, 2009) which contributes to denial of their personal mental-health state. Rudman (1996, p. 42) pondered: “To what extent do we maintain professional power and distance to prove the other person is irrational or sick, and thus maintain our own sense of integrity and sanity?”

Attitudes of health professionals towards accessing support have been widely researched. The clinician’s carefully honed “self-as-healer/patient-as-wounded” paradigm (Gilroy, Carroll, & Murra, 2002, p. 402) creates barriers to admitting distress and impairment and accessing support (Fleischer & Wissler, 1985). Barnett and Hillard (2001) found that psychologists feared the consequences of seeking personal-therapy citing embarrassment, loss of status or credibility with clients. Amongst those who access therapy there is increased chance they will disparage their therapist’s expertise and knowledge, resist interpretations, and be more competitive and confrontational than other clients (Kaslo, 1996). The stigma associated with

mental-health difficulties may limit help-seeking behaviour, concordant with Goffman's (1963) theory of 'spoiled identity' in which self is perceived to deviate from the norm.

Much literature on the 'woundedness' of therapists is primarily conceptual, based on relatively few qualitative studies, drawing largely on theoretical positions. Many opinions have been presented but questions remain regarding empirical foundation. Sussman (2007) hypothesised those offering psychotherapy might have greater chance of entering the profession with 'wounds' due to past experiences and a desire to resolve their own psychological conflicts. Malan (1979) proposed some people in helping professions compulsively assist others to the detriment of their own needs, rendering them prone to depression. He termed this the 'helping profession syndrome' and considered their chosen vocation influenced by an unconscious drive from the 'patient within'.

Bowlby (1977) proposed that some entered the helping professions to mitigate lack of care and attention received in childhood. He hypothesised 'compulsive care-giving' filled the void left by unsatisfactory early attachment but left the individual in a perpetual care-giving position.

Barnett (2007) interviewed 9 psychotherapists about their unconscious motivations for choosing to train as psychotherapists. The author identified early loss, deprivation and narcissistic desire to be idealized parental figures to clients, creating an "overvaluation of themselves and a projection of all that is bad into clients" (p. 267). Dunne (2002) however proposed the relationship a healer has with their wounds matters more than actual woundedness; willingness to wrestle with psychological conflicts and use experiences to help others.

Huynh and Rhodes (2011) found while mental-health difficulties played a part in career choices by psychology students, past distress contributed to development of empathy,

desire to help others and emulate helping professionals also influenced their decisions.

Corey and Corey (2007) emphasised the need for awareness by psychotherapists of motivations for entering the profession, being mindful of qualitative influences upon interactions with others.

The wounded psychologist

Jung (1963, p. 134) proposed “only the wounded physician heals”, an idea furthered by Remen et al. (Remen, May, Young, & Berland, 1985) as “it is the woundedness of the healer which enables him or her to understand the patient, which informs the wise and healing action”. The process of engagement with one’s wounds and vulnerabilities was considered to enhance clinical use of empathy. Carl Rogers (1957) identified empathy, warmth and genuineness as key skills that the therapist requires to work with a client. Hayes (2002) used the term “empathic duplication” for the process by which the therapist uses aspects of their own experiences which reflect those of their client, leading to a “deep empathic understanding” and facilitating change. Whan (1987) proposed the possibility therapists can also experience “empathic wounding” if opening themselves to a client’s distress.

Hayes (2002) drew upon the literature to explain how the therapist’s personal suffering and unresolved conflict are used as a point of reference to understand the client’s suffering, suggesting this is countertransference. He proposed that although therapists and researchers have attempted to mitigate the impact of countertransference in therapy, it is through countertransference that one sees the client’s world.

Countertransference is considered a form of therapist self-disclosure (TSD) highlighting the importance that the therapist remains self-aware (Corey & Corey, 2007). The literature advises therapists use caution when deliberately disclosing past wounds to clients (Henretty & Levitt, 2010). However TSD of the wounded-healer has not been explicitly researched.

Audet & Everall (2003, 2010) and Audet's (2011) qualitative studies exploring TSD endorsed personal, historical and low-intensity TSDs that highlight similarities between therapist and client, stating that TSD's help in cementing the therapeutic-relationship. Zur (2011) advised those who choose to use TSD first seek supervision to discuss their rationale. Cain's (2000) qualitative study highlighted that stigma from colleagues might prevent clinicians from disclosing wounds to supervisors. Literature provides cautious encouragement for use of TSD under carefully judged circumstances, however the nature and impact of TSD by wounded-healers remains largely undocumented.

Interest has grown to involve people with experience of mental-health problems in care-delivery, supported by increasing evidence (Gilbert & Stickley, 2012). Chinman et al. (2006) found clinicians with experience of mental-illness better able to empathise and display tolerance, flexibility and persistence towards clients. Psychologists such as Patricia Deegan, Rufus May, Rachel Perkins and Marsha Linehan openly discussed their personal experiences of mental-health problems (Gilbert & Stickley, 2012), advocating patients' rights and dignity be upheld. Literature is lacking regarding how the combined experience as patient and psychologist impacts psychologists' practice.

Rationale for present study

The literature shows psychologists are as likely as others to experience mental-health issues affecting daily life. The existing published research is predominantly conceptual and only provides hypothetical insight into how previous mental-health problems affect psychologists' practice. Therefore the following questions were explored in semi-structured interviews with 10 clinical and counselling psychologists with previous mental-health problems:

- 1) How does the experience of mental-health problems influence the experience of being a

psychologist?

- 2) Do psychologists with an experience of mental-health problems draw upon their own experiences in their practice and if so, how?
- 3) How do psychologists experience working with clients who have had similar experiences to themselves and how do they make sense of the advantages and disadvantages of having had similar experience for the therapeutic work?
- 4) How does working with clients with similar experiences of mental-health problems, impact upon the psychologists' well-being?

Particular attention was paid to how the experience of mental-health difficulties impacts upon personal-therapist integration, self-disclosure and empathy.

The present study

This study explored how the experience of having had personal mental-health difficulties affects psychologists' approach to practice. Does it help or hinder practice? Do practitioners defend against or draw upon it while working with clients? Do these experiences help in understanding clients better?

A qualitative enquiry was conducted, interviewing 10 clinical and counselling psychologists to elicit their personal experiences of how past mental-health problem affected their practice. Since this research attempted to gain an in-depth understanding of the personal experience of psychologists who received treatment for a mental-health problem, a qualitative methodology was used. Interpretative phenomenological analysis (IPA) was an appropriate form of analysis, aiming to identify commonalities and unanticipated new understanding of participant experiences through careful analysis of semi-structured interviews, within the context of specific social, historical and cultural locations (phenomenology; Smith, Flowers, & Larkin, 2009). IPA's epistemological position takes into account that the researcher in

does not identify an objective reality but will bring their own interpretations and assumptions to the meanings uncovered. In the context of this study the researcher was a member of the subject profession and had some experience of therapy for mental-health issues in the past.

The rigour of IPA analysis and audit processes enabled this experience to enhance and not bias the exploration of the phenomena. The researcher was able to remain aware of her biases and assumptions through use of a reflective diary and discussion with supervisors in order to remain cognisant of any influence over the process of analysis (reflexivity).

Method

Participants

Sampling

Purposive sampling (Smith et al., 2009) was used to recruit participants whose experiences reflected the subject of this study. Ten clinical and counselling psychologists who had fully recovered from diagnosis and treatment of a mental-health problem in adolescence or adult life were recruited through advertisements in relevant publications. A small sample-group is recommended for IPA (Smith et al., 2009) so analysis can capture the richness of participants' experiences but therefore may not represent the entire population. The participants needed to have returned to practice within the profession of psychology since their difficulties. The sample was largely homogenous as recommended by Smith et al. (2009), having all experienced mental-health difficulties. The demographic characteristics of the sample group can be seen in table 1.

Table 3: Demographic characteristics of the participants (N = 10)

Characteristics	N
Profession	
Clinical Psychology	6
Counselling Psychology	4
Age range	
20-30	1
31-40	3
41-50	4
51-60	2
Diagnosis¹	
Depression	2
Depression & Anxiety	3
Anxiety	2
Mild reactive depression	1
Psychotic episode	1
Schizophrenia	1
Gender	
Male	5
Female	5
Therapy obtained	
Yes	8
No	2

Ethical considerations

This research study obtained full ethical approval from the Salomons (Canterbury Christ Church University) Ethics Panel (Appendix 2). Research information and consent forms were distributed and issues pertaining to confidentiality were discussed (Appendix 3). Consent was obtained from the participants before interview. Opportunities for breaks and questions were provided and debriefing was included in the interview protocol. Anonymisation and storage standards of professional practice (British Psychological Society, 2010) were adhered to and a summary of research findings distributed to relevant parties (Appendix 4).

¹ The diagnoses included in this table represent the participants' own understandings of their difficulties.

Participants could have experienced distress when discussing past mental-health problems. Distress was minimised by emphasising to candidates the necessity of having sufficiently recovered from their mental-health problem to be able to reflect on it with another person, and also identifying existing support resources should they be required after the interview.

Had a participant aroused concern during the interview that they were not fit to practice in accordance with the fitness to practice guidelines of the Health and Care Professions Council (HCPC, 2012), or were a danger to themselves or others, the researcher was ethically bound to discuss this with the lead supervisor to determine necessary action. Participants were made aware of this prior to commencement of the interview.

Procedure

Prior to commencing interviews, signed consent forms were reviewed and questions discussed. Interview was audio-recorded, transcribed and analysed. Interviews were conducted at a venue of the participant's choice which included home, work or by telephone if location or time-constraints necessitated. Three of 10 interviews were completed by telephone.

The interview schedule (Appendix 5) consisted of 12 questions developed through reviewing available literature. The interview questions focused on participants' experiences of how their mental-health difficulties had affected their practice. Careful effort was made to avoid leading participants and points were clarified during interview to prevent assumptions being made. Prompts were used to assist participants conveying a rich account of their experiences. The schedule was identical for all interviews.

Analysis

The analysis of the transcribed interviews followed IPA recommended stages (Smith,

Jarman, & Osborn, 1999). Transcripts were read and re-read in order to gain intimate sense of the participant's experience. Comments, connections and preliminary interpretations were then made which led to emergent themes of the interview. Two transcripts were independently reviewed by two supervisors (one each) as an audit of the analysis process and to confirm plausibility of emergent themes. A list of emerging superordinate themes and subthemes was developed for four interviews.

The remaining six interviews were similarly read and re-read with particular attention to similarities and differences with the first four interviews. Any new emergent themes were noted and reviewed upon completion of all 10 analyses. Following this, a process of "abstraction" (Smith et al., 2009) was used to group superordinate and subthemes into clusters. Connections between these themes were identified, providing master themes encompassing all interviews. The transcripts were then re-read according to the iterative approach of IPA to assess the salience of the themes.

Credibility of the research

The credibility of the research was ensured by following Yardley's (2000) guidelines. These include:

- 1) *Sensitivity to context*: IPA's commitment to phenomenological and idiographic ontologies lent itself to the sensitivity of the context within which the participants were situated (Smith et al., 2009). By following this analytic technique as well as being immersed in philosophical understandings of qualitative enquiry, the researcher was able to explore the participants' personal contexts and perspectives thereby adhering to Yardley's (2000) recommendation. The context within which the interviews took place was carefully considered. The researcher was training to become a member of the participant group and therefore, issues surrounding power imbalances during the interview were considered. Additionally the researcher was a member of the participant group with past experience of a mental-health problem. Brief and limited

disclosure of this was made to participants in the information sheet, to assist them understanding the researcher's interest in the topic and to engender trust. As a trainee clinical psychologist and member of the participant group, careful effort was made to step outside of this natural position and adopt a "phenomenological attitude" (Smith et al., 2009) This balance between objective listening and insider bias was achieved through systematic analysis of the themes, audit processes with supervisors and incorporation of a research diary.

- 2) *Commitment and rigour*: Prolonged engagement with the topic under research was achieved by thorough review of the available literature, immersion in data and process of analysis. This engagement was enhanced by personal interest from the researcher's own experience of mental-health difficulties. The participants' interviews were reviewed and considered comprehensive for the purpose of answering the research questions. The sample provided sufficient variance due to the type of mental-health difficulty experienced, the time at which difficulty had occurred as well as their area of practice in psychology. This increased transferability of results whilst satisfying IPA's requirements of homogeneity.
- 3) *Coherence and transparency*: Coherence was obtained through the epistemology and philosophical perspective of IPA which allowed rigorous exploration of participants' idiographic experiences and social cognitions. Transparency was delivered by clear presentation of the analytic process and provision of quotes to enable the reader to evaluate interpretations. A transcript and detailed analysis of the data can be viewed in Appendix 6. Appendix 7 shows how the themes developed.
- 4) *Reflexivity*: In order to 'bracket' or put aside biases and assumptions of the researcher (Smith et al., 2009), a bracketing interview was completed between the researcher and supervisor. This allowed conscious awareness of the researcher's biases so every effort could be made for participants' meanings to emerge through the data. Throughout the research process, a research diary served to 'bracket' the researcher's preconceptions and personal reactions prior to analysis. This diary can

be seen in Appendix 8.

- 5) *Impact and importance*: Due to the lack of literature exploring the impact a past mental-health problem has on a psychologist's practice, this research was considered by the researcher, supervisors and ethics committee to have potential to start closing the gap. The contributions and clinical relevance of the findings have been reported in the discussion of this research.

Results

Presentation of themes

Five master themes and 15 sub-ordinate themes were identified from the interviews (table 2). Master themes represented broad features of participants' shared experiences. Each master theme was broken down into multiple sub-ordinate themes highlighting different perspectives of the master theme. Verbatim quotes are provided below to illustrate master and sub-ordinate themes obtained from interviews. Participants have been assigned pseudonyms (Smith et al., 2009) to maintain anonymity. Numerical references are provided for each quote, with page followed by line number (e.g. 4.16).

Overview

Five master themes were identified from the transcripts. 1) *The personal-self of the psychologists* refers to how participants actively drew upon their experiences and difficulties that they encountered. 2) *Ambivalence* spoke to conflict that participants experienced regarding their status as a professional and service-user, the way they worked and acceptance of their mental-health difficulties. 3) *Identity as a psychologist* spoke to the strategies used to mitigate their difficulties, sacrifices they made to parts of their identity and the way identity as wounded-healer was integrated into their lives. 4) *Psychologists as agents of change* spoke to the way participants harnessed experiences for the greater good

of their clients. 5) *Finding meaning in suffering* summarised participants' gratitude towards their experiences, noting these experiences led them into the profession.

Table 4; Master and sub-ordinate themes.

Master & sub-themes
<p>1. Use of personal-self of psychologist</p> <p>1.1 Empathy</p> <p>1.2 Perspective on self-disclosure</p> <p>1.3 Drawing on own experience</p> <p>1.4 Approach to self-care</p>
<p>2. Ambivalence</p> <p>2.1 Insider vs. outsider</p> <p>2.2 Personal & professional boundaries</p> <p>2.3 Models of therapy and practice</p> <p>2.4 Ownership of emotional distress</p>
<p>3. Identity as psychologist</p> <p>3.1 Dual identity</p> <p>3.2 Self as fortunate</p> <p>3.3 Self as troubled</p>
<p>4. Psychologists as agents of change</p> <p>4.1 Advocacy & upholding patients' rights</p> <p>4.2 Challenging & questioning accepted practice</p>
<p>5. Finding meaning in suffering</p> <p>5.1 Attributing career choice to own experience</p> <p>5.2 Gratitude</p>

1. Use of personal-self of psychologist

The following subthemes were present across all participants' accounts and highlighted how experience of mental-health problems influenced practice of psychology and how they drew upon these experiences in practice.

1.1 Empathy

Many participants reported an increased level of empathy towards clients as a consequence of their experience, supporting the findings of Chinman et al. (2006) that clinicians with experience of mental-illness are better able to display more empathy, tolerance, flexibility and persistence towards clients.

Gordon stated;

“...[my mental-health difficulty has] given me such a depth of experience to really support other people... because I’ve worked with all the different kinds of thoughts in my mind... it doesn’t faze me in fact, I’m really open and confident to help them, far more than where I was before.” (8.1)

Joanne felt that her experience was a source of information, which she could draw on intuitively;

“I don’t have to think about it logically. There’s more of a kind of intuitive sense of kind of getting where someone’s coming from a bit.” (3.39)

Conversely, Sally said that her perspective on her own difficulties might have reduced her ability to empathise with certain clients as much;

“...I’m a little bit unsympathetic to people who seem to be whining about very minor things (...) maybe because I felt it was self-indulgent for me to be talking about my problems because they seemed so minor.” (16.6)

This response contrasts with much wounded-healer literature reporting increased empathy. Social comparison theory (Festinger, 1954) posits that individuals strive to define the self and gain accurate and positive self-evaluations by comparing themselves to others. This understanding could be applied to psychologists with mental-health difficulties who compare

themselves to patients with similar difficulties and evaluate themselves or a particular client as less worthy of empathy. This could be a defensive strategy against their own vulnerability or unresolved difficulties.

Frank spoke about his prejudice towards those with drug-induced psychosis or learning disabilities and how he was unable to talk to others in psychology about them. He said that as a result of these prejudices, he was unable to work or empathise with particular client-groups.

“You know most people will kind of like go “oh one prejudiced bastard what are you doing in this profession?” But I really needed to metabolise it because I’m not my prejudices but I can see them.” (19.20)

Frank’s prejudice might be a defensive strategy to project unwanted parts of the self onto the other (Fenichel, 1945). While this study presents evidence that supports enhanced empathy in those with experiences of mental-health difficulties, there is also evidence of a ‘selective empathy’, indicating that there needs to be a space in which this ‘stifled’ prejudice can be spoken about and reflected upon in the profession.

1.2 Perspectives on self-disclosure

Although supporting of self-disclosure, participants recognised how it might impact upon the client’s impression of them or hinder the client’s progress by increasing concern about their therapist.

Sylvia explained;

“...which is why you wouldn’t use huge [self-disclosures) that make them worry about me...” (9.37)

Most participants chose to draw on less intimate experiences in self-disclosure, which was recommended by Audet and Everall (2003), to highlight similarity between the therapist and the client to enhance the therapeutic relationship.

David indicated, however, that he used his own experience to illustrate how difficulties can be overcome.

“I have no problem with self-disclosure... [I] this isn't a case of you're mad, (...) we all have similar problems (...) I want them to know that I have my problems but that you know you can be fairly successful in life even if you've got a few problems.”

(8.39)

Rick admitted that his self-doubt prevented him from self-disclosing although acknowledged that he felt that it was useful;

“I'm very, very inhibited (...) [because of self-] doubt absolutely (...) I listen to what my colleagues say to their clients and (...) feel a little inferior (...) I think they seemed very much more steering the ship of the therapeutic encounter.” (14.37)

Rick's difficulties with self-disclosure may reflect the finding that less experienced clinicians tend to disclose less (Bottrill, Pistrang, Barker, and Worrell, 2010), though personality characteristics may also play a part. If self-disclosure does not reflect a clinician's character it can convey an artificial quality which may be detrimental to the therapeutic alliance (Wells, 1994).

Joanne spoke about how difficult she found it when clients found information about her mental-health difficulties on the internet (inadvertent self-disclosure, Pizer, 1993).

“The first year I had clients they were like, “I Googled you and found some information about you on the internet and I know that you've had mental-health problems”. And I just try to get round it quite quickly” (6.41)

It is clear from participants' discussion of self-disclosure that decisions and ramifications of self-disclosure can create discomfort. Therapists' confidence, fear of stigma and personal style appear to affect decisions about self-disclosure.

1.3 Drawing on own experience

Drawing on experiences of personal-therapy was a recurrent theme within eight of the participants' interviews. Participants spoke about how they explicitly drew from skills and techniques of their personal therapist in their own practice. They spoke in particular about drawing on their personal experiences through 'channelling' their personal therapists. Some also offered their own self-care strategies to clients since they had worked so well for them.

Sylvia's experience provided additional motivation to provide help to those who were experiencing difficulties;

“... [my practice is] informed by the fact that I've had my own struggles and maybe I found my way through it [through] this way so I like to help people in the same way ...” (11.47)

Debbie noticed the important role her personal therapist had played in informing her in her own practice;

“But I think I probably, just the way my therapist was with me... I remember, like, silly things that now I look back, I think that was really important.” (14.8)

Frank noticed parallel process occurring in his practice and personal-therapy;

“...I have gone through my own therapy and themes have come up, whether it's just, I don't know if its serendipity or if it's some kind of attention bias effect, but issues that I go through, I go through with some of my clients.” (12.20)

There is evidence from these participants, as seen in Dunn's (2002) proposal, of a willingness to work through difficulties and use experiences to help others. As Frank posited this might be evidence of attention bias or it could be evidence of healthy integration of experience to practice, which may help others to overcome similar difficulties.

1.4 Approaches to self-care

Participants' approaches to self-care were a focus in interviews. Personal-therapy was one self-care strategy used by participants which is reflected in literature on use of therapy and reflective practice (e.g. Mahoney, 1997; Bike et al., 2009; and Norcross et al., 2009).

Additional self-care strategies included applying therapeutic models to themselves and practical strategies such as socialising, exercise and additional training. One participant's own identity as a 'coper' impeded her ability to access support and self-care strategies, reinforcing the earlier-mentioned "self-as-healer/patient-as-wounded" paradigm as barrier to admitting distress and impairment (Gilroy et al., 2002, p. 402).

The idea of 'practicing what I preach' appeared in the interviews. Sylvia reported;

"I tried to apply a therapeutic model to myself and that's how I've learnt how to get through it." (8.35)

The participants attributed psychological training to their continued wellbeing. It seemed that they were able to apply strategies and theories learnt to their own experiences, helping them to manage difficulties more effectively, providing support to the idea that some entering the profession hope that skills acquired can help them deal with their own difficulties in line with Sussman's (2007) assertions.

Frank felt that his personal-therapy was important to his continued wellbeing but also noted that additional training also assisted;

“My therapy and I’m thinking the other method has been um, going for extra courses (...) what drives a lot of my search for trainings is, how can I just deal with my own feelings. I feel awful about how I’ve not been able to help some people. Um, especially when they insist you can save them.” (24.15)

Frank’s regret at not being able to help some people may reflect views proposed by some writers that those entering the therapy profession do so to become idealized parental figures to clients (Barnett, 2007), stemming from their own experiences of loss and failure.

Ruth spoke about the difficulties she experienced in accessing support as a psychologist;

“(…) being a clinical psychologist erm and knowing that inpatient wards usually aren’t very helpful...And also as you say worrying about who might know you.” (18.19)

Ruth’s difficulties with her dual role of psychologist and service-user are elaborated in the work of Rachel Perkins (1999), who described colleagues’ judgement of her treatment choices, her anger and frustration at being treated by professionals as ignorant.

Sally spoke about how her identity as a “giver and a coper” (10.3) made it difficult for her to accept support;

“... [Personal-therapy] was about giving permission for there to be a space for what seemed very self-indulgent to me.” (15.21)

Corrigan (2004) wrote that stigma and self-stigma can impede people from obtaining support for mental-health difficulties due to fear of social disapproval or reduced self-esteem. It appeared that these fears limited both Sally and Ruth’s access to support services. Ruth’s concerns had further implications for self-disclosure to colleagues and employers. Mental-health stigma within the profession appeared to have prevented Ruth from feeling able to access support for fear someone she knew might find out. These findings reflected the literature that wounded-healers are less likely to self-disclose to colleagues and supervisors due to fear of stigma (Cain, 2000).

2. Ambivalence

Participants indicated they experienced conflict between professional role and status as service-users. They also experienced ambivalence towards use of boundaries within practice both as clinician and client. Additionally they reported conflict between being an employee needing to adhere to policies and what they feel would be best for the client considering experiences of being a client themselves.

2.1 Insider/outsider

The participants recognised that although they were an ‘insider’ having experienced mental-health difficulties they also felt very different from those whom they treated. Sally felt that she did not have the right to “whinge” about what she felt were comparatively insignificant problems;

“I look at clients who have not got those protective things and (...) I’ve got a bit of a ‘don’t whinge about it; you’re blessed in so many ways’ kind of thing when I look at myself by comparison.” (9.20)

Psychological distancing might be evident here as a defensive strategy put in place to protect one’s self-esteem from believing that one might have similar characteristics to another and therefore a shared fate (Schimel, Pyszczynski, Greenberg, O’Mahen, & Arndt, 2000). Sally suggested on a few occasions that she felt less empathy for those with similar problems to her own and accepted “whingeing” from them (and herself) less readily. This defensive strategy might have served to deny her own “shadow” (negative side of herself; Jung, 1951/1959) that she spent a lot of time fearing and doubting.

Ruth described how her depression had meant that she had been treated as an outsider when returning to collect her possessions from work;

“...for some reason my boss made my secretary come in on the weekend to supervise me as if being off with clinical depression I’d suddenly become a... a thief”
(20.27)

‘Othering’ or ‘splitting’, in mental-health settings, as it appears that Ruth was describing, can be viewed as a way of distancing the self from the “madness” of the other (Pilgrim & Rogers, 1993). The tendency to view mental-illness as dichotomous, with mental-health at one pole and illness at the other, can exist in clinical settings and has served to objectify and depersonalise those accessing services (Lakeman, 2006). A struggle existed within participants in determining on which side they belonged. To hold both positions appeared to be challenging.

2.2 Personal and professional boundaries

Due to their personal experiences, participants described how they felt about boundaries in personal-therapy and their own practice. They also spoke about how they implemented personal boundaries in their own lives to maintain personal well-being and ethical practice. Eight of the participants found they could work effectively with those suffering from similar difficulties to theirs.

Joanne said;

“(...) a lot of people [that I work with] have got a lot of similar kind of symptoms [to those I experienced], although the content is very different (...)” (5.11)

Two participants’ felt that this would not be appropriate. Ruth spoke about a personal boundary she had implemented to ensure both she and her clients could be protected from her past experience of mental-health difficulties;

“On purpose I avoided adult mental-health as a... a chosen career path. (...) I might be able to not distance myself from say what the other person was feeling. (...) I might make assumptions about them based on my own experiences...” (4.5)

Frank spoke about his experience of strict professional boundaries as a service-user in therapy and within his family of origin, and as a result adhered to boundaries less in his own practice;

“(...) the coldness of traditional analytic attitude, abusive and rejecting and issues around abandonment are a big deal for me.” (5.38).

Sylvia felt that there were times when boundaries were necessary but emphasised the need to do what helps the client;

“I don’t like the idea of (...) really strict boundaries (...) I think it’s interesting that we don’t really think about that on a general level and all touch in therapy is such a no, no and these grey areas of care. Of what helps them to actually get better, to have that human connection.” (6.36)

It seems that participants’ experiences contribute to how they implemented boundaries in practice, either in terms of who they work with and how they used boundaries with clients. It appears that personal-therapy was a great source of information for them in determining this.

2.3 Models of therapy and practice

Participants’ ambivalence towards different models of therapy and practice seemed to be directly linked to their own experiences in receipt of mental-health services. One participant advocated use of medication due to the success he had experienced from taking it, whilst others spoke about how difficult they found current practice in the NHS since they did not feel that they would have fared well as a client.

Frank reported that he was conflicted in his practice;

“Well I see myself as being err, a child of the evidence based generation and so I feel that we no longer have much of a choice over what work we want to do or think enables us best to help others.” (7.19)

Donald felt that he is very much influenced by the treatment that worked for him which was medication;

“...my attitude to medication has influenced me a lot. And has made [me have] far more sympathy for a psychiatric approach ... “(5.33)

The data suggests that ‘insider-information’ obtained by professionals through personal experience can inform practice and enhance care clients receive. Conversely a bias towards certain practices may risk limiting client choices.

2.4 Ownership of emotional distress

Three participants admitted they found it easier to acknowledge and address personal physical difficulties more readily than emotional difficulties, possibly due to the stigma associated with mental-health (Link & Phelan, 2006).

Rick said that despite experiencing significant distress, he only took time off work when he had the flu;

“...but actually stopping work I don’t think I’ve ever done that (...), I’ve just kept going, (...) But it’s possible that occasionally flu type things have come and taken me over.” (16.30)

Sally agreed with this when she stated;

“I quite like the whiplash because when there’s a physical symptom that pings up and say, “You’re overdoing it” and gives you a legitimate reason (...) the physical symptom reminds me to do what I might not be very good at doing (...)” (22.15)

Ruth recalled not receiving phone calls or get-well-soon cards when she was off work with depression;

“(...) if I’d gone off with a heart attack, if I’d gone off with cancer people would be... would’ve asked how I was doing.” (21.1)

Although these findings represent a minority view they remind us that societal, institutional and self-stigma surrounding mental-health difficulties has significant impact on those having previously experienced them. These factors impede ownership and acceptance of emotional distress from the self and others.

3. Identity as psychologist

Nine of the participants’ interviews contained a reference to identity. Evidence suggested a conflict between their professional and personal-identity, when owning experience of emotional ill-health. For others the experience appeared integrated into a robust personal-identity that shaped their professional-self.

3.1 Dual identity

The desire to be known as a psychologist who happens to be a service-user rather than the other way round is a factor which might complicate integration of the professional’s dual identity - a point well illustrated by a number of participants.

Joanne quite explicitly stated that she wanted to be known as a psychologist first and a service-user second

“I’ve wanted to be known as a psychologist who happens to have had, to be a service-user rather than the other way round.” (7.20)

Debbie feared that people would doubt her as a psychologist;

“I think maybe it’s that sense of wanting to be seen as a bona fide expert psychologist who’s done the training, rather than somebody who’s just like them and kind of is just being a bit of a quack.” (12.25)

These concerns indicated the participants’ awareness that others might view those with a mental-illness as less credible or professional. This again reminds us of the interplay between stigma and self-stigma within the wounded-healer.

Frank noted how he had to adopt a professional-identity which is sometimes in conflict with the service-user identity;

“... I’m conflicted. I work in the NHS (...) so [there is] a lot of emphasis on the therapist to really make the money count (...) you know that’s the parenting I got from my father (...) There’s no time (...) to just be fallen apart. Do I have to be really unwell before you take me seriously; before you just give me time (...) [This] is an ethic in the NHS. “(5.2)

This dilemma highlights difficulty those with past experiences might have in offering their clients support that they feel would not have been suitable for them. Participants discussed how they modified their practice to reduce their impasse.

Frank stated;

“(...) so I’ve always gone for jobs where I have the opportunity to work fairly long term in modern standards.” (6.6)

3.2 Self as fortunate

Responses from participants suggested tension concerning 'sameness' and 'difference' between themselves and their client influencing their experience of empathy. In eight of the interviews participants viewed themselves as fortunate in having the resources, education, opportunities and experiences they had. This was often compared with a less fortunate position of clients.

Sylvia acknowledged;

"I think I was really lucky, I had and have good friends, lots of who are obviously psychologists so very helpful, an amazing husband and the ability to have learnt academically how to help myself as well." (15.7)

Sally considered her fortune to have been her protective factor;

"(...) I still feel like I'm a person that's so blessed with so many positive things about my life that I would never fall as low as the clients I see." (9.7)

Debbie considered herself lucky to have had options that many of her clients lacked;

"And I think I was very lucky to have the choice I had, in terms of I had some money to pay for my own private counsellor." (20.13)

This sub-ordinate theme again highlights the presence of psychological distancing that allows participants to differentiate themselves from clients and protect their self-esteem (Schimmel, et al., 2000). This could also be seen as recognition of economic and social factors that play a crucial role in people's "illness-pathways".

3.3 Self as troubled (acceptance)

Some participants considered their difficulties to be part of their identity and were careful to emphasise that they remained troubled. A primary goal of acceptance and commitment

therapy (ACT; Hayes, Luoma, Bond, Masuda, & Lillis, 2006) is acceptance as an alternative to avoidance. Participants' identities included the self as troubled and subsequent acknowledgement and acceptance of the difficulties that this engendered.

David said;

"I've just learned to live with it. So it's still around, still a fellow traveller but it hasn't stopped me from getting it done." (2.45)

Rick wanted to offer the perspective that being cured was not always possible;

"...I consider myself to have been distinctly troubled all my life and have learned to live with it." (18.39)

Rick and David's sentiments seemed to be in line with Melanie Klein's (1997) 'depressive position' which indicated that they were in contact with inner and outer reality.

The participants used ways of managing difficulties which ensured that they could function adequately as psychologists. Sylvia said;

"... [In my more] recent struggles (...) I tried to apply a therapeutic model to myself and that's how I've learnt how to get through it (...) using ACT (...)" (7.35)

Participants clearly described circumstances that challenge them more and how they shaped environment and behaviour to mitigate negative impact that their work might have on their wellbeing.

Donald had adapted his professional role around his identity as 'anxious';

"I have adapted my working style to the sort of person I am. (...) I am not entirely happy with that, I think that it's the way it is, the way I am and I think that I have managed to get on okay with it really." (3.36)

Rønnestad and Skovholt (2003) identified that through a professional's career, theoretical perspectives and professional roles become increasingly consistent with personal values, beliefs and life experiences. They described an active choice the professional makes to adapt their role to meet their strengths, weaknesses and personality characteristics in line with David's statement.

4. Psychologists as agents of change

The use of the self as a tool to engender change both in clients and services arose in the interviews. Seven of the participants referred to how they positioned themselves within their practice as an advocate for patients or as someone who challenged norms which they felt did not meet the needs of their clients.

4.1 Role as advocate/upholding patient rights

Many of the participants in this study spoke about their role as advocate or focus on upholding patient rights. This is mirrored in actions of other psychologists who have had experience of mental-health difficulties such as Patricia Deegan and Rachel Perkins (Gilbert & Stickley, 2012). Additional emphasis was made by participants' questioning and challenging of accepted practice, motivating a number of them towards further training or ways of practicing which better meet their values and principles.

Ruth noted how her own experience influenced her practice;

“...if I hadn't had that experience (...) I wouldn't feel as passionate as I have done sometimes about the lack of dignity and respect that I've seen patients being treated with. (9.16)

Joanne stated;

“I think it [my experience] makes me quite sympathetic and quite keen to campaign for people’s rights...I think I’m quite dedicated to what I do...I see it like a vocation rather than just a job.” (4.1)

Some participants in this study reported they might choose to leave the profession rather than fight helplessness they felt when working with clients in a restricted way. Having experienced a mental-health problem is likely to make people more aware of the social aspects of the experience such as exclusion and limitations of services.

Sylvia reflects this experience;

“...I get quite frustrated being a clinical psychologist. I’m not sure how long I’m going to do it for. (...) because I find it very frustrating because we are very limited in how we support people ...” (14.3)

5. Finding meaning in suffering

Many participants considered their experience of mental-health difficulties had been invaluable to their professional practice and felt it made them who they are as psychologists.

5.1 Gratitude

The notion of gratitude for one’s own suffering can be seen in wounded-healer literature. Guggenbuhl-Craig and Gubitx (1971) proposed that it is only through wounds that the healer within is activated, suggesting that without wounds, therapists would not be able to heal.

Debbie said;

“I almost feel quite privileged actually, that I’ve been through it. I think it can... because I’ve been through it, it allows me to, um, not see those people as different from me.” (9.16)

David agreed;

“So it’s a great, great job. Great job and anxiety gave me this job” (12.13)

Sally acknowledged how her experience, particularly of personal-therapy, had allowed her to be more thoughtful about how her actions impacted upon her clients;

“... I think it’s good to also have been a recipient of the service and to kind of see the best and the worst of what it’s like to receive, (...) [when] your therapist is late or cancels, or what does it feel like if your therapist is prepared to let the session run over because you’re talking about something interesting.” (18.13)

Joanne considered that her mental-health difficulties provided her with invaluable experience;

“I’ve been quite fortunate to have been (...) studying psychology when I became unwell. Sometimes I see it as my kind of, very earnestly taken work experience.” (17.23)

This sub-ordinate theme summarised the potential value in being a wounded–healer, suggesting that for a sizeable minority of participants it had provided them with insight, enhanced abilities to empathise and normalisation of emotional distress.

5.2 Attributing career choice to own experiences

Rather than mental-health difficulties having an adverse effect on practice, some participants in this study reported they would not have entered the profession had it not been for their mental-health difficulties.

David acknowledged;

“I don’t think I would have got into psychology, I don’t think I’d have my jobs that I got in psychology if it hadn’t happened in the first place ...” (8.33).

Debbie noted how far removed she was from the field of psychology prior to her mental-health difficulties;

“I don’t even know if I’d be there [psychology], if I’m honest. Uh, because I came from such a practical background and my family is very practical as well, uh, you know, God, the hardest thing in the world was to tell my parents that I was depressed.” (14.41)

Sylvia also felt that her experiences brought her to the profession;

“I’m not sure; I don’t think I would be a psychologist actually.” (19.38)

These findings reflect Huynh and Rhodes’ (2011) conclusions that mental-health difficulties increase interest in the profession.

Discussion

The research questions will be briefly considered in relation to themes identified in participant interviews, following which discussion of some of pivotal ideas identified in the research are presented.

The influence of previous mental-health problems on psychologists’ practice

Participants spoke about difficulties in managing their dual-identity of service-user and psychologist. At times they viewed their experience as beneficial to their practice but were also cognisant of times when they experienced internal conflict associated with dual-status. They referred to enhanced empathy they experienced for some service-users but also acknowledged reduced empathy and at times prejudice towards certain client-groups. This is a new finding in wounded-healer literature which will be developed upon further in this discussion.

How psychologists draw on their past experiences in their practice.

Participants described how they actively drew upon their experiences in practice. They reported using statements of self-disclosure, “channelling” their therapist within practice and imparting strategies they had found helpful. Participants acknowledged advantages as well as difficulties and anxieties associated with self-disclosure (TSD) of past wounds. Some participants spoke about using TSD to instil hope in clients, while others did not feel able to use TSD at all due to self-doubt.

Psychologists working with those with similar difficulties.

Most participants felt they could work with clients having difficulties both similar and different to their own. Three participants, however, spoke about particular difficulties associated with certain client groups. Many participants spoke about how their experience had increased identification with their clients and enhanced their propensity to advocate for and uphold patient rights.

The impact of working with those with similar difficulties on psychologists’ wellbeing.

Analysis of participant data highlighted that psychological distancing, splitting and projection might serve to protect self-esteem and self-efficacy when working with clients experiencing similar mental-health difficulties. Participants indicated that their experiences had a dual effect on their well-being. They reported conflict and ambivalence about the therapist’s insider-outsider identity (but also greater ability to be insightful) and acceptance of being a wounded-healer.

Stigma, identity and practice

Stigma towards those with mental-health difficulties is well documented as are ways that stigma reduces social inclusion (Corrigan, 2000). Secondary effects of stigma are related to the adoption of stigmatising notions by those with mental-health difficulties. Those facing self-stigma experience reduced self-esteem and self-efficacy as a consequence (Corrigan & Watson, 2002). Stigma and self-stigma appeared to have significant impact on at least three participants. Particular reference is made to Frank's admission of prejudice towards those with drug-induced psychosis and learning disabilities, Sally's reduced empathy for those who "whinge" (16.6), and Ruth's experiences of othering in her workplace (20.27) as well as avoidance of certain client-groups reflecting her own experiences.

The data in this study suggests the self-view of psychologists with dual-identities is conflicted and can impact on how they practice professionally. Defensive strategies are put in place to protect oneself from evidence one might have similar characteristics to their patients and therefore share a similar fate (Schimmel et al., 2000). Furthermore for participants in this study self-stigma was found to result in a sense of "spoiled identity" (Goffman, 1963) and reduced help-seeking behaviour (Vogel, Wade, & Haake, 2006) which might account for some participants' reluctance to access psychological treatment; indeed some felt more comfortable acknowledging physical illnesses than emotional distress (e.g. Rick; 16.30).

Social identity theory (Tajfel & Turner, 1979) can provide further understanding of tension apparent within the participants' accounts. This theory proposed that individuals aspire to become members of a high-status group towards which their ability to move is dependent upon boundaries of their existing and aspirational group. When this individual mobility is not possible social competition occurs which manifests in members of the group positively distinguishing their group from others. This could manifest in primitive defences such as

splitting, othering or projecting in order to separate unwanted parts of the self, experiences or feelings (Krantz, 1998). These behaviours seemed evident in participants' accounts and particularly Ruth's account of her employer.

This research illustrated how complex, entrenched and multifactorial stigma is, being reinforced daily through social processes occurring in the relationship between people's micro, meso and macro-social systems. Further research is needed to identify whether other wounded-healers are affected in this way.

Clinical and Practice Recommendations

This research has shown a wealth of experience those with this particular dual-identity possess. By valuing and harnessing this knowledge, service-design and patient-experiences can be improved. This research also emphasises the benefit of personal-therapy in development of therapeutic skills and understanding of client experiences. This research underlines the need for self-care as well as provision of support within organisations that can meet the needs of clinical and counselling psychologists. Of particular interest in this research was a new finding that illustrated how wounded-healers can be affected by societal stigma, evident in attempts to distance themselves from clients who have problems similar to their own.

These findings lead to the conclusion that open and reflective discussion is required within the profession about the nature and prevalence of prejudice and stigma in psychology. It was hypothesised that wounded-healers might self-stigmatise in part due to the prevalence and hidden nature of discrimination in the profession. This stigma and self-stigma prevents those in need of support from accessing it when needed. This might also prevent wounded-

healers from speaking openly to supervisors and colleagues about their clinical decisions such as therapist self-disclosure.

Recommended research

Many of the findings of this research are congruent with related research (e.g. Barnett, 2007; & Gilroy et al., 2002) whilst other findings open up areas for further exploration. For example an exploration into prejudice within the profession might establish whether this research's findings do in fact represent the experience of other wounded-healers. Due to the sensitive nature of prejudice and discrimination, a survey design might increase psychologists' willingness to speak openly about their feelings. It would also be useful to establish how other psychologists manage their practice based upon their feelings.

A qualitative exploration into self-stigma of wounded-healers might help understanding of how wounded-healers feel about their "right" to have wounds and factors that might impede their access to support. Furthermore investigation of experiences of clients whose therapists have had mental-health difficulties versus those who have not is indicated by the findings of this research. It would be useful to quantitatively explore the effect on outcome, therapeutic alliance as well as clients' subjective experiences through qualitative research. Due to the paucity of literature available, further qualitative exploration of how psychologists draw upon their personal-therapy would also be valuable in understanding how psychologists use their experience and how this changes over time as the evidence of participants in this research suggests.

Limitations

These findings and interpretations need to be considered with caution due to the self-selected nature of the participants. Some wounded-healers might have chosen not to participate since they were not 'out' about their status or felt they did not meet the inclusion criteria due to the definition they had attributed to their difficulties. As with any qualitative research generalizability is limited, however careful effort was made to increase the degree to which generalizability could be achieved. The small sample group interviewed further reduces transferability of findings, however this research is transferable in populations from similar socio-economic/historical/geographical contexts. The experience of the researcher in conducting research may also be a limitation. While every effort was made to reduce possibility of the researcher's biases, personal idiosyncrasies and assumptions from influencing findings, this needs to be considered when the reader draws their own conclusions.

Conclusion

Results of this research show that psychologists with a history of mental-health problems actively draw upon their experience and find it enhances their practice in most instances. In managing their dual-identity of service-user and professional, they report a degree of ambivalence which influences the way they view themselves and their practice. Their personal experience seems closely tied to their professional-identity, which either conflicts with their sense of self or complements it through recognising how fortunate they are compared to others. The interviews frequently highlighted how psychologists' experiences can provide an impetus to speak out for patients' right to be treated with respect and dignity. A number of psychologists with an experience of mental-health difficulties felt they might not have pursued their career had they not had those experiences or were grateful for having gained the insight that those experiences afforded.

There were mixed findings concerning whether participants felt their mental-health difficulties had helped or hindered practice. While acknowledgement was made to positive factors, there was evidence that stigma within society and the profession becomes assimilated into the wounded-healer's identity which increases self-stigma. This self-stigma reduces wounded-healers' ability to speak openly about their experiences, access support and impedes other clinicians' learning from knowledge and experience the wounded-healer holds. The wounded-healer's unique combination of professional and service-user perspectives can be harnessed to deepen our understanding and improve the experience of mental-health care for service-users.

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Elizabeth Davison

MAJOR RESEARCH PROJECT

SECTION C

Title: Critical Appraisal

Word count - 1900

Research skills and learning

Lessons learnt

The task of completing research was an entirely new experience for me, from which I learnt how to plan, propose, obtain ethical approval, recruit participants, interview, analyse and write-up the results obtained. I have learnt about the epistemological foundations of interpretative phenomenological analysis (IPA) as well as how they differ from other qualitative methodologies. IPA's strongly idiographic approach exploring "the lived experience" (Reid, Flowers, & Larkin, 2005, p. 20) of the individual in an inductive way with no pre-existing hypotheses, seemed the appropriate methodology to use in order to capture the meaning that the participants assigned to their experiences. The fact that grounded theory (Glaser & Strauss, 1967) has quantitative underpinnings in its belief that there is a reality to be discovered through the interpretation of experience, further informed my decision to use IPA.

Since this project was independently developed and proposed to prospective supervisors, I was personally invested in the way that it was carried out. I learnt how to retain ownership of the research while considering recommendations made by the supervisors. My initial plan for the research was to obtain respondent validation and to include the participants' responses to the analysis in the write-up. Upon further reading, however, it became apparent that respondent validation is no longer recommended as a tool in IPA (Mason, 2002) and this, combined with time-constraints, meant that the participants' were not consulted in the analysis.

Obtaining a referral for my first submission was challenging to overcome emotionally. It was very difficult to find the motivation to re-visit the work. Despite this, I think that the referral process allowed me to spend more time on the analysis and develop the interpretation further. Re-writing 'section A' in a more focused way, meant that I went deeper into therapist

self-disclosure and was able to use the findings from the review to guide further interpretation of the data.

Discussions with my cohort provided additional learning. I was able to discuss difficulties that they were experiencing associated with obtaining ethical approval, recruitment, interviews and analysis. This helped me to understand my own experiences further and to recognise how different research experiences can be. Furthermore, in order to ensure that there was sufficient time to complete the various elements involved in a major research project in combination with other course demands, time management was a key learning in this process.

Gaps in learning

Additional experience in IPA as a methodology would help to further develop my skill and confidence. As a novice researcher, additional experience in research as a whole would contribute to the development of my skills. I think that the opportunity to work on one piece of academic work at a time would increase the degree to which I could immerse myself in the data. The referral process allowed an additional month in which this could be achieved. I would like to complete some quantitative research in the future since I feel that this is an area in which I could benefit from learning more. A different, perhaps clinical sample might provide new challenges associated with ethics, recruitment and interviews.

What would I do differently?

I feel very fortunate to have had a relatively smooth process in terms of recruitment, ethical approval and the interview process. I was able to observe and support my cohort, some of whom did not have the same fortune. My confidence was one of my main hindrances, however, and I would in future not have the same fears that I had during this experience.

Self-doubt and anxiety associated with the write-up of particularly 'section A' initially hampered my ability to feel a sense of ownership over the research.

Should recruitment have proven difficult, I would have relaxed the inclusion criteria to include those working with clients in a therapeutic capacity; counsellors, psychotherapists etc. The recruitment process went relatively smoothly, however, so this 'plan B' was not necessary to implement.

The one element used in grounded theory which I would have liked to have utilised was the ability to change the interview questions as the interviews progressed (Glaser et al., 1967). Certain areas such as the participants' use of supervision would have been good to have explored. Although it was mentioned by some, the vast majority did not. This might have further contributed to the knowledge-base in terms of how and whether they used this forum to address how their work was impacting upon their wellbeing and their clinical practice.

Boundary and power issues associated with being both an aspiring member of the participant group as well as a person who has had mental health difficulties, did create conflict within me during the analysis process. I became aware that I was reluctant to make interpretations of the participants' interviews as I felt that I was not qualified to do this for those who were far more qualified than I was. I overcame this reluctance by discussing it with my supervisor who encouraged me to have faith in my understanding of the interviews as well as the interpretative process outlined by Smith (Smith, Flowers, & Larkin, 2009).

An additional consideration associated with this population group, existed in the ethical requirements that support service contact details are offered in case something in the interview upset them. This provided much thought and discussion since it felt patronising to offer qualified, practicing psychologists' a list of support which seemed redundant. This feeling resulted in a discussion at the beginning of each interview that established whether

the participants had support available to them should anything in the interview have distressed them or provided them with something that they felt they needed to discuss further. Had they not confirmed this, then a list of resources would have been provided. This made me aware how assumptions are made when thinking of psychologists that somehow, they do not need support or they are able to access this independently. During the interviews, however, it became apparent in at least one instance, that it is not very easy to access support as a psychologist due to stigma and the financial burden. The support that the NHS provides was felt by two of the participants, inadequate for qualified psychologists.

Due to the above concerns, upon completion of each interview, I asked the participants how they had experienced the process. All of the participants felt that the interview had been a positive experience. Some of them said that they were surprised how they had become emotional during the interview. One participant had said that it had helped her to realise that she needed to increase the amount of self-care she was doing and another said that the process of the interview had helped her to synthesise her understanding of her experience and observe how it had changed.

I asked the participants why they had chosen to participate in the interview to understand their motive to participate. Some highlighted their desire to help me in my recruitment while others said that they felt that others might be able to learn from their experiences in the same way that they had. One participant said that he wanted to offer a different story, one which does not fit with recovery but rather with survival despite difficulties being continually present. Another participant wanted to emphasise the importance of personal therapy for all psychologists.

I would have preferred to have completed all of the interviews face-to-face rather than some over the telephone. I was concerned that it might hinder the development of the participants' stories and my responsiveness to their non-verbal communication. I asked one of the

participants how she had experienced the interview over the phone. She explained that it had prevented her from becoming over-emotional and her involvement felt more anonymous than face-to-face. She viewed these factors as benefits of the completing the interview over the telephone.

The omission of a separate complaints section in the participant information sheet might have prevented the participants from feeling able to lodge any complaints. There were contact details for the researcher, the university and both supervisors, who could have been contacted, however, if a separate section had been provided, the participants might have felt that their concerns would be addressed.

Clinical practice

The outcome of this research indicated that psychologists with experience of mental health difficulties actively draw upon their own experiences in their practice. I feel more confident now to do the same, having found that experienced professionals have successfully implemented this and are able to reflect on their experiences. Since completing this research and literature review, I have found that I am more inclined to use immediacy and judicious self-disclosure in my practice with the understanding that it can enhance the therapeutic alliance and the outcome for my clients.

The research highlighted the conflict or ambivalence that the participants' experienced in their work associated with both therapeutic models as well as policy. While I do not think that this is unique to those having experienced mental health difficulties, I do feel that further involvement of those with this dual identity would be useful in service-design and development of therapeutic guidelines. Professionals such as those who participated in this research, have a perspective from both sides of the figurative table, which could be a great resource upon which to draw.

In addition to the contribution that these participants can make to policy and practice, it had an impact on me in terms of my own career choices. I am at the point of applying for positions as a clinical psychologist and the, sometimes negative perspective that the participant group engendered, left me feeling somewhat hopeless about my own journey and whether the NHS is in fact a place in which I could continue to work.

Future research

I would like to continue this line of enquiry by exploring the experience of clients whose therapists have had mental health difficulties versus those who have not. It would be useful to explore the effect on outcome, therapeutic alliance as well as the clients' subjective experiences. In exploring the effect on outcome and therapeutic alliance, a quantitative enquiry would be useful while a qualitative IPA exploration might be useful to understand the clients' experiences of therapy.

As mentioned in 'section B', I think a further exploration of how psychologists draw upon their personal therapy would also be useful. This might benefit from a grounded theory methodology so that a model might be developed in order to understand how psychologists draw on their experience and how it changes over time as it appears it might from the participants in this research.

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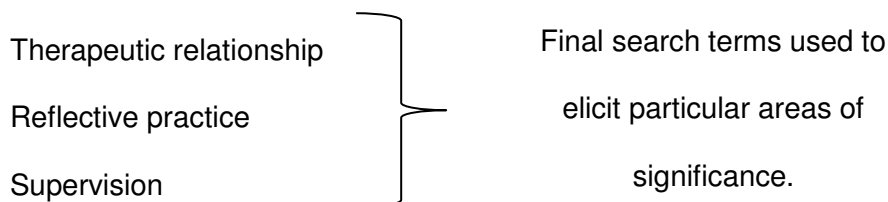
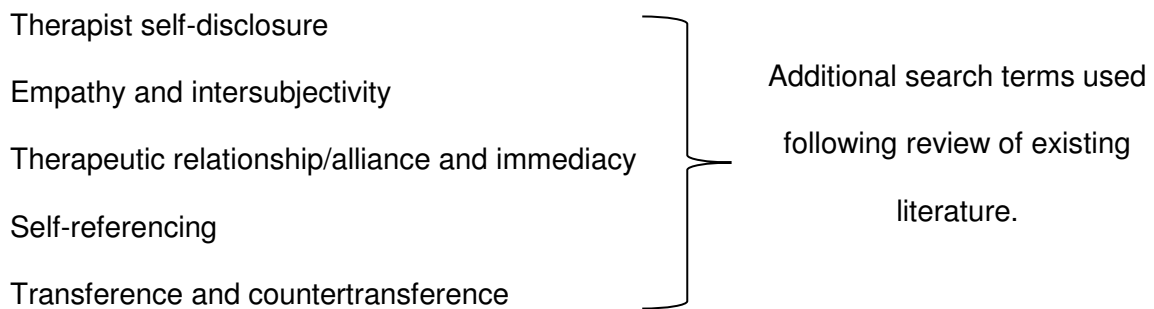
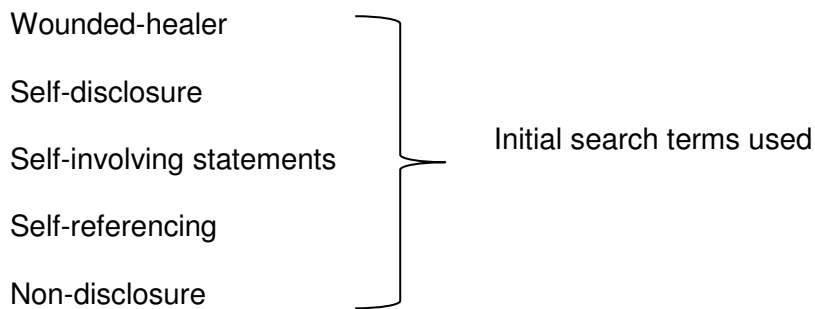
Elizabeth Davison

MAJOR RESEARCH PROJECT

SECTION D

Title: Appendices

Appendix 1: Search strategy for literature review



Appendix 2: Ethical approval

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Appendix 3: Research information and consent form.

Title of study: The wounded healer: Clinical and Counselling psychologists with experience of mental health problems.

Thank you for your interest in participating in this research study. My name is Liz Davison and I am a trainee clinical psychologist, carrying out this study in partial fulfilment of a doctorate in clinical psychology under supervision. This study has been reviewed and approved by the Salomons Research Ethics Committee and is sponsored and indemnified by Canterbury Christ Church University.

Before you decide whether or not to take part, please read the following information carefully; it tells you more about the study and what is involved in taking part. Please feel free to contact me if you have any further questions (see details at the end of the sheet).

Who will be involved in this study????

I am hoping to interview qualified clinical and counselling psychologists who have experienced and received treatment for a mental health problem in their adolescent or adult lives. In order to participate in this study, the participants need to have recovered from their mental health problem, feel able to reflect on it in an interview and be currently practicing in the field of psychology.

What is the purpose of this study?

This study aims to gain a psychological understanding of how a previous mental health problem impacts upon clinical and counselling psychologists practice. There is a paucity of literature in this area: however literature discussing various elements of the therapeutic relationship suggests that psychologists' experiences may influence the process in a number of ways. It may help the therapeutic experience for the client, assist in recovery for the therapist, harm the client or even harm the therapist.

Dependent upon the findings, this research could be utilised to inform recruitment, supervisory and support processes. Additionally, this research may justify the need for further research into the impact that these experiences have from the client's perspective.

Why am I am doing this study?

In addition to the contribution that this study could make to enhancing understanding of psychological practice, as someone who has had some experience of mental health problems in the past, I would like the ways that this may have shaped our work to be a matter that can be thought about more openly by the wider psychological community, for instance in relation to recruitment and supervision.

What counts as a mental health problem?

For the purpose of this study, “mental health problem” is defined as a health condition that changes a person’s thinking, feelings and/behaviour, causing the person distress and difficulty in functioning and requiring psychological and/or psychiatric intervention.

I wish to encourage diversity in my sample since prospective participants will have their own unique experiences. You are welcome to contact me if you require any clarification in this regard.

Do I have to take part?

No. Participation in this study is entirely voluntary. Please use this information sheet to help you decide whether you want to take part. You are also welcome to contact me if you have any further questions. If you decide to participate, you will be asked to sign a consent form to confirm that you understand, and agree to take part in, the study. You will be able to withdraw from the study at any point prior to or after the interview, without having to give a reason.

What will be expected of me if I agree to take part?

If you agree to take part, an interview will be arranged to take place either over the phone (if you live outside of the south east of England) or at a venue such as your place of work, your home or the Canterbury Christ Church University Salomons Campus at Tunbridge Wells.

Before the interview commences, I will ask you to identify your existing sources of support so that you could access them should the interview upset you. During an approximately hour long, audio-recorded, semi-structured interview, I will ask you questions about your experiences. You will be able to take a break or stop the interview at any time.

I will ask if I may contact you again by telephone to ask some additional questions or clarify what you have said. This is optional and you will still be able to participate in the interview even if you do not wish to be contacted afterwards.

You will also be offered the opportunity to engage in the process the analysis by receiving the transcript of your interview and will at this stage be asked again for your consent for the material to be used. Upon completion of analysis, you will be provided with a 1-2 page summary of the key interpretative phenomenological analysis (IPA) themes obtained from all the data.

What will happen to my information?

Your interview will be password-protected and transcribed, either by myself or an external transcriber. If an external transcriber is used, I will listen to your tape beforehand and remove any identifying information, and s/he will sign a confidentiality agreement. The audio recording will be destroyed once it has been transcribed. Your demographic questionnaire and interview transcript will be assigned a number or pseudonym to protect your identity and will be stored in a locked filing cabinet. Your consent form will be stored securely and separately from these documents. I will be the only person with access to these details. The information will be kept for ten years and then destroyed. It will not be used by anyone else.

The content of your interview will be kept confidential. However, there may be certain circumstances where it could be necessary to breach confidentiality (for example, if you were to share information which indicated to me that you might harm yourself or someone else, or if you could be unfit to practice as per the HPC and BPS fitness to practice guidelines). If this were to happen, I would ensure that you were actively involved in any discussions about the best way forward. I will act at all times in accordance with the relevant HPC (2009) and BPS (2009) guidance.

The study will be written up and anonymised quotes from your interview may be used. I also intend to submit the study for publication and anonymised quotes from your interview may therefore appear in print. I will take all practical steps necessary to disguise your identity, but it is possible that you might be able to recognise the content of some quotes.

What happens if I become distressed as a result of participating in the study?

Participation in this study involves the discussion of a potentially distressing experience or set of experiences. It is recommended that you carefully consider whether you feel able to discuss your experience with the researcher and that you feel confident that you have sufficiently recovered from your difficulties. You will be able to take a break at any point during the interview or to stop it altogether, without having to give a reason. If I feel that you are becoming distressed, I may also suggest a break or early end to the interview. You will

also be provided with a list of services that you could contact should you require additional support.

Contact details

Thank you for taking the time to read this information sheet. If you would like to participate in this study, please contact me, using the details below. If you would like more information before making a decision, please also feel free to contact me.

Researcher

Liz Davison

Trainee Clinical Psychologist

Department of Applied Psychology, Canterbury Christ Church University, Salomons Campus, Broomhill Road, Tunbridge Wells, Kent, TN3 0TG.

Email: ed110@canterbury.ac.uk

Supervisors

Dr. Louise Goodbody

Year 2 Director

Doctoral Programme in Clinical Psychology, Department of Applied Psychology, Canterbury Christ Church University, Salomons Campus at Tunbridge Wells, Broomhill Rd., Southborough, Tunbridge Wells, Kent, TN3 0TG.

Email: louise.goodbody@canterbury.ac.uk

Dr Noelle Blake

Croydon Health Services NHS Trust,

Broad Green Centre, 1-13, Lodge Road , Croydon, CR0 2PD

Email: Noelle.blake@nhs.net

Consent form

Title of study: The wounded healer: Clinical and Counselling psychologists with experience of mental health problems.

Researcher: Liz Davison, Trainee Clinical Psychologist

Supervisors: Removed for anonymisation

Please ensure that you have read the information sheet accompanying this consent form carefully before completing. If you have any further questions, please do not hesitate to contact the researcher, using the details found at the bottom of the information sheet.

- | | Please initial yes or no | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 1) I confirm that I have read and fully understand the research study information sheet. I have had the opportunity to ask questions or seek clarification. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) I understand that my participation is voluntary and that I can withdraw from this study at any point prior, during or after the interview. I do not have to give a reason for my withdrawal. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) I give permission for my interview to be audio recorded and for anonymised quotes from this interview to be used in any subsequent write-up. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) I give permission for the researcher to contact me by telephone or email to discuss my participation in this study and to arrange a convenient time for interview. | <input type="checkbox"/> | <input type="checkbox"/> |

Please initial yes or no

Yes

No

5) *(Optional)* I give permission for the researcher to contact me by telephone or email following my interview to ask further questions or clarify any issues raised.

6) (Optional) I would like to receive a copy of my transcript once it has been completed.

7) I would like a summary of the study's findings following its submission and approval.

Name (printed):

Signature:

Researcher's signature:

Date: / /

Participant contact details *(This will be detached from the consent form & kept separately and securely. The information will be destroyed once the project has been completed).*

Name (printed):

Email address:

Telephone number:

Preferred contact method: Email / Phone / Text (please circle as appropriate)

Appendix 4: Summary of findings

The wounded healer: Clinical and Counselling psychologists with experience of mental health problems. An IPA study

Aim and Objectives of the study

The aim of this study was to fill the gap in the current body of literature by exploring how the experience of previous mental health problems affects clinical and counselling psychologists' approach to practice. This objective was met by interviewing qualified clinical and counselling psychologists who had experienced mental health problems about how they individually experienced its impact on their practice.

Method

Ten clinical and counselling psychologists from the United Kingdom who responded to advertisements placed in relevant publications were interviewed using a semi-structured interview, which was analysed through the use of interpretative phenomenological analysis (IPA).

Overview of the Results and Conclusions

The results of this research showed that psychologists with a history of mental-health problems actively draw upon their experience. In managing their dual identity of service-user and professional, they reported a degree of ambivalence which influenced the way that they viewed themselves and their practice. Their personal experiences seemed to be closely tied up with their professional-identity, which either conflicted with their sense of self or complemented it through highlighting how fortunate they were compared to others. The interviews frequently highlighted how psychologists' experiences can provide an impetus to speak out for patients' rights to ensure that they are treated with respect and dignity. A number of psychologists with an experience of mental-health difficulties felt that they might

not have pursued their career had they not had previous mental-health difficulties. There appeared to be mixed findings concerning whether the participants felt that their mental-health difficulties had helped or hindered their practice.

This research has highlighted a wealth of experience that those with this unique dual-identity possess. It is through harnessing this knowledge that service-design and patient-experiences can be improved. This research also emphasised the particular use that personal therapy can have in the development of therapeutic skills and the understanding of the experience of the client. Finally, this research underlined the need for self-care as well as the provision of support within organisations that can meet the unique needs of clinical and counselling psychologists.

Appendix 5: Interview Schedule

1. Before we start, I would like to ask whether you have available support should anything in this interview distress you or give you things you want to think further about for yourself?
2. I wonder whether you could orientate me in terms of when your mental health difficulties began and ended and how this has fitted into your career path.
3. How do you find that your experience of mental health problems, affects your practice? (Has this changed at all over time?)
4. Do you work with clients with similar problems to those you experienced?
 - a. How do you experience working with clients with similar problems to the one that you experienced?
 - b. If you do not work with people who have similar problems, please say how this has come about? Is it a conscious decision not to?
5. How do you experience working with client with different problems to the one that you experienced?
6. Do you ever draw upon your experience while working in your practice? If so, how? If not, what stops you?
7. How do you think that your practice would be if you had not had a mental health problem in the past?

8. How do you keep yourself well while in your practice?

9. Do you ever find aspects of your work remind you of your past experiences?

10. How do you feel that your experience of mental health problems helps or hinders your practice?

11. What made you choose to participate in this research?

12. What was it like to participate in this interview? What was it like to talk about your mental health problem in this way?

Appendix 6: Transcript and analysis

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Interview 2 – development of themes

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Appendix 7: Illustration of how themes developed (two participants)

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Appendix 8: Research diary

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