UCLouvain

Faculté de psychologie et des sciences de l'éducation

Understanding the Therapeutic Relationship Between the Wounded Healers and their Patients

Auteur : Rey Félix
Promoteur : Jochem Willemsen
Année académique 2023-2024
Master en sciences psychologiques, finalité approfondie

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Declaration About Plagiarism

« Je déclare sur l'honneur que ce mémoire a été écrit de ma plume, sans avoir sollicité d'aide extérieure illicite, qu'il n'est pas la reprise d'un travail présenté dans une autre institution pour évaluation, et qu'il n'a jamais été publié, en tout ou en partie. Toutes les informations (idées, phrases, graphes, cartes, tableaux, etc.) empruntées ou faisant référence à des sources primaires ou secondaires sont référencées adéquatement selon la méthode universitaire en vigueur. Je déclare avoir pris connaissance et adhérer au Code de déontologie pour les étudiants en matière d'emprunts, de citations et d'exploitation de sources diverses et savoir que le plagiat constitue une faute grave sanctionnée par l'Université catholique de Louvain ».

Abstract

A wounded healer (WH) is a practitioner who has been personally affected by past experiences and, through training in therapeutic accompaniment and their own therapy, assists others in their journey towards recovery. This paper has twofold aim: firstly, to gain a better understanding of the therapeutic relationship between WHs and their patients; and secondly, to provide practitioners with a visual tool that will assist them in conceptualising the concepts inherent in the therapeutic relationship of WHs. In order to achieve this, we employed a literature review method known as the Theory-Generating Literature Review (TGLR). This seven-step method is designed to assist researchers in constructing a literature review with the objective of developing a framework pertaining to a specific phenomenon. In light of this, we will examine the therapeutic advantages and disadvantages of the relationship between WHs and their patients. On the positive side, it has been demonstrated that WHs have a stronger empathic relationship with their patients and that there is a redistribution of therapeutic power between the different parties in the relationship. However, it has also been shown that past wounds could influence the therapeutic power of WHs, potentially leading to risks of overidentification. Our research has also led us to investigate the concepts of self-disclosure and countertransference in the therapeutic relationship. These two concepts could also lead to an increase in the strength of the relationship, but would have the risk of unprofessional behaviour. The findings of our research have enabled us to integrate them into a new theoretical framework with the objective of providing visual support for practitioners. Furthermore, the discussion will encompass the practical implications of referring to therapists as wounded healers, as well as wounded researchers or even how the work environment can influence the WH's therapeutic abilities

Key-Words : Wounded Healers, Therapeutic Abilities, Self-Disclosure, Countertransference, Literature Review

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Understanding the Therapeutic Relationship Between the Wounded Healers and their Patients

The present paper focus on the impact of the presence of a wounded healer (WH) in a therapeutic relationship. For the current purpose we will have to define the field of mental health care in which we will investigate the concept of WH. Then we will have to characterize the healing process and the healing connection. Discussing these two components will provide us with a common basis for further reflection.

For the purposes of this article, we will be focusing on mental health professionals who are "employed in non-peer designated mental health roles," as defined by Byrne et al. (2022, p. 10), e.g. as clinical psychologists and psychotherapists. This means that we will not be discussing associations based on peer support, such as alcoholics anonymous, but rather only professionals who have graduated from a recognized organization or university. It is important to note that the exclusion of this population from our definition of the wounded healer does not imply a lack of recognition for the support they provide to the mental health community. The reason for their exclusion is that their therapeutic techniques require disclosure of personal life experiences, which is not a requirement for non-peer-designated wounded healers (Byrne et al., 2022).

Because this paper explores the impact of the presence of a WH in the therapeutic relationship, we have to have a focus on the importance of the healing process. Healing can be defined in different ways. It can be the movement from illness to a healthy condition where the subject has recovered all their potential (Hutchinson et al., 2009). Alternatively, it can be defined as a relative improvement in everyday life (Mount et al., 2007). The process of healing is based on the relationship between a healer and a patient, with two important components in the process. If the objective of the care is the complete recovery of the individual, the first component involves a transition from pain to a state devoid of pain. The second component pertains to the inner characteristics of the patient. The healing process is modulated by the patient's inner capacity (Ingram, 2015). Throughout the healing process, both the healers and the patient feel a sense of connection. This connection may serve as a tool for the therapeutic process and is described as a "deepening experience of integrity and wholeness" (Boston & Mount, 2006, p. 25). Steven (2001) suggests that the therapeutic process involves a connection with others, which may be related to Jung's concept of individuation. In fact, Frisone (2019) has described Jungian individuation in the therapeutic relationship as the process that enables the patient's singularity. Thanks to the instinctive relationship, patients learn to know

themselves in depth and to free themselves from a psychological state that is imposed on them in order to move towards their own psychic state.

The Wounded Healer

Definition

According to Ingram (2015), the WH concept is firstly described by Jung, and he refers to a practitioner who alleviates the suffering of their patients through their own past wounds. In other words, WHs are “professionals with experience of patient-hood” (Lads et al., 2021, p. 63) due to past wounds or traumas. This definition closely aligns with Jung’s (1951) characterization of the WH, where he referred to the WHs as the result of wounds from the therapist’s past (Wheeler, 2007). The power of healing possessed by the WH is derived from these wounds. The time spent healing themselves provides practitioners with wisdom that enables them to better understand the recovery process (Morishita et al., 2020; Zerubavel & Wright, 2012).

The crucial aspect of the WH definition is that the turning point is not the practitioner’s suffering, but rather how they deal with their own wounds. To put it another way, the WH status is not determined by the results of past injuries, but rather by the manner in which he learns to live and work with them. (Barnett, 2007). The recovery process helps future WHs to improve their understanding of the knowledge acquired during the recovery process. All of these processes mentioned above intrinsically modify and influence their therapeutic process (Cvetovac & Adame, 2017; O’Brien, 2011). According to Sedgwick (1997), this healing process enables WHs to align themselves with their patients’ unconscious healing tendencies.

Another point that could be included in the definition of WH is the importance of recognizing the human element behind every practitioner. Every wound can serve as a reminder for WHs to remember that healing is a long journey (Kron & Avny, 2003). Additionally, this definition emphasizes the importance for WH professionals to focus on their own wounds as well (Laskowski & Pellicore, 2002).

These definitions help us understand that being a wounded healer is not only about being a practitioner who has been wounded, but also about being a practitioner who has undergone or is undergoing a psychotherapy process to try to heal past wounds (Wheeler, 2007). However, in this paper we will talk about WHs who have been hurt in their past experiences. In short, a WH is a practitioner who has been personally affected by past experiences and, through training in therapeutic accompaniment and their own therapy, assists others in their journey towards recovery.

Anthropology of the Wounded Healer

Unlike in Western societies, where academic performance is closely linked to the possibility of becoming a healer. It is evident that a high level of academic achievement is a prerequisite for certain health professions, such as neurosurgery. In comparison, in ethnomedicine values experience with injury or pain as a prerequisite. In fact, the past experiences of pain or illness are a source of knowledge and wisdom for the healer who is in contact with other people's pains (Ladds et al., 2020; Morishita et al., 2020). In shamanic medicine traditions, initial illness is considered both a call to vocation and a necessary process for individuals to acquire the power to heal (Kirmayer, 2003). During this initiatory journey, the shamans symbolically fight the forces of evil who were trying to kill them. Following this conflict, those who have recovered from their wounds become transformed into new beings imbued with the capacity to heal(Comas-Diaz & Padilla, 1990). This power is based on the assumption that an individual who has previously experienced illness is better positioned to comprehend the intricacies of the illness and the most effective treatment options (Kirmayer, 2003). These ethnological considerations have enabled some authors to suggest that the shamanic traditions would be the starting point of the modern Western psychotherapeutic tradition (Ceconi & Urdang, 1994). These shamanic traditions can be seen as the starting point for the concept of WH, in which the practitioner serves as the link between their patients' illness and their own wounds (Stone, 2008; Brandon, 1999).

History of the Wounded Healer

The concept of the carer as a WH can be traced back over 2,500 years and has its origins in the shamanic vision of certain societies, as well as in the civilisation of ancient Greece (Kirmayer, 2003; O'Connor, 2001; Christie & Jones, 2014). In Greek mythology, the concept of WH can be linked to the centaur known as Chiron, who learned medicine from the gods Artemis and Apollo (Daneault, 2008). One day, the demigod Heracles wounded Chiron with a poisoned arrow, and due to his immortality, the centaur was doomed to live forever with eternal pain. In this period, he met Asclepius who taught him all his knowledge of healing (Christie & Jones, 2014; Kron & Avny, 2003; Stones, 2008). This act of teaching while the teacher is in pain can be seen as a representation of the transformation of pain into new knowledge. According to Christie and Jones (2014), this act also enabled him to reduce his pain. From a linguistic point of view, the term "surgery" is derived from the French word "chirurgie", which in turn is a linguistic evolution of "Chiron" (Daneault, 2008).

Many centuries after antiquity, psychoanalysts have turned their attention to the concept of WH. In the psychodynamic tradition, the therapist must follow a therapy to reduce and

prevent the disturbances during the healing process with their patients (Cain, 2000; Rober, 2021). Although Jung was one of the first psychoanalysts to question the implications of past wounds on the effectiveness of therapeutic treatment, his point of view has evolved over the years:

> *"In his early writings, Jung (1963) described therapists' personal struggles as contamination that must be eliminated, using the metaphor of a surgeon's clean hands, yet later in his career, his conceptualization shifted, and he wrote that "only the wounded physician heals" (Zerubavel & Wright, 2012, p. 483)"*

With this revision of his theory, the WH becomes the only effective healer. The therapist's task is to work on his own wounds and personality to enable him to participate in the therapy without interfering with the patient's therapeutic process (Boston & Mount, 2006; Daneault, 2008). In summary, Jung developed the concept of WH and have influenced the therapist's capacity to reflect on their own wounds (Amundson & Ross, 2016; Garti & Bat Or, 2019). The post Jungian authors have also develop this concept. According to Daneault (2008), Guggenbühl-Craig (1985) has pointed to the healing power inside the patient as an important lever for the success of therapy.

Nowadays, the concept of WH is used in a variety of fields, including professions that provide help for vulnerable people, social work, teaching, and even religion (Christie & Jones, 2014; Hudzik, 2019; Piredda et al., 2022). This recognition of the health , emotions, wounds, and vulnerability of practitioners is an improvement for the quality of care provided by caregivers and, therefore, for the patients (Daneault, 2008; Corso, 2012). Finally, our brief history of the WH concept would not be complete without mentioning Alcoholic Anonymous and its derivative groups. Such programs are based on the idea that without experiencing addiction or similar struggles, one cannot fully comprehend and cope with it (Cain, 2000).

Prevalence

Engaging with the topic of mental health is a responsibility we owe to ourselves and those around us. As Harris and colleagues (2016) reported, 75% of therapists have experienced a mental health problem, and Gilroy et al. (2002) reported that over 60% of psychologists have experienced depression, while 42% of those seeking treatment have reported suicidal tendencies (Victor, 2022). It is important to acknowledge and address these challenges in order to promote a healthier and more effective mental health professional culture.

Approximately one-third of therapists who work with traumatized individuals have also experienced trauma themselves (Weingarten, 2010). Healthcare workers experience mild mental health issues 1.5 times more frequently than the general population (Brandon, 1999). Women working in the mental health field report experiencing traumatic events such as the death of a family member, parental substance abuse, or sexual violence more than women in other professions (Grave, 2008). These statistics raise questions about the potential impact of mental health problems on therapeutic techniques and positions.

Besides those already working in the field, it is also worth considering students who aspire to become therapists. Salzer (2022) has shown that there was an increase (from 30 to 40%) of students with mental health problems who want to become therapists in the past decade.

The presented statistics indicate that the issue of mental health has been a concern for some time. The preceding study demonstrates the necessity to address the psychological well-being of future practitioners. Consequently, the question of the therapeutic relationship between carer and patient is of significant importance for practising therapists and those in training.

Becoming a Wounded Healer

In the context of our work, a wound is defined as an injury that can be linked to a traumatic event, a lack of care in childhood, a mental illness, or other factors. It can manifest physically or psychologically, or in a combination of both (Dee & Fernandez, 2023; Grave, 2008). The initial injury can have various effects, depending on the pathology and its severity. It is generally believed to originate in social or family relationships (Kalmakis & Chandler, 2014).

The process of becoming a WH is not solely contingent upon having been wounded in the past; it also encompasses the capacity to recognise the impact of this wound on one’s personality and the motivation to address the consequences of this wound (Hayes, 2002; McDonald & Grau, 2019). One risk when the therapist does not recognize their own wounds is the confusion between the one who heals and the one who is wounded (Hayes, 2002). This recognition is the origin of their healing power and their therapeutic identity, encompassing both their strengths and weaknesses as caregivers (Amundson & Ross, 2016; Cvetovac & Adame, 2017). The process of becoming a WH must be linked to a state of mind that allows for self-reflection, attentive listening to one’s emotions and active participation in the process (Krasner, 2004).

Kirmayer (2003) proposed the first model of the WH development in five steps. The initial step is denial, where therapists fail to recognize their own wounds and attempt to distance

themselves from their patients, creating a clear separation between the healer and the patient. Then after commencing their own therapy, therapists experience an upheaval of the denial and can begin to confront their wounds. The removal of boundaries between the patient and therapist can cause role confusion. However, after destruction comes reconstruction, and the therapist begins to accept their own healing power. Despite this, they may still feel uncertain about how to facilitate healing. To complete their professional development, therapists who have experienced personal wounds should acknowledge that they may never fully recover. Therefore, individuals aim to remain closely connected to their inner wounds, using them both as a source of strength and a limitation of their healing power.

The second model is proposed by Conti-O'Hare (2002), in which she conceptualised the model of the "nurse as wounded healer" (Piredda et al., 2022). Although this model is based on the nursing profession, it is still relevant because it can help us understand the process of transformation of a caregiver from a wounded therapist to a WH (Piredda et al., 2002). According to Christie and Jones (2014), the model can be described in four main steps that explain the process of becoming a WH. Furthermore, according to her model, becoming a WH is not just a decision, but a calling. Past traumas can lead individuals to choose to care for others. Initially, the therapist must acknowledge the wholeness of their own personality, which includes accepting past wounds. In this model, every human being has been hurt at least once. It is impossible to become a WH without being aware of one's own wounds. Conversely, failing to recognize these wounds may compromise the therapeutic potential. In addition to being aware of it, she emphasized that the WH must transcend and transform its past wounds. Through this transformation process, the WH will become capable of healing others thanks to its own therapeutic journey. This will have a positive impact not only on the therapists and patients but also on society and the healthcare system.

Moreover, becoming a WH offers "at least three perspectives: the pre-dispositions of clinicians, the treatment's effect on clinicians, and the opportunity for clinician growth" (Nolte & Dreyer, 2008 as cited in Amundson & Ross, 2016, p.114). Furthermore, it serves as a crucial starting point for the patient's treatment. As Jung (1963) famously stated, "The patient's treatment begins with the doctor" (Yeh & Hayes, 2011, p. 322). With this formula, he asserts that a doctor must first learn to cope with their own problems before teaching their patients to do the same.

Nevertheless, even for a therapist there is no such thing as complete healing from a wound. Thus, during all of their career, they will have to continue the construction and the deconstruction of their own identity, and theses reflections will help them to stay as closed as

possible to their healing power (Dee & Fernandez, 2023). The process to become a WH is not a single step, but a unique journey that lasts throughout one's therapeutic practice (Hayes, 2002; Dee & Fernandez, 2023).

There are two models to explain what happens after becoming a WH: the model of trajectories and that of functional levels (Zerubavel & Wright, 2012; Graves, 2008). The trajectories model proposed by Zerubavel & Wright (2012) outlines the various potential possibilities that may be observed in each WH following the process that formed them into this specific WH. These trajectories can be explained by the nature of the wounds, as well as by each therapist's perception of their own wounds. For instance, if the wound is chronic, the perception and healing process differ than in the case of an acute wound. The four different trajectories are: recovery over time, post-traumatic trajectory, fluctuation between relapse and well-being, and dysfunctional trajectory where subjects anticipate future struggles.

Graves (2008) proposed the functional levels model, which suggests that each therapist will have a different level of functioning. They can be well-integrated, dysfunctional or still affected by their past wounds. The two last levels involve therapists working with patients while dealing with their own unresolved childhood traumas or past wounds.

In both models of post-process possibilities, reference is made to the WH who has not successfully completed the process in an optimal way to be able to care for people. These therapists are functioning as "walking wounded" (Christie & Jones, 2014, p. 28). Walking wounded healers are the therapists "who have experienced […] trauma in their lives that they have not dealt with, allowing alterations in their ability to cope with current stressors, leading to negative results" (Christie & Jones, 2014, p. 29). A stigmatic way to described them is to refer to theses therapists as "me-searcher" therapists (Victor et al., 2022, p.21), because they are looking in the therapeutic relation for the way to heal themselves (Victor et al., 2022). Several issues arise for the therapy when therapists are walking wounded. This may interfere with their abilities to relate with their colleagues or their private life, but also with the therapeutic process and relationship (Christe & Jones, 2014; Horwell, 2019; Zerubavel & Wright, 2012).

Concepts of Interest

In this section, we will introduce two important concepts that will enable us to address our research question: the concept of therapist self-disclosure and countertransference. The aforementioned concepts can be employed to develop a framework that elucidates the various factors that influence the therapeutic relationship between the WHs and their patients.

Self-disclosure

Therapist self-disclosure can be defined as an explicit declaration from the therapist to the patient about something personal that they have experienced (McDonald & Grau, 2019; Yeh & Hayes, 2011). The extent to which the therapist's communication can be considered self-disclosure (SD) is still a matter of contention. (McDonald & Grau, 2019). For some authors, the content of self-disclosure includes "facts about the therapist, feelings the therapist has had or is having, insights the therapist has gained from their personal experiences, or strategies the therapist has used to cope with situations similar to what the client is presenting" (Elliott & Ragsdale, 2020, p. 678). In other words, for some authors disclosures are considered as a common therapeutic tool, these include the spontaneous expression of emotions or feelings during the session (Byrne et al., 2022).

In therapeutic practice, there is a debate between psychoanalysts and therapists from other orientations regarding the use of SD. Some psychoanalysts do not recommend SD, as they believe it goes against the principles of self-awareness for the patient and the interpersonal changes that can be achieved through anonymity, equanimity, and the absence of speech. In contrast, therapists from other orientations are more open to SD as a therapeutic tool. These therapists tend to prioritize the human relationship through equality and trust (Bainbridge, 2022; Elliott & Ragsdale, 2020).

Countertransference

The concept of countertransference (CT) is not new. Its definition is very controversial and this concept has been gaining more interest from researchers in recent years (Yeh & Hayes, 2011; Lederman & Shefler, 2023).

Gelso and Hayes (2007) have suggested four different definition of CT. Each of them has its particularity: the classical, the totalistic, the complementary, and the integrative definition (Lederman & Shefler, 2023). The classical definition is based on Freud's work and is focused on the unconscious reaction of the therapists to their patients when the reactions come from unresolved wounds (Hayes, 2002; McHenry, 1994). The totalistic definition is based on all of the therapist's reaction that they might feel during the therapy session, be it anger, joy or any other emotion. This definition can be very useful both to get information about the patient and to investigate the treatment effectiveness (Hayes, 2002). The complementary definition is based on the way the relationship works between the therapists and their patients. This encompasses not only emotional factors but also the explicit or implicit inputs into the relationship. The integrative definition is the most used in research currently (Yeh & Hayes, 2011). According to this definition, CR refers to "the therapist's internal or external reactions

that are shaped by the therapist's past or present emotional conflicts and vulnerabilities" (Gelso & Hayes, 2007, p. 25). In other words, the integrative definition is based on the actualisation of past wounds.

In addition to Freud's definition of the unconscious, Jung defined it as the dialectic between the wounds of the therapist and the wounds of the patient. The collective unconscious is a powerful force that can transform both parties in the therapeutic relationship. During the process, the therapist is confronted with what the patient presents communication (Kron & Avny, 2003; Laskowski & Pellicore, 2002). This includes what they have experienced, both in their words and in their non-verbal communication.

CT can therefore be viewed as a valuable tool in the therapeutic relationship. It helps therapists reflect on their objectivity during the therapeutic process and avoid any possible interference caused by their own wounds (Cain 2000). CT also aids in better understanding the therapeutic relationship with the patient by allowing therapists to take a step back from what is brought to the sessions (Boston & Mount, 2006; McHenry, 1994). To conclude, CT is "the place where vulnerability and old wounds can come together to the benefit of the treating professional" (Amundson & Ross, 2016, p. 119).

American Psychological Association (APA)

The APA has given recommendations for when therapists are wounded (Bearse et al., 2013; McDonald & Grau, 2019). According to these guidelines, the "A principle" states that every therapist must be aware that their own mental health condition can influence their healing capacity (Bearse et al., 2013). Besides, the APA suggests that therapists stop practicing if their mental health can affect the quality of care they provide (McDonald & Grau, 2019).

Method

To construct a new framework that better explains the therapeutic relationship between a wounded healer and their client, we will use the method outlined by Tsiotsou et al. (2022), called Theory-Generating Literature Review (TGLR). This method aims to generate a new perspective on a specific topic through a literature review. To ensure accuracy, we will follow the guidelines specified in their methodological paper.

As explained by Tsiotsou et al., (2022), the use of TGLR must be based on the researcher's desire to reconsider the way in which a specific subject or phenomenon is described in the literature. This method is based on the "Triple-A framework" described by Kabadavi & Tsiotsou (2022, p. 866) as an Authentic, Advancing and Applicable work. The characteristic of authenticity is applied with the aim of providing the most objective possible

account of the phenomenon being studied. This method also attempts to be as progressive as possible in understanding the phenomenon from a theoretical point of view. Finally, this method aims to complement theoretical research by providing results that can be applied in the field (Kabadavi & Tsiotsou, 2022). In other words, we can be defined this method as "activities of conceiving and constructing out of the phenomenal world—as represented in the review data—with extant theory to inform subsequent work" (Hoon & Baluch, 2019, p. 1246).

The TGLR Method

In the present study, the TGLR method has been implemented following the guidelines by Tsiotsou et al. (2022), which include seven principal steps. The initial stage of this methodology entails an examination of the existing literature on the subject matter in question. This is followed by a clarification of the research question, which is informed by the findings of the preceding literature search. The subsequent stages of the methodology focus on the review of literature itself, as well as its description. The fifth stage allows for consideration of the manner in which the literature will be presented in the paper. The subsequent stages, namely the sixth and seventh, are concerned with the methodology of developing a novel theoretical approach through the work conducted in the preceding stages.

To initiate this review, we have specified and considered the maturity level of the research field based on our previous reading of this area of investigation. We determined a medium level of maturity of our subject aera because of two main points. First, the lack of a review that associates the impact of the SD and the CT to understand the relationship between WHs and their patients. Moreover, the literature is very specific on some concepts (e.g. focusing on process of becoming a WH (Dee & Fernandez, 2023) but seems to forget the integration of the different concepts that we have highlighted in this review.

The second step is closely related to the first one. Here, we must define and consider the questions that will guide our reflections on the research topic. In this review, the initial question concerned the relationship between the wounded healer and their patients. After exploring the literature, several further questions arose. The most important of them was about the implications of the SD of the past wounds for the WHs in their clinical practice; the impact of the CT in this dialectic relationship between WHs and their patients and as a main purpose; the impact of the interaction of these two concepts on the therapeutic relationship.

The TGLR method does not prescribe a specific literature review method. Depending on our goals or limitations, we can choose the review method that best fits according to the needs (Tsiotsou & al., 2022). In our case, we have used the narrative review method. As explained by Nambiema et al. (2021), the narrative review is useful for gaining a

comprehensive understanding of a research topic, both for summarizing the existing knowledge and for identifying potential gaps or contradictions. Additionally, this method is well-suited to the scope of our research question, which would not have been feasible with a systematic review. In contrast to a literature review, a narrative review permits the formulation of a question that is often broad and not focused on a single specific concept.

Although, in accordance with the conventions of the field, the narrative review does not require an explanation of the protocol and research strategies employed (Nambiena et al., 2021), we will nevertheless develop this aspect of the review in order to minimise the potential for bias inherent to narrative reviews (Grant & Booth, 2009).

To begin our research, we have selected key words to use in our search strings. These words have been separated into three categories: the patient, the wounded healer, and the concepts related to their interaction. For the patient category, we have used the key words "patient" and "client". For the category of WHs, we have selected the terms "wounded healer", "therapist", and "psychologist". For the interaction, we have chosen the terms "relation", "alliance", "process", "match", and "transference".

Then, to order to maximize our search results, we have created different research strings after several trials and errors tests on each database. On the APA PsychArticles database, the research string (Patient OR Client) AND Wounded Healer AND ("Relation" OR Alliance OR "process" OR "Match" or "Transference") yielded 170 articles. In PubMed, the research string (Patient OR Client) AND Wounded Healer yielded 213 articles. In Scopus, the research string (Patient OR Client) AND (Wounded Healer OR "therapist" OR "psychologist") AND ("Relation" OR "Process" OR alliance OR "match" OR "transference") yielded 68 articles in this database. Appendix 1 summarizes the process in lines with the guidelines of the PRISMA convention (Page et al., 2021).

After completing the initial step of the identification, the total number of papers was 451. During the pre-screening phase, 28 papers were deleted. Of these, 26 were double entries, one was a retracted paper, and the last one was not a peer-reviewed article. After the pre-screening, 423 articles were selected

Then, we have launched the Screening phase which is divided into two distinct phases: the title and abstract screening and the full-text screening. We used the software Ryyan for this process.

The title and abstract phase enabled us to categorize the papers into three different statuses: included, excluded or undecided. To be included, the title or abstract had to contain the wounded healer concept and to be either in French or in English. The "undecided" category

was used for articles whose certainty could not be established without reading the entire text or for those where the concept of WH was not clearly identified. After screening the titles and abstracts, 274 papers were excluded, 79 were categorized as undecided and 70 were included.

The full text phase only included the papers that were categorized as decided or undecided. In total, 149 articles were analysed in this phase. To be included in the narrative review, the full text had to clearly mention the wounded healer concept and describe the interaction between a wounded healer and their patient or client. Papers that did not provide information relevant to our research question, were not accessible in full text, or were not in French or English, were excluded. At the conclusion of the screening phase, 56 articles were deemed eligible for inclusion, while 93 were excluded.

Before synthesizing our results in a new framework, we must select a method to present the literature. We will cross-reference our sources to group our concepts into different categories, providing a better global view of our research topic.

In the sixth step, the research question needs to be reconsidered in light of the level of maturity. In the seventh step, a "consistency model" (Tsiotsou et al., 2022) must be selected to construct the new framework. The consistency model consists of trying to match the review to the level of evolution of the literature in order to best highlight the results (Durach et al., 2021).

As we have defined our subject with a medium level of maturity, we must choose which gap to fill in the literature. For this paper, we have chosen to answer the question of "what". As a reminder, our research question can be formulated as "what are the concepts which influence the therapeutic relationship between WHs and their patients".

We have chosen as consistency model the "interpretive model". This model has been selected because it can fit with all levels of maturity but also because it is the continuity of the consistency model. The main objective of this model is to try to make sense of the information and to focus on specific concepts to address particular points rather than the phenomenon as a whole (Tsiotsou et al., 2022).

Results

Wounded healers

The findings of this research will be presented in the form of different visual and theoretical frameworks, which will illustrate the results of the review. The presentation will commence with an analysis of the impact of the presence of WHs in the therapeutic relationship. This will be followed by an examination of the use of therapeutic tools, such as the use of SD or CT for understanding the therapeutic relationship.

Therapeutic Principles

It is important to understand that the therapeutic power of WHs draw upon the individual's intrinsic resources. As healers, they are the method for healing (Kirmayer, 2003). The process of becoming a WH is the starting point for developing professional skills and understanding the healing process. The struggle against one's own wounds is key to unlocking the healing power (McDonald & Grau, 2019; Goldberg et al., 2015; Wheeler, 2007). The therapeutic relationship with others is enabled through the use of one's own wounded and reconstructed personality. This same personality serves as the main therapeutic tool for building a successful therapeutic process (Safi et al. 2017; Rober, 2021). Wounds from the past enable WHs to provide a better care for their patients. Understanding the source of therapeutic power is not only for the information about the recovery process but also an ethical duty to minimize risks during therapy (Horwell, 2019). Recognizing the therapist's vulnerability can reveal the patient's power to care, establish an engaging therapeutic relationship with the patient, with the aim of fostering a sense of mutual connection (Kirmayer, 2003).

Although understanding the role of a WH is essential to understand therapeutic techniques for the healing process, it is just as important to consider other postures in the workplace. Radical listening is a therapeutic posture in which the practitioner listens to everything the patient expresses, both in words and in what is left unsaid (Weingarten, 2010). This approach emphasizes the importance of silence as well as language in understanding the patient's inner world. Patients feel deeply heard when they communicate what makes sense to them (Weingarten, 2010). Radical listening can be a lever for both the internal elaboration of hypotheses and for the mean-making or in-depth comprehension of the inner world of the patients (Hayes, 2002).

Furthermore, as pointed out by Mitchell (2000), therapeutic neutrality has often been criticized for being illusory. This is particularly relevant in the therapeutic practice of WHs. While neutrality may be a desirable therapeutic skill for therapists to strive towards, it is important to remember that practitioners are also human beings who are affected by and can affect any relationship. Therapists often question themselves and can grow both as caregivers and human beings due to their adaptability. The different evolutions they undergo during their therapeutic work can lead to an improvement in their care skills and understanding of their own internal processes during sessions (Horwell, 2019).

On the one hand, it is important for WHs to adopt a therapeutic posture and avoid having any preconceived ideas about what the patient will bring to therapy (Weingarten, 2010). These preconceived ideas may arise from personal experiences or from impersonal sources such as

university courses or readings (Hayes, 2002). Regarding the relationship between WHs and their patients, it is important for therapists to acknowledge their patient's unique experiences of their illness, while also applying the knowledge acquired during their own training (Barnett, 2007). However, in the case of WHs, implicit knowledge about the healing process can be a relevant factor in care. As stated by Stern (2002), "the expansion of implicit knowledge about the therapeutic relationship that becomes intersubjectivity shared between patient and therapist is a potent mechanism for therapeutic change" (p. 12). On the other hand, patients should approach therapy with an open mind and avoid solely focusing on the negative aspects of their personality. This positive approach can aid in rediscovering their true selves (Weingarten, 2010). In sum, the therapeutic relationship between WHs and their patients is a relation where the two parts "welcomes the unexpected and sometimes the unwanted" (Ingram, 2015, p. 146).

Thanks to these different postures and techniques, the two parties can create a stronger and more durable therapeutic relationship (Weingarten, 2010). This could be explained by the process of becoming a WH, which helps practitioners become more involved in the struggle against the mental health problems of their patients. Thus, the therapeutic relationship is engaging for both parties (Sedgwick, 1997). According to Horwell (2019), the strength of a therapeutic relationship may be explained by mirrors neurons. These have an effect on the empathy level and might help the WHs to have a better understanding of their patients regarding what they are going through emotionally and physically. This capacity for understanding is called "embodied simulation" and described as the "functional mechanism of intersubjectivity whereby the actions, emotions, and sensations of others are mapped by the same neural mechanisms that are usually activated when we experience something similar" (Horwell, 2019, p. 155-156).

During the healing process, both the therapist and the patient will change. The healer will learn and grow as a practitioner thanks to the interpersonal relation, while the patient will have a better understanding of themselves (Cvetovac & Adame, 2017; Stone, 2008). Jung (1963) defined therapy as a transformative process for both parties involved. This description aligns with the concept of interrelation, which states "that therapeutic change occurs for both the therapist and the client" (Horwell, 2019, p. 152). This concept explains the interaction processes between parties and how shared pasts can serve as a therapeutic lever. The dialogue between the patient and therapist creates a connection between them, called the "relational unconscious" (Gerson, 2004, p.65)

Therapeutic Implications

The relationship between WHs and their patients has both positive and negative implications for the therapeutic process. On the positive side, three main clusters can be identified: the therapeutic relationship itself, the relationship with the illness, and a particular capacity for empathy offered by the WHs. The advantages mentioned must be viewed in the context of the therapeutic relationship with a WH. WH's own experiences can aid patients in comprehending the significance and purpose of their own distressing experiences (Ladds et al., 2021; Morishita et al., 2020; Boston & Mount., 2006; Christie & Jones, 2014).

Therapeutic Relationship

Power Redistribution. The redistribution of power is taking place on both the therapeutic and institutional levels. Salzer (2022) has noted that patients working with WHs are less frequently victims of institutional injustice or stigmatization because, having experienced it themselves, WHs do their best to avoid passing it on to their patients. On a more therapeutic note, working with WHs promotes intervention and the creation of the "inner healer" (Kirmayer, 2003, p. 251). This process arises from the initiatory journey of the WHs and is used to help patients become more autonomous in their daily lives. This can be achieved through the use of strategies for managing stressful periods (Zerubavel & Wright, 2012; Salzer, 2022). In summary, the distribution of powers in the therapeutic relationship between WHs and their patients allows for a meeting between two individuals who share a common experience of injury. This relationship allows for a step back from the traditional roles of caregiver and patient (Callahan & Dittloff, 2007).

Relationship with Patients. WHs have the ability to establish a positive therapeutic relationship with their patients (Christie & Jones, 2014), regardless of their age (Ceconi & Urdang, 1994). This may be due to their increased involvement in the patient's care, stemming from their life experiences (Piredda et al., 2022). Furthermore, this involvement allows a better communication and understanding of the patient's care pathway (Morishita et al., 2020; Horwell, 2019).

The connection with the client may be explained by recognition of the difficulties encountered by the patients. Theses difficulties will be accepted as part of the care process (Cvetovac & Adame, 2017). The best understanding of patients also comes in part from identification with one's own care journey. Identification allows greater changes in the therapeutic relationship (Piredda et al., 2022), and when the identification between the WH and the patient is strong, it can improve "the relationship, the alliance, and the healing" (Cain, 2000, p. 25). More than this, the understanding of the healing process allowed the patients to relieve

some of the pressure of being “sick” and what that entails (Morishita et al., 2020). For WHs, their pasts wounds are a lever for a better understanding of the phenomenological feelings of both patients and their families (Callahan & Dittloff, 2007; Piredda et al., 2022).

Relation to the Illness

When patients meet with WHs in therapy and a well-established therapeutic relationship is present, they can be inspired by them. WHs can serve as a model of recovery for their patients (Boyd et al., 2016; Ceconi & Urdang, 1994). These models produce several inner recovery levers such as “ability to mobilize self-care, optimism about recovery, and focus on posttraumatic growth” (Boyd et al., 2016, p. 611). In addition, working with WHs can help to minimize the “clinician’s illusion” which can be defined as “a phenomenon in which providers naturally become unduly pessimistic about prognosis because of spending a disproportionate amount of their time with the most acute and most chronic cases” (Boyd et al., 2016, p. 610).

In addition to embodying a model of healing, WHs assist patients in coping with their illness. This is achieved through communication, where the WH helps the patient express the difficulties they face during their care process (Kirmayer, 2003). If the relationship allows for exchanges where there is no longer a dichotomy between the caregiver and the patient, but rather a relationship between two people facing the illness, then there can be a discussion on how to manage the emotions provoked by the unknown nature of illness (Dee & Fernandez, 2023; Cvetovac & Adame, 2017; Boston & Mount, 2006).

Care Capacities

Empathy. Empathy can be defined as the capacity 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” (Rodgers, 1975, p. 2). Empathic skills are developed in WHs during the process of becoming a WH. During this process, they learn how to step back from what they have experienced and how this affects their daily work. The aim is to provide better care for their patients (Elliott & Ragsdale, 2020). In this way, WH’s empathy comes from the problems that led them to become mental health workers in the first place (Elliott & Guy, 1993). Subsequently, empathy is created during therapy with their patients thanks to their past learning (Dee & Fernandez, 2023), but also thanks to the contact they will keep with their past wounds. It is the experience of their past wounds that will promote empathic engagement (Kirmayer, 2003; Bearse et al., 2013).

In the therapeutic relationship between WHs and their patients, empathy serves different functions. It allows practitioners to assist patients in accepting their difficulties during the

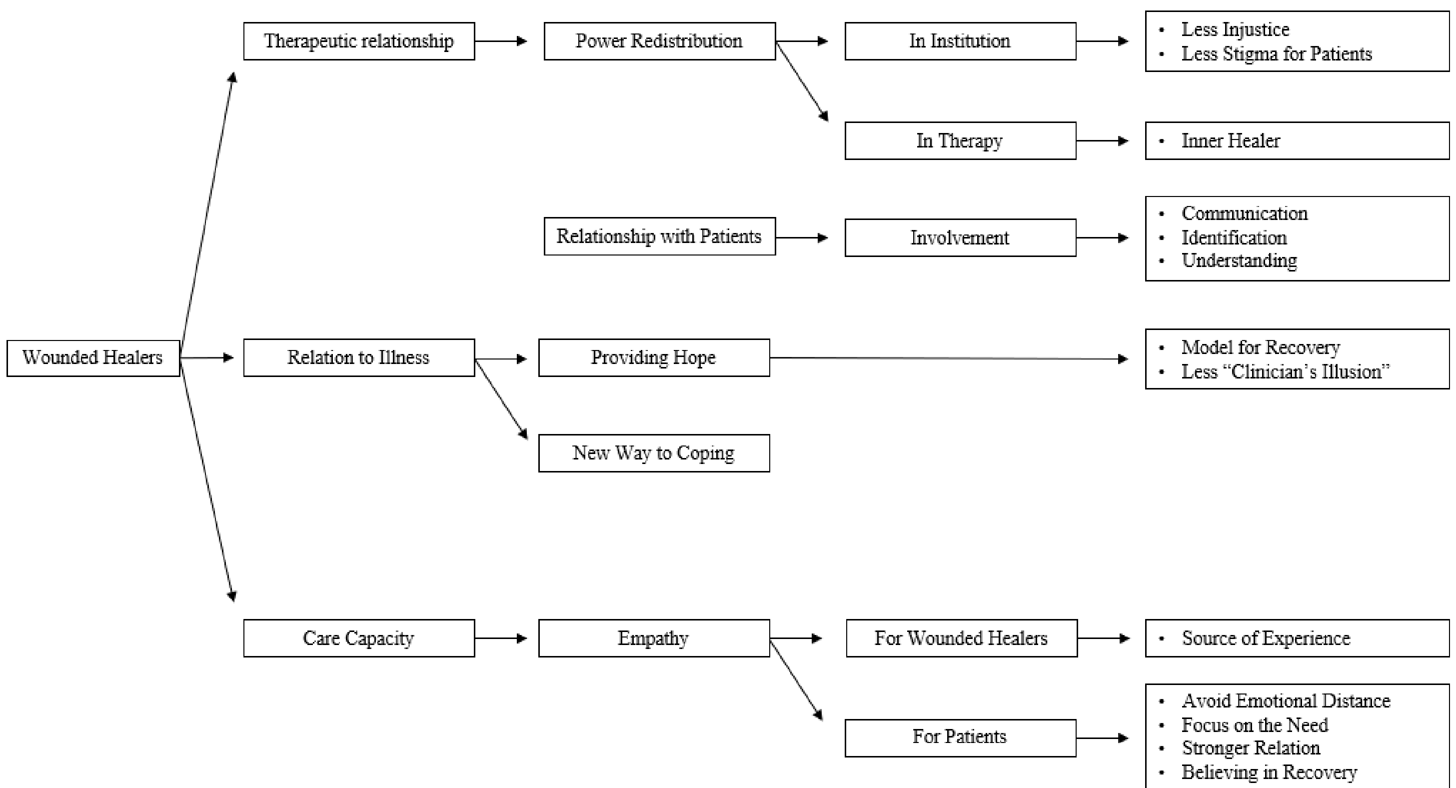
therapeutic process (Comas-Diaz & Padilla, 1990). Additionally, empathy serves as a supplementary vocational force for WHs (Elliott & Ragsdale, 2020).

Empathy has several positive impacts on the therapeutic process when working with WHs. It helps them to use their experiences as a tool to bounce back from different challenging situations (Hayes, 2002). Additionally, according to the experience of a healthcare professional from the case study by Ceconi and Urdang (1994), empathy aids in spotting patients' defensive mechanisms. Empathy is a valuable tool for building a strong relationship with patients and avoiding emotional distance in Western medicine (Morishita et al., 2020). It also enables a greater focus on the needs of patients during the healing process (Piredda et al., 2022). Empathy can lead to a relationship with less stigmatization of the illness and a stronger bond that allows for more patience in the care process (Cvetovac & Adame, 2017; Salzer, 2022; Victor et al., 2022). In sum, empathy is a fundamental aspect of any therapist who would like to cultivate caring qualities. (Morishita et al., 2020).

Figure 1 summarises the positive therapeutic advantages of the relationship between a WH and a patient.

Figure 1

The Advantages of WHs in Therapeutic Relationship



On the negative side, the therapeutic relation between WHs and their patients can be explained in terms of risks, with regards the possibility of the negative influence of the wounds from the WH's past on its therapeutic power. Indeed, we have to distinguish WHs from non-competent therapists. The lack of professional competences, in this context, refers to the negative impacts of the personal live of the practitioner on the therapeutic relationship (McDonald & Grau, 2019). This section divides risks into two main groups: risks associated with therapeutic work that could affect the therapeutic power of WHs, and risks in the therapeutic process caused by the presence of a WH in the relationship.

Personal Risks

Past Wounds. This risk can arise when WHs are not sufficiently aware of the impact their past wounds can have on their therapeutic power. In other words, it can happen when the WH does not take sufficient distance from their own feelings (Corso, 2012). In addition, Cain (2000) has shown that the fluctuations of the mental health of the therapist can impact the therapeutic relationship. The main risks are a feeling of vulnerability in relation to others, empathic fatigue in understanding the suffering of others, leading to reduced tolerance of others, and ambiguous deals with possible trigger issues (McDonald & Grau, 2019). Furthermore, the recognition of past wounds by WHs also affects their therapeutic ability. Kirmayer (2003) demonstrated that denying the caregiver's own injured part has a negative impact on their therapeutic power. This will result in a false and limited therapeutic encounter. Boston & Mount (2006) support this by showing that being aware of one's own limitations is a therapeutic key for WHs.

Personal Life. The daily work of care workers can have a negative impact on their personal lives, which in turn can increase potential risks in their therapeutic work. Neglecting their own psychological and physical needs can lead to various risks associated with their profession (Zerubavel & Wright, 2012). Neglecting the responsibilities involved in the care process can increase the risk of therapeutic disconnection with patients due to impatience, negligence, or impaired concentration (Horwell, 2019; Cvetovac & Adame, 2017).

A WH in the relationship

Failure in the Process to Becoming a WH. The process of becoming a WH is of significant importance in the context of the therapeutic healing power of the therapist. Christie and Jones (2014) found that unresolved past traumas can negatively affect the therapists' abilities to empathise with their patients. For instance, if therapists have not properly addressed their pathological bereavements, patients may perceive them as less empathetic (O'Brien, 2011). More than this, Barnett (2007) suggests that individuals with unresolved narcissistic issues may

have a strong desire to become exceptional practitioners. However, this desire is not primarily to help others, but rather to create an ideal image of themselves as a defence mechanism against their own limitations. This self-constructed barrier can cause the therapist to dominate the therapeutic relationship, limiting the space for therapeutic elaboration.

Motivation for Healing. Eliott and Guy (1993) argued that people who became caregivers with the aim of treating or learning to live with their own disorders had lower therapeutic power than those who have a motivation external to heal people. Twenty years later, Bearse et al. (2013) also demonstrated that therapists who had external motivations to become caregivers increased the possibility of having a risky therapeutic relationship. To illustrate, Barnett (2007, p. 261) describes the phenomenon of the "Dedicated Physician". This phenomenon occurs when the desire to care for others is motivated by the image it will reflect back on the caregiver. Therefore, the primary objective in the caregiver-patient relationship is for the caregiver to nourish their self-image. This phenomenon is particularly prevalent among children who had to care for their parents during childhood. By putting their parents' needs ahead of their own, these children can experience difficulties. If this issue is well managed during therapy or treatment, it could allow access to the role of WH and the therapeutic advantages previously mentioned. Otherwise, a sense of guilt may arise if therapy is unsuccessful:

> "we found it difficult to distinguish what was in the service of the client and what was in service of ourselves. When taught in an academic setting, this process appears to be much more straightforward, but in practice, it is hard to see the line at which serving the client crosses over to overworking as a coping method" *(McDonald & Grau, 2019, p. 170)*

Relationship Between WHs and Patients. The primary risk in the therapeutic relationship between WHs and their patients is the possibility that the WH may become preoccupied with their own past wounds, causing them to lose focus on the present moment of the relationship. This duality is illustrated between the wounds expressed in the present moment by the patient and the wounds from the past that are part of the WH's inner world (McDonald & Grau, 2019). Some therapists may struggle during therapy sessions with memories of their own past resurfacing. This creates a duality between the therapist's role as a caregiver and their identification with the patient (Cvetovac & Adame, 2017). In relation to the phenomenon of over-identification, Kron and Avny (2003) explain that the relation of duality between the patient and the WH can create more harm than good in the care process. If this duality is too

pronounced, the WH may end up projecting their wounds onto the patient, leading to a role reversal. If a WH denies their past wounds, they increase the risk of projecting them onto their patient, which can reduce their therapeutic power (Garti & Bat, 2019). Therefore, it is important for the WH to be cautious about overidentification and avoid projecting their issues onto their patient (Zerubavel & Wright, 2012).

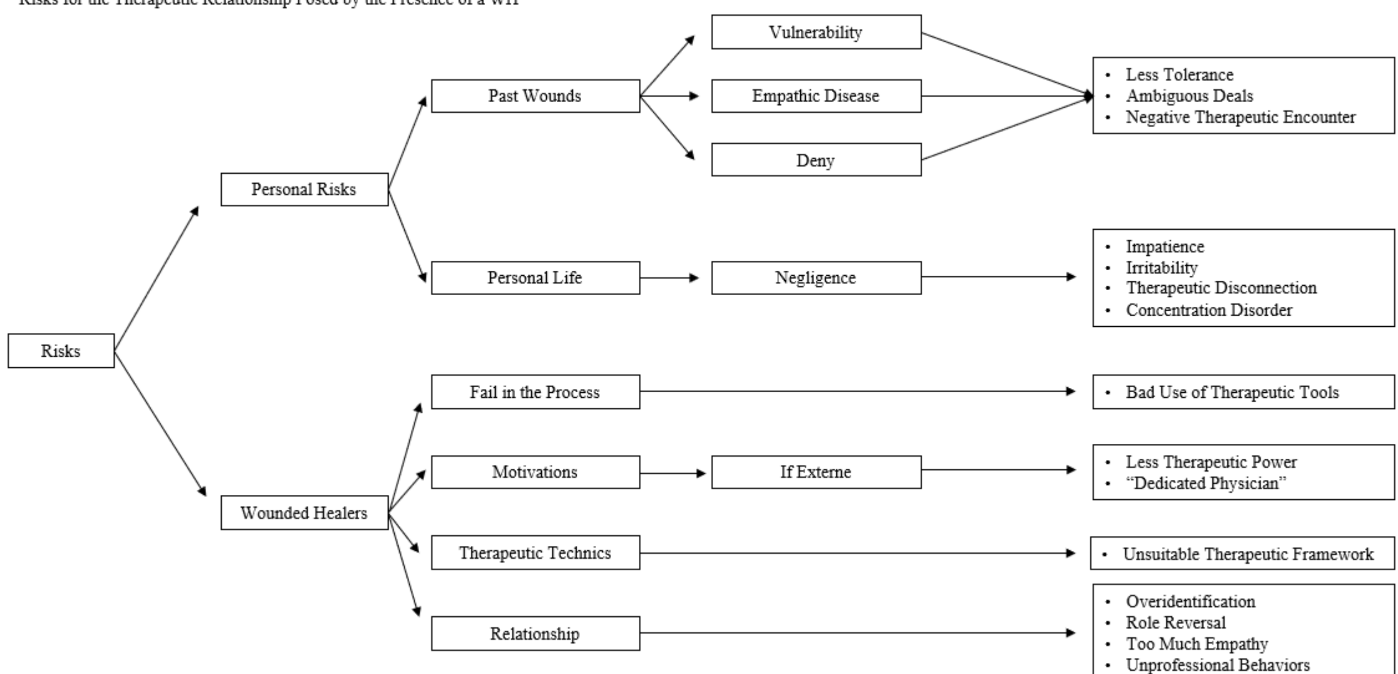
There are additional risks to the therapeutic relationship beyond projection or over-identification (Niven, 2008). Firstly, there is an increased risk of excessive and misplaced empathy (Hayes, 2002). Working with vulnerable individuals can mirror our own experiences, leading to an overflow of empathy and over-identification with patients (Kirmayer, 2003). Excessive empathy can lead to unprofessional behaviour, such as an uncontrollable desire to become friends with patients (O'Brien, 2011), or adopting a paternalistic stance by treating the patient based on the WH's personal journey rather than their own needs (Kron & Avny, 2003).

Therapeutical Techniques. Due to certain issues related to the therapeutic process, such as concerns about self-image as a therapist or identification with patients (Horwell, 2019), some therapists struggle with establishing and maintaining the therapeutic framework. Barnett (2007) explains this by outlining two opposing problems within the therapeutic framework. Some therapists may choose to end therapeutic work earlier than planned due to fear of identification with patients, while others may prolong therapies indefinitely to consolidate their self-image.

Figure 2 represents the risks of the presence of a WH in the relationship which could have a negative impact on the therapeutic process.

Figure 2

Risks for the Therapeutic Relationship Posed by the Presence of a WH



Self-Disclosure

Providing insight into a WH's self-disclosure (SD) of past wounds can be useful for two main reasons: firstly, to evaluate the advantages and disadvantages of using this therapeutic tool for therapists, and secondly, to avoid the contradiction of accepting patients as both strong and weak, while denying this same duality to therapists. (Dee & Fernandez, 2023).

Therapeutic Implications

As with the presence of a WH in the therapeutic relationship, the use of SD as a therapeutic tool can have a positive or negative impact on the healing process. The advantages of using self-disclosure can be grouped into two categories: creating and maintaining the relationship and practical benefits.

Therapeutic Relationship. The optimal approach to utilising SD as a therapeutic tool involves discussing it at an appropriate time, rather than introducing it at the beginning of the interview. The disclosure need not be centred around a deeply personal topic; sharing casual information may suffice (Bainbridge, 2022). The use of SD can be effective in creating and maintaining a therapeutic relationship. This is because it helps the patient to perceive the therapist as a human being. SD can humanize the caregiver by conveying to patients qualities such as sincerity, agreeableness, and warmth (Moody et al., 2021). The use of SD and the perception of human qualities that results from it allow the patient to see themselves as something other than a client received by a detached practitioner who sees them only as an appointment (Bainbridge, 2022), but also allows for a deeper connection between the therapist and patient. Furthermore, therapists who use SD are perceived by patients as more competent than those who do not use this tool. (Moody et al., 2021).

As previously mentioned, the use of SD can help to establish a stronger therapeutic relationship (Moody et al., 2021) and promote more equal power dynamics between the caregiver and patient (Bainbridge, 2022). This can lead to the exploration of new perspectives in patient care, ultimately increasing the patient's hope for recovery (Bainbridge, 2022; Cvetovac & Adame, 2017; Moody et al., 2021). This redistribution of power between the caregiver and the patient will help them to improve their inner healer (Zerubavel & Wright, 2012). The authenticity of the relationship may explain this stronger connection (McDonald, & Grau, 2019).

The use of the SD also helps to maintain the therapeutic alliance. When they are using SD, therapists can maintain the therapeutic alliance by listening to and validating the subjective experience of the patient (McDonald, & Grau, 2019). According to a meta-analysis conducted

by Henretty et al. (2014), therapists who used SD were less likely to have patients drop out of therapy compared to those who did not.

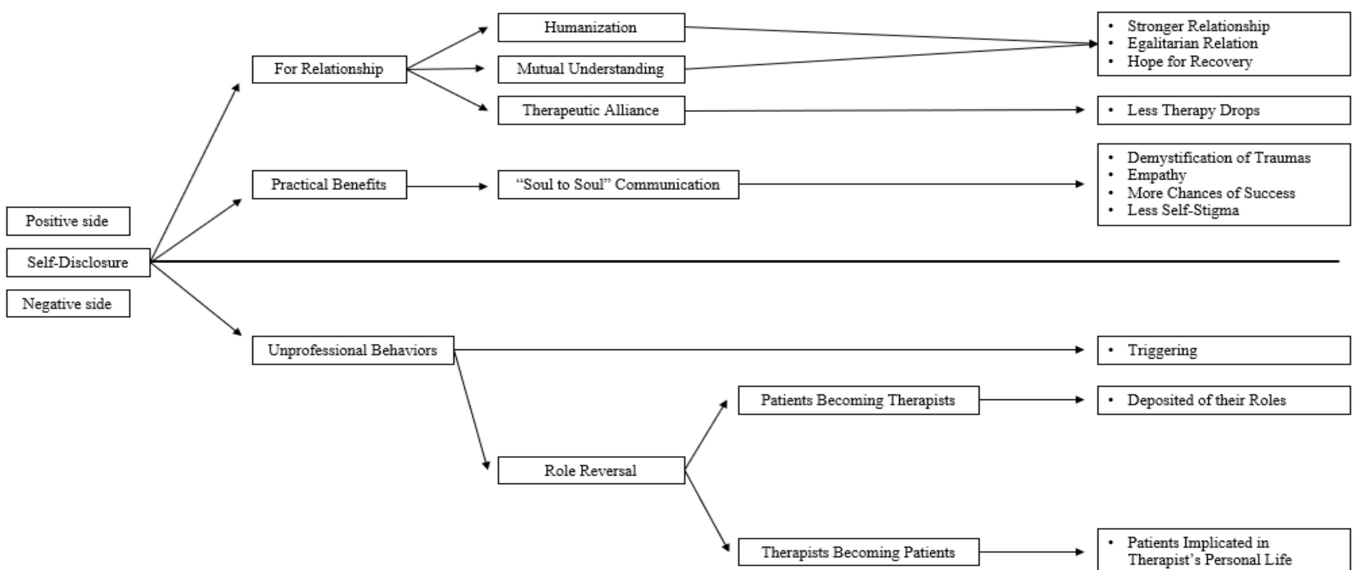
Practical Benefits. SD can offer therapeutic benefits through "soul to soul" communication between therapist and patient (Bainbridge, 2022, p. 1094). This type of communication can increase empathy (Elliott & Ragsdale, 2020; Horwell, 2019) and reduce self-stigma for the patients (Victor et al., 2022). Sharing personal information can also help to demystify traumas and aid in the patient's integration of their effects (Bainbridge, 2022). The self-disclosure tool has the potential to enhance the success of care and improve patient outcomes (Elliott & Ragsdale, 2020).

Therapeutic Risks. The use of SD in therapy also carries risks that may harm the therapeutic relationship. Firstly, it may cause the therapist to appear unprofessional or display attitudes that are not appropriate for the situation (Moody et al., 2021). In fact, as noted by Zerubavel & Wright (2012), some patients prefer not to know anything about their therapist. Secondly, SD may lead to a risk of role reversal between the therapist and patient (Moody et al., 2021). SD by the patient can lead to the therapist becoming too involved in the patient's personal history or, conversely, the therapist becoming at once carer and cared for. Both scenarios pose a risk of psychological harm to the patient. Additionally, there is a risk of triggering the patient (Dee & Fernandez, 2023). The therapist may have inadvertently harmed the patient by addressing a sensitive topic too directly while attempting to provide treatment.

Figure 3 illustrates both the advantages and disadvantages or risks of using SD in therapy. The upper part of the diagram illustrates the advantages of using SD in both the

Figure 3

The Advantages and Disadvantages of Using SD in Therapy



relationship and the therapeutic process. The lower part is reserved for the disadvantages or risks associated with the use of SD.

Countertransference

Countertransference (CT) is the second therapeutic concept that emerges in the literature to understand the relationship between WHs and their patients. Cain (2000) defines CT as an inevitable force and concept in the therapeutic relationship, with potentially positive effects. Kron and Avny (2003) add that this invisible force is bilateral between the two parties in the relationship because it involves and impacts everyone. Furthermore, Deak (2019) suggests that this force can even extend beyond the therapeutic relationship to impact one's personal life.

Jung (1953) developed a theory of CT. According to him, a therapist will always develop both a conscious and unconscious response to their patients. The latter response is known as CT and can be beneficial in the therapeutic process if the therapist has sufficiently dealt with their past wounds. Later, Jung extended his theoretical treatment of CT by defining it as the locus for the growth of projections from the different parties in the relationship (Jung, 1966).

Post-Jungian analysts proposed a new theoretical framework for understanding CT and its consequences. According to them, CT is no longer found in the relationship itself, but rather in the unconscious of each individual. This new therapeutic site is defined as a third person in the relationship, who has their own importance (Deak, 2019). This evolution is a continuation of "what Jungian analysts call the analytic container, temenos, or alchemical vessel that is cocreated by the analyst and patient who mutually become involved in the process" (Deak, 2019, p. 334

The content of CT generally pertains to the therapist's relationship with the patient. However, Cain (2000) notes that in the case of the WHs, it arises from their own experience of the therapeutic process. The content of CT can be classified into four categories, all of which involve the therapist's relationship with the patient and how the patient reminds them of their own experience. The four categories are: "concerns about hospitalization of clients, comparison of therapist with client, identification with clients, and over identification with clients" (Cain, 2000, p. 24).

There are several conditions for the use of CT among WHs to be as optimized as possible with the aim of improving the therapeutic process of their patients. Firstly, the WH must be aware of their own limitations induced by the illness (McDonald & Grau, 2019), so they must work on themselves daily in order to prevent this from interfering unfavourably with

the patient's care process (Comas-Diaz & Padilla, 1990; Cvetovac & Adame, 2017). Kron & Avny (2003) even add that the WHs cannot do good therapeutic work if they do not have enough perspective on themselves. Then, the WHs must be involved in the therapeutic relationship. Indeed, there is no possibility of working with CT if the therapists are not involved in the therapeutic dialectic (Laskowski & Pellicore, 2002). However, we must not forget that CT is something deeply personal (Sedgwick, 1997). The difficulty for WHs could therefore be juggling the personal and the interpersonal in understanding the relationship.

"In practice, however, this ideal is impossible to attain due to the fact that there is always an ongoing dynamic interchange between two or more people. The therapist is both observer and participant (Sullivan, 1953), and both the influencer and the influenced. […] The patient reacts to the therapist by interpreting numerous verbal and nonverbal communications in terms of their personal view of self and others. The therapist in turn does the same with the patient. […]. Both members of the dyad react to and influence the feelings, thoughts, wishes, projections, defenses, fantasied selves, and real selves of the other." (McHenri, 1994, pp. 557-558).

Therapeutic Implications

As with the use of SD, the concept of CT can also have advantages or disadvantages for the patient, the therapist, or the therapeutic relationship.

Advantages. To start, let us examine the benefits of utilising CT as a therapeutic concept. We will explore the advantages for both the patient and their care process, as well as for the healthcare professional in their daily practice.

The use of CT among WHs has primary advantages in reducing patient stigmatization and increasing empathy levels in the therapeutic relationship (Cain, 2000; McDonald & Grau, 2019; Yeh & Hayes, 2011). These benefits can be attributed to the experiences and past of WHs before becoming therapists (Garti & Bat, 2019; Zerubavel & Wright, 2012). The process of becoming a WH can "facilitate the development of empathy" (Comas-Diaz & Padilla, 1990, p. 128). The use of CT can facilitate mutual understanding between WHs and their patients. This deeper understanding can come from the journey of becoming a WH, where using their own stories becomes an asset in understanding what patients go through during the care process (Cain, 2000; Yeh & Hayes, 2011). In addition to empathy and mutual understanding, this therapeutic concept enables better identification with the inner world of patients. The process

of becoming a WH once again plays a role because it allows us to better understand what is at stake for patients when they require treatment (Garti & Bat, 2019; Cain, 2000). Empathy, reduced stigma, better understanding, and improved identification can all play a role in the patient care process. This can also enhance the therapeutic relationship between healthcare professionals and their patients. Firstly, it can improve the connection and sensitivity between the two parties (Cain, 2000; Boston, & Mount, 2006). Secondly, it can offer patients more hope of recovery (Cain, 2000; Yeh & Hayes, 2011).

For WHs as subjects, the use of CT can also have advantages. According to Cain (2000), this allows them to gain more self-awareness and increase their perspectives on themselves and their illness, ultimately enhancing their therapeutic abilities. Furthermore, therapists who regularly take on both the role of carer and caregiver have better control over the therapeutic framework and can test it from both perspectives. This dual role also provides them with the opportunity to reflect on their therapeutic practice.

Disadvantages. The use of CT in a therapeutic relation with WHs can have disadvantages, particularly when WHs have not properly followed the process of becoming WHs and are therefore more likely to struggle with their own past wounds. This can become apparent when WHs are faced with their own wounds in their patients, especially when treating patients with ailments that the WHs themselves have suffered from in the past (Dee & Fernandez, 2023; Cvetovac & Adame, 2017). Yeh and Hayes (2011) refer to classic psychoanalytic theories, in which CT can block the therapeutic process due to the therapist's reaction to their own neuroses. The objective of the WHs is to reflect on what the relationship puts at stake for them, in order to protect themselves from negative effects and advance the therapeutic process (Boston, & Mount, 2006).

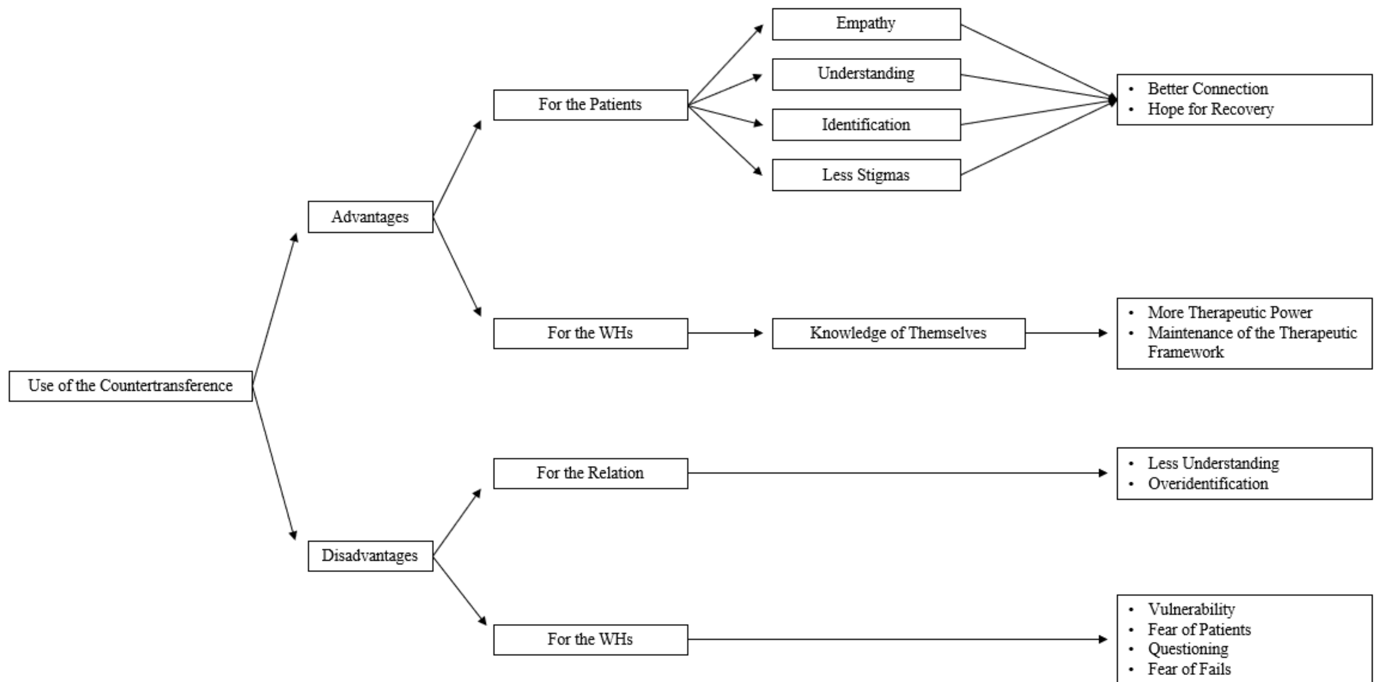
The main therapeutic disadvantage is the risk of over-identification with patients. Over-identification with patients can lead to a reduction in the patient's understanding of their inner self because the WH would project too much into the other's story (Cvetovac & Adame, 2017). It could also lead to a reduction in the dialectical relationship between the WH and their patients, creating a relationship in which the therapist feeds on the wounds of others in constructing their role as WH (Dee & Fernandez, 2023). Another therapeutic disadvantage would be the risk of overstepping boundaries and frameworks by projecting onto patients (McDonald & Grau, 2019; Zerubavel & Wright, 2012).

On a personal level, the use of CT could lead to reactions in WHs such as feelings of vulnerability, fear of others, questioning the ambivalence of their role as carer, and fear of failure (Comas-Diaz & Padilla, 1990).

Figure 4 presents a visual representation of the advantages and disadvantages of using the CT as a therapeutic concept by WHs. The benefits and drawbacks are relevant to the care process, the patient, and the WH themselves, as their experience can also impact their healing power.

Figure 4

The Advantages and Disadvantages of Using Countertransference in a Therapeutic Relationship with a WH



Discussion

The findings of our review have enabled us to achieve two of our original objectives: a more comprehensive theoretical understanding of the therapeutic relationship between WHs and their patients, and the creation of diverse visual representations to facilitate an enhanced comprehension of the manner in which these concepts influence the therapeutic process.

Firstly, with regard to theoretical understanding, it was established that WHs could bring therapeutic advantages to the care process. In the course of our literature review, we identified a number of results which could have a positive impact on the process. In particular, we found that the redistribution of power between patient and carer could have a significant effect on the way patients cope with illness. For instance, this could be evidenced by the WH facilitating the acquisition of novel insights regarding the nature of their wounds or instilling in them the prospect of a cure. Finally, we noted during this review that empathy skills would be strengthened in the WHs, thanks to the WH's position but also thanks to its use of the SD, for instance. However, working with WHs can also have negative impacts. This would be

particularly notable at the level of the therapeutic relationship, which could be reversed or tinged with an over-identification of the caregiver to the patient. Furthermore, the very position of the WH could be a risk for the therapeutic relationship. In the case where the past wounds have a significant impact on the therapist's work, this could potentially impact the WHs themselves and consequently affect their personal sphere. In summary, the impact of working with WHs in a therapeutic process should not be underestimated, but must be supervised in order to reduce risks and increase the chances of positive effects for patients

Subsequently, we look at the effectiveness of two therapeutic approaches from a more practical perspective, examining their impact on the care process for WHs. First, we evaluated the SD. With regard to the potential impact of SD on the therapeutic process, it may be perceived as either positive or negative. From a positive perspective, its use could facilitate more effective relationships with patients, as it emphasises the centrality of the human aspect of care. Conversely, from a negative standpoint, the SD could be perceived as unprofessional by patients potentially leading to a reversal of roles between patient and carer. In essence, the use of SD must be contemplated with the objective of conferring benefit upon patients, rather than upon the therapists who employ it. Finally, we also questioned the utility and reflective value of CT as a concept in the context of the therapeutic relationship. It appears that a good dealing process with their own CT may have positive effects for patients, as it facilitates a stronger therapeutic relationship. It allows WHs to gain a deeper understanding of themselves, which in turn enhances their therapeutic abilities. However, its use can also have negative consequences. In particular, it can have an adverse impact on the therapeutic relationship due to overidentification, as well as an impact on the WHs themselves, potentially leading to existential crises and fears of failure, which could jeopardise the therapeutic relationship.

In a nutshell, WHs have positive and negative impacts on the therapeutic process. The main point to consider is how the process of becoming a WH unfolded. If the process was positive and enabled the carer to take lasting care of their past wounds, then the distance from themselves and the defences they have managed to build in a healthy way will enable them to be as effective as possible in the care process. Conversely, if the process has left gaps in the therapist's relationship with past wounds, this could have a negative impact on the therapeutic relationship. In terms of their abilities, the WH's journey enables them to develop a series of tools (e.g., empathy, reflections on the role of the carer, mobilising the patient's strengths in the care process) to optimise the care process. However, certain situations could be detrimental to the therapeutic process, such as wounds that resurface or CT with which the WH has difficulty dealing.

In addition to the findings of our research, certain points can also be discussed in terms of their implications for the therapeutic relationship between WHs and their patients : the impact of the everyday life on the relationship between the WHS and their patients, the conditions for SD and the impact involved in SD

Impact of the Everyday Life

According to our researchs, being a WH appears to have different kinds of impact on both professional and private life, which also affect therapeutic capabilities. Firstly, being a WH appears to help therapists to develop greater resilience and better cope with their own wounds (McDonalds & Grau, 2019). Secondly, it provides them with a better perspective on the meaning of their lives. The latter is particularly evident in five specific domains: understanding the internal duality between the wounded subject and the non affected subject who wants to heal themselves, discovering their own inner power, enjoying life more simply, gaining a deeper understanding of everyday occurrences, and improving interpersonal relationships (Zerubavel & Wright, 2012). The healing of childhood wounds through the WH process is not just a matter of care, but a life-changing experience that allows for a different perspective on the journey of self-discovery (Ladds et al., 2021; O'Connor, 2001). Additionally, being a WH has been shown to have a positive impact on professional performances (Victor et al., 2022; Rober, 2021). This could be attributed to their past experiences in therapy, which led them to aspire to become the best possible therapist due to their heightened awareness of the importance and benefits of therapy (Elliott & Ragsdale, 2020; Dee & Fernandez, 2023; Amundson & Ross, 2016). All of these characteristics can positively impact the therapeutic relationship and increase healing power. By being more open to the world, healthcare workers can improve their work and personal lives (Horwell, 2019).

However, in everyday life, being a WH can also have different kinds of negative impact both for the work in the workplace and in the private life. The most important impact in the workplace seems to be the stigma attached to WHs. A stigma is a negative representation of a person that can affect him or her in everyday life or in the workplace (Tavormina, 2016). In their study, Elliott & Ragsdale (2020) have found that about 75% of the WHs have suffered form stigmatisation in their workplace. The stigmas surrounding wounds may be attributed to two main factors: the nature of the wounds themselves and the emotional burden carried by the healer (Zerubavel & Wright, 2012). In other words, the stigma associated with a disease can be attributed to two distinct factors: the nosography of the disease itself and the way in which the WH manages to deal with it on a day-to-day basis. These stigmas can lead to a fear of being

judged by others (Morishita et al., 2020; Cvetovac & Adame, 2017), and may also result in a perceived decrease in the caregiver's abilities (Morishita et al., 2020).

The fear of being judged by colleagues may stem from the perception of WHs as unreliable and unstable in their approach to patients and their health issues (Brandon, 1999). Colleagues' repeated questioning of the WH's therapeutic abilities, particularly regarding objectivity in diagnosis or in the stakes of struggling against the mental health of their clients, may decrease the perception of their ability to heal (Bearse et al., 2013; Brandon, 1999; Victor et al., 2022). To summarize the issue of stigma among WHs, they are often perceived by their colleagues as being "crazier" than the patients they are trying to treat (Boyd et al., 2016). Stigmatization among WHs is a widespread problem, which leads to the phenomenon of silence among those who do not reveal themselves as WHs to their colleagues (Zerubavel & Wright, 2012; Elliott & Ragsdale, 2020).

The culture of silence in WHs implies a denial of their own illness, which has negative consequences in their daily lives. This denial is increased by the "post-residency disease," as explained by Klitzman (2008), which is defined as the practitioner's knowledge of the disease allowing them to reduce their own disorders after training. Furthermore, denying their own troubles can be dangerous for individuals with mental health issues because it prevents them from recognizing the potential consequences of not seeking treatment (Kirmayer, 2003). This can also reinforce the unequal power dynamic between therapist and patient (Morishita et al., 2020).

While our discussed some of the factors that have an impact on the WHs' therapeutic work, Rønnestad and Skovholt (2001) obtained slightly different results regarding the impact of past injuries on the daily lives of WHs Their study suggests that being a WH has few direct therapeutic advantages, but many indirect positive ones. According to the interviews conducted, they found that past wounds may have allowed individuals to rise socially or economically, without necessarily increasing their therapeutic power. Another interesting finding is that therapists who chose this profession were able to expand their field of interpersonal relationships. This statement does not align with our research findings. Indeed, their study would demonstrate that being a WH primarily offers advantages, with minimal disadvantages. This differs from our results, in which there are a majority of advantages, both therapeutic and personal. However, the disadvantages associated with the role of WH should not be underestimated, as they could significantly impact the therapeutic process of the patient (e.g. our research indicates that the impact of stigma, which can negatively influence the therapeutic process). The variation in results may be attributed to therapists selected in their whose are not

disclosing their past wounds or even of societal changes. The results were published in 2001, and a possible explanation could be a shift in the communication approach towards personal experiences to others. It would be worthwhile to investigate the evolution of discussing past traumas in mental health systems from a cultural point of view

The place of the WHs in their working environment could therefore also have an impact on the therapeutic power of WHs. It is noteworthy that stigma continues to be a significant challenge for WHs, underscoring the need for further reflection on their integration into the healthcare landscape. In other words, the setting in which the WH works could also influence the WH and therefore the therapeutic relationship. Judging by the studies we have review, we could summarised that a supportive environment for WHs would enable them to make optimum use of their care capacities, whereas a setting in which the WH felt uncomfortable or stigmatised could be detrimental to the therapeutic relationship

In light of these considerations, it is possible to pose two key questions: firstly, what is the most appropriate manner to disclosure and secondly, what impact would the SD have on their colleagues?

Condition for a Good Self-Disclosure

Before deciding to disclose aspects of their past, WHs have to think about the context and the aim of their disclosure. The context includes several factors (Elliott & Ragsdale, 2020) which can have a multitude of positive or negatives impacts on the therapeutic relation or even on the consequences this could have on the therapeutic process (Victor et al., 2022). First of all, whatever the informations the therapists will disclose, the most important aspect to consider is the way in which they will disclose and the context in which they will use this therapeutic tool (McDonald & Grau, 2019). The context considerations must take into account "factors as the therapeutic alliance, knowledge of each particular client's likely receptiveness to the disclosure, and the clinical intention of the disclosure" (Moody et al., 2021, p.182). More than just the context, in function of their orientation, the use of SD will vary between WHs (Yeh & Hayes, 2011).

On a more practical level, before disclosing, therapists should reflect on the reasons for disclosure, considering the healing benefits on the process, rather than what they might gain for themselves. It is often suggested to reflect on the desire to disclose during supervision in order to minimise possible bias (Zerubavel & Wright, 2012). D'Aniello & Nguyen (2017) have suggested five different questions to help therapists reflect on whether or not to use disclosure: "Does disclosure benefit the client? Is there a therapeutic purpose? Will disclosure move

psychotherapy forward? Could disclosure damage the therapeutic relationship? Could disclosure negatively impact the client?" (McDonald, & Grau, 2019, p. 166).

Two main information must be taken into account before disclosure: the temporal relationship between the therapist and his past wounds as well as the quantity of information to be revealed. According to Moody et al., (2021), the time when the therapist chooses to disclose can make a real difference on its impact for the patient. If therapists disclose an injury that they are struggling with or that the injury is still nearby, then they are generally less favourably regarded by their patients than those who disclose wounds that are distant in time. Regarding the amount of information to disclose, McCormic et al. (2019) showed, on the one hand, that therapists who disclosed personal information moderately were perceived better than those who disclosed too much or not enough, and on the other, that the fact of disclosing (regardless of the amount) was generally better perceived than saying nothing at all.

The Impact Involved in Self-Disclosure

Just as in their workplace, the greatest impact of SD by a WH is linked to the stigma that can ensue with the peers. The main reason why therapists are often hesitant to disclose personal information to their colleagues is due to fear of stigma (Bainbridge, 2022). This stigma is prevalent in most institutional mental health systems (Cain, 2000). In several states of the USA, institutions must report any disclosure to the competent authority in the field (Byrne et al., 2022). However, therapists may be more inclined to disclose to their patients rather than their peers, and may even avoid supervision for fear of consequences (Zerubavel & Wright, 2012). This fear of colleagues and the work environment could negatively impact the patient's therapeutic process through the therapist.

The stigmatization of therapists who reveal themselves in their workplace can take various forms, including judgement and discrimination against the individual, rejection by colleagues, questioning of their abilities as therapists, devaluation of their skills, and even hostility towards the person (Victor et al., 2022). These various expressions of disclosure can affect therapists both personally and professionally. Some have reported that revealing personal information has hindered their career progression within their institution (Cain, 2000), while others have experienced negative impacts on their social relationships at work and have lost institutional privileges (Cvetovac & Adame, 2017). These consequences can have "serious professional repercussions" (p. 355). If clients do not reveal their true selves, therapists may feel a sense of dishonesty towards themselves and others, which could lead to frustration and boredom at work (Cvetovac & Adame, 2017).

Following a discussion of the specific implications of WHs regarding the positive and negative impact of the work environment, as well as the conditions and the potential impact of WHs' SD to their colleagues on them, we will now examine more specific questions concerning conflicts in the literature regarding the use of the term "WH" and the WHs' continuum between carer and patient

Conflict Trough Wounded Healer's Denomination

Some authors do not agree with the use of the concept of "WH," because they believe it promotes overidentification with the therapist's own suffering, dissociating the caregiver part from the patient part of the WHs. These authors are more inclined to reflect on the fluidity of the position between the caregiver and the wounded subject. This fluidity is conducive to the different psychic dispositions that are possible in human beings. Indeed, these authors are more inclined to recognise the movements between the caring and the cared-for parts of the WHS (Dee & Fernandez, 2023). Other authors, in contrast, emphasise the use of the WH concept, "arguing that the constant process of making sense of our lives and the suffering in them deepens and broadens our knowledge of the human condition, shared by all" (Niven, 2008, p. 287). The lack of epistemological clarity in the naming of the term 'WH' could therefore be a hindrance to the study of the functioning of the presence of WHs in the therapeutic relationship. Moreover, if dogmatic beliefs lead to a differentiation between the carer and the cared for, this can also lead to a disconnection from experience as a source of therapeutic power (Morishita et al., 2020).

Continuum of the Wounded Healer

Another aspect to consider is the subjective experience of WHs. The present review has allowed us to better understand how the presence of WHs impact the therapeutic relationship. But it is important to understand also how being a WH impacts the individual. Some authors propose defining WHs not as a dichotomy but rather as a continuum. This continuum is expressed by the intensity of the effects that past wounds have on the therapeutic power of the WHs. The continuum ranges from the inability to provide care to the use of past wounds as a therapeutic lever without any negative personal effects on the caregiver (McDonalds & Grau, 2019; Dee & Fernandez, 2023; Zerubavel & Wright, 2012). Maintaining this continuum, however, can be complicated in a work framework (without taking into account the influences on the subject). Indeed, on the one hand, WHs may feel out of step with the principles of Western medicine, in which the roles of caregiver and patient are clearly distinct (Morishita et al., 2020). On the other hand, the therapists may experience conflicting emotions regarding the

positive impact of their past wounds on their therapeutic practice, while also acknowledging the potential for these wounds to negatively affect their professionalism (Grave, 2008).

As previously discussed, working in the field of mental health allows for intense personal reflection on the meaning of one's work. Further research could be conducted to better understand the implications of using personal experiences as work tools in daily life (McDonalds & Grau, 2019). However, Stone (2008) notes that the therapeutic effectiveness of WHs may be influenced by the caregiver's struggle to find the appropriate balance between projecting too much onto the patients and not getting involved enough. One possible solution is suggested by Morrison and colleagues (1993), which emphasises the experience of WHs in this continuum situation. According to them, the WH are subject to questions about their position leading them to reconsider the fact of practicing therapeutic work with others. Given that their study dates back 30 years, it would seem interesting to question the subjective implications of WHs on their therapeutic power in order to offer follow-up (e.g. supervision) that is as appropriate as possible to their position on the continuum represented by being a WH, but also with a view to minimising the disadvantages inherent in the therapeutic practice of WHs.

Further research

Building upon the insights presented in this review, three potential avenues for future research emerge. These include investigations into the impact of the process of integrating the wounds of the past in the field of psychological science. Specifically, research could examine the experiences of wounded researchers, the disclosure of CT to patients, and the role of supervision for WHs.

Firstly, as therapists draw upon their personal histories in their therapeutic work, researchers may also use their own life experiences in their research. Deak (2019) suggests that researchers may also draw upon their past wounds as a source of intuition in their research. He proposes that the "wounded researcher" (Deak, 2019, p.335) goes "into his or her unconscious complexes, which he or she then strives to make conscious" (Romanyshyn, 2020, p. 108). It may be beneficial to explore this concept further. Victor and colleagues (2022) suggested that past wounds can be advantageous in research. Indeed, this approach allows researchers to develop a distinctive perspective on their research topic, which can enhance data collection, the design of the study, and even the generation of original hypotheses. More work or reflections on the wounded researchers may also facilitate a more comprehensive understanding of the impact of past wounds on the work of academics.

Secondly, a further question that could be posed is that of the SD to patients of the feedback provided by the CT of WHs. In other words, should therapists talk to their patients about how they feel in therapy. This would enable us to complete our study on the disclosure of personal information. In their study, Yeh and Hayes (2011) found that the disclosure of the CT can also have an effect on the patient's feelings towards their therapist. According to their results, the most important factor that can impact the patients' perception of this therapeutic act is the strength of the relationship. If the therapeutic alliance is strong, the disclosure of the CT will be positively perceived. Conversely, when the alliance is weak, the disclosure of the CT may be perceived as unprofessional or unqualified. These results align with our findings, yet a more comprehensive examination of the content of the disclosure is warranted. The use of SD and CT by WHs should also be approached with caution. In instances where WHs are entirely at ease with the integration of these concepts into their therapeutic practice, they should not forget that the involvement of WHs in the therapeutic relationship inevitably has an impact on the care process. It is therefore incumbent upon each individual to consider whether, why or how to disclose their CT. Where appropriate, this can be facilitated by the input of a specialist supervisor, with the objective of optimising the care process for patients.

Throughout this review, we have observed that the therapeutic relationship between WHs and their patients has both advantages and disadvantages. Other questions could be studied in order to gain a deeper understanding of the WH phenomenon and to enhance the capacity for care. It would therefore be appropriate to pose questions about therapeutic posture and techniques. Furthermore, it would be beneficial to consider the manner in which supervisors should interact with WHS. This question should take into account both the work on the WHs' feelings in their everyday work and their own ability to work within the limits inherent in WHs. This question including the relationship between the healer and the wounded person, ethical limits and anything that might influence the therapeutic work of the WHs.

Limitations

Three main limitations have been identified in the realization of this review. As outlined in the methodology section, a TGLR was employed with a narrative approach. It is important to note that narrative reviews of the literature are subject to a number of inherent limitations that can lead to various biases (Grant & Booth, 2009). The principal limitations of this approach are the less rigorous criteria for selecting articles than in a systematic review; the fact that the objective of reproducibility is not specifically targeted (although for this paper we have attempted to specify our method as fully as possible); and the fact that the results are not based

on statistical or empirical evidence, but on an inference from the subjectivity of the author (Nambiema et al., 2021). It is important to note that the use of the TGLR acknowledges the potential biases inherent in the process (see Methods section).

The next limit is the place of the personal unconscious of the author of this review in the elaboration of this work. The choice regarding the subject, the method, the articles or the angle from which the writing was done can be greatly influenced by the author's unconscious. The unconscious image of the desired outcome when writing this work could have influenced the work in a desired direction. For example, this could influence the selection of relevant information according to the researcher's theoretical background The choice of method was therefore made by considering the need to leave room for the author to work while framing the method in the most rigorous way possible.

This final limitation may be considered a line of thought for researchers engaged in any scientific study. Indeed, if we assume that researchers will be influenced unconsciously in their work, we may also inquire as to the extent to which their past wounds influence their perception of the results obtained. In the context of this study, if we assume that the researchers in the team were "wounded," we may question whether the positive findings in relation to WHs have been overvalued and the negative findings undervalued. Consequently, throughout the research process, we may inquire on the influence exercised by the researchers' past experiences .

Conclusion

In conclusion, the findings of this review indicate that the presence of a WH in a therapeutic relationship can influence the patient's care process in both positive and negative ways. Furthermore, the very fact of being a WH has an impact not only the relationship, but also on the therapist's ability to provide care. With regard to the concepts that have been developed to better understand the relationship, we could consider SD and CT as two therapeutic concepts that can be applied to better understand the relationship with a WH. From a theoretical standpoint, it would be advantageous to examine the epistemological framework of the denomination of the WHs and to enhance the comprehension of the associated concepts (e.g., SD, CT, wounded researchers). From a practical point of view, on the other hand, we sought to concretely illustrate the different clusters resulting from our research in order to allow practitioners to reflect on their own practice and for supervisors to acquire a more in-depth understanding of this phenomenon when they must work with WHs in their professional practice.

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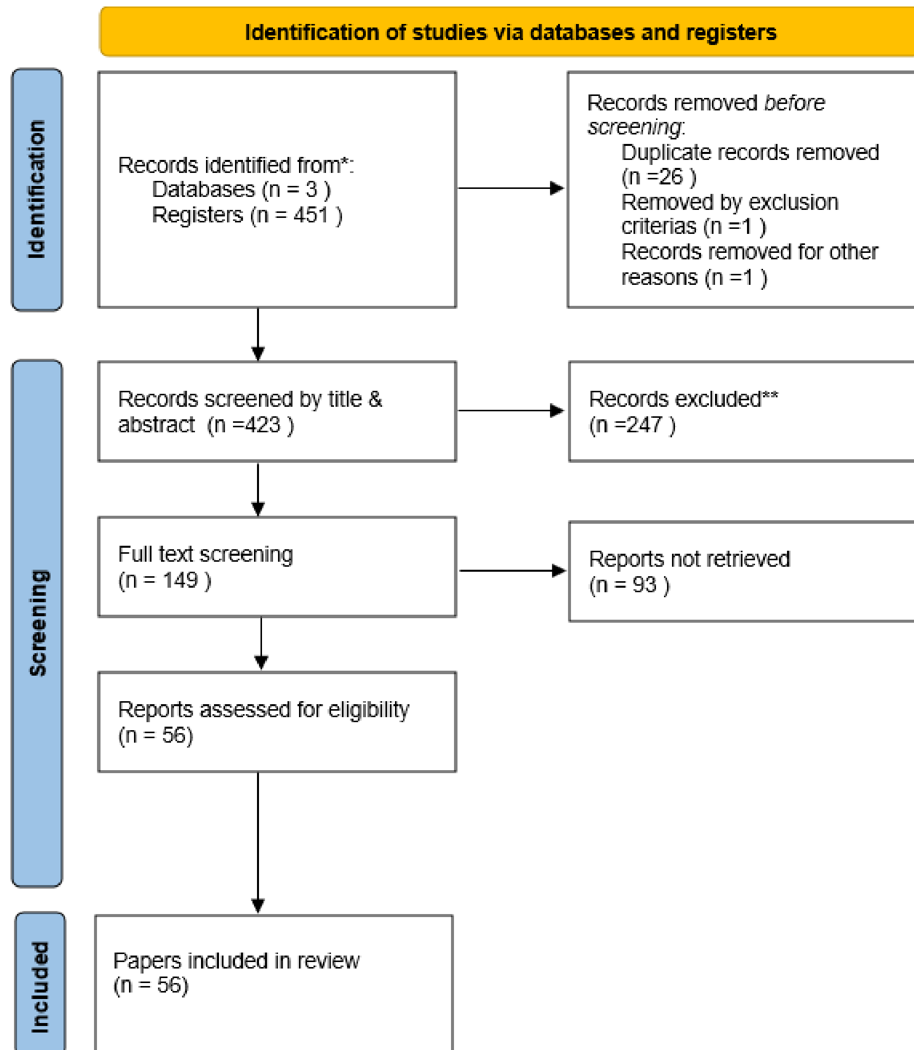
Appendix

Appendix 1



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