Full-Length Article

Trauma, Disability and the 'Wounded Healer'

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Abstract

A medical memoir addressing the author's history of trauma, limb loss, use of music as a resource, and how these experiences shaped his pursuit of education and career in music therapy. The significant influence of Jung's "wounded healer" concept on the development of the author's identity as a clinician with a history of trauma is discussed. The importance of addressing the needs of wounded clinicians, and the risks and benefits of disclosure, are explored.

Keywords*: trauma, wounded healer, countertransference, limb loss*

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The concept of the "wounded healer," popularized by Jung, [1] has a venerable presence in the cultural imagination and the philosophy and practice of healing modalities throughout history. Numerous theorists have described the unique strengths (and vulnerabilities) that wounded healers offer. Given sufficient introspection and application of insights gained, a therapist's vulnerabilities can become a valuable asset to enhance the efficacy of her practice. All clinicians may view their work through the lens of their "wounds," and can thus transform these into valuable strengths. Below, I relate my personal history of emotional and physical trauma and physical disability and the factors impacting my resilience in light of these challenges. I discuss how these experiences influenced my decision to pursue music therapy and shaped the development of my clinical identity. I explore how the "wounded healer" concept enables me to regard my history as a resource which enhances my resilience (and my capacity to facilitate resilience in my clients), deepens my empathy and strengthens my clinical presence. Additionally, I address the place of the "wounded healer" in current therapeutic practice, the need for appropriate resources and support, and the dilemma posed by disclosure.

Trauma

Trauma can be broadly categorized into two subtypes: "shock trauma," which, "refers to the result of a one-time event or events that occur over a relatively short term…[including] accidents, physical or emotional abuse, and sudden and devastating illness or loss"[2] on the one hand, and "developmental trauma," involving "events occurring over a period of time relative to a person's developmental stages," such as "constant abusive or neglectful treatment from parents, siblings, and other children or adults with whom the child might have regular involvement", [2] on the other. Sutton, citing Damasio, refers to "primary" and "secondary" emotions activated by trauma:

> 'Primary' emotions relate to ancestral survival responses that can be said to be 'wired at birth', while 'secondary' emotions are linked with the patterns of behavior set down through early life experiences. 'Primary' emotions are set in place while living through a potentially life-threatening situation (the familiar 'fight-or-flight' responses), and 'secondary' emotions offer opportunities for finding ways of adjusting to having experienced such situations. These processes are inevitably interconnected. [3]

Porges suggests that "early experiences [may] play an important role in changing the threshold or vulnerability" to pathological reactions to trauma, and posits that "[W]hether or not an individual feels safe with the parent, caregiver, family members, or others during early development might moderate individual differences in vulnerability to trauma."[4] Sutton and McDougall offer that in the wake of trauma, "intense, overwhelming, and unassimilated affect remains, which can be touched by, connected to, or amplified

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by future cumulative traumas". [5] Because it shapes the development of personality, sense of agency, and coping strategies, and directly impacts neurological development, developmental trauma can significantly influence the nature, intensity and duration of an individual's reaction to shock trauma. Complicating matters, shock trauma may re-activate dormant developmental trauma(s). Adults with a history of developmental trauma are particularly vulnerable to pathological reactions to shock trauma. However, sufficiently processed and integrated trauma can be utilized to improve outcomes and even to enhance the future clinician's effectiveness. My history of trauma, once adequately metabolized, helped transform my experiences into catalysts for profound emotional growth. I believe this ameliorated the impact of post-traumatic stress while deepening my therapeutic skills.

What is a "wounded healer," and how can my progression from "trauma survivor" to "wounded healer" be understood?

My Journey

My childhood, though more stable than some, included major challenges to healthy emotional development. Parental substance abuse, physical and emotional abandonment, codependent role reversal wherein I was thrust into a "caretaker" role, alongside bullying and ostracism by peers, provided significant challenges. My history of trauma impaired my ability to trust, and thus to socialize. I gravitated to music as a means of coping. Organized musical activities provided a context to connect with other children through creativity and aesthetic enjoyment, and I learned to use music to mitigate the impact of trauma. Music remained a potent resource for me through high school and college, as I played guitar and wrote songs in local bands. By my early thirties, as work and domestic demands increased, my musical life became less active. I was then faced with the challenge of sudden, unexpected loss through life-threatening injury, extended hospitalization, and permanent disability. Pushing a shopping cart on the sidewalk, I witnessed a car crash in the street. Before I knew it, one of the cars had jumped the curb and was bearing down on me. I was barely able to pull myself onto the hood as the car crashed into a tree. Although my quick thinking probably saved my life, my left leg, dangling over the bumper, was crushed between the car and the tree. As the car backed up, I collapsed to the ground in mind-numbing pain. A large pool of blood formed around me as I lay in the street, screaming for help. I remained conscious, not knowing if I would survive, or if I would keep my leg. After being rushed into surgery, I awoke the next day to begin a difficult new chapter of my life. The attending physician told me my left leg had been amputated at the knee; subsequent surgeries left me with an amputation four inches above the knee, and a long road ahead.

A traumatic event of this magnitude contains multiple layers: utter unpredictability; extreme pain; immanent possibility of death; profound feelings of helplessness; anticipation of terrifying outcomes. Such a sudden, violent occurrence has "ripple effects" as one contemplates how one's life may change. I struggled to process this enormous loss, this assault on my body image and sense of self, and my new status as permanently disabled. As Sutton states, "…what one had previously held safe is no longer reliably so. One's perception of the world changes irrevocably…Trauma is enmeshed in an internal process of an attempt to assimilate how the event has irrevocably affected the individual." [3]

Already traumatized by the merciless randomness of my accident, I next faced routine traumatization in the hospital. Daily wound cleanings by physicians were unimaginably painful. Threats to survival continued as I weathered serious infections. I felt helpless, humiliated and infantilized – bed-bound, with a catheter, multiple IVs, and a suction line attached to my wound, a previously healthy, strong, 6'4' 32-year-old man suddenly unable to take care of his most basic needs. I felt a constant underlying sense of threat. Patients with a history of developmental trauma who are hospitalized following shock trauma are vulnerable to *medical trauma*. As Porges points out, 'medical procedures may convey cues to our body that are similar to physical abuse…Even interventions administered with positive intentions that may involve restraint may trigger trauma responses and even PTSD.'[4] This interaction between multiple forms of trauma creates a complex, challenging situation.

Once acute threats subsided, I faced the daunting task of regaining mobility and independence. Early physical therapy sessions were discouraging and embarrassing. I feared I'd never get the hang of using crutches. Amputation wounds heal slowly, and I would spend six weeks at home recovering before returning for inpatient prosthetic training. Crutching eventually became second nature, boosting my optimism, but my mobility remained limited. Returning to rehab felt like a major setback. Learning to walk with an above-knee prosthesis was far more difficult than I'd imagined. I felt discouraged and barely able to motivate. Indeed, my physical therapists warned, this is a crucial period for amputees, and a significant number give up and rely on crutches thereafter. Some get caught in a downward spiral of painkiller abuse. Considering my family history, I went off oxycodone as soon as I was discharged. Obstacles aside, I persisted, gradually reintegrating myself into "normal" life. I returned to work after 4 ½ months, first commuting in taxis, then slowly acclimating to buses. It would be years before I felt confident enough to ride the subway again. My weekly routine included outpatient physical therapy for the next year-and-a-half. At the end of that period, being able to walk 2.7 miles per hour on a treadmill, or to walk a mile crosstown without stopping, felt like huge achievements.

Music was integral to my emotional survival and ability to motivate. A friend brought a portable CD player and CDs, and

music listening became my primary means of coping. I gravitated to slow, calming electronic pieces with lush, soothing arrangements that created a "holding" effect, restoring some of the basic sense of safety I'd lost. As soon as able I was playing guitar in my hospital bed, using songwriting to work through my feelings of loss. No completed "product" resulted, but the *process* of songwriting was tremendously valuable. Still, I recall a pervasive sense of pessimism and powerlessness, the feeling that songwriting wasn't enough to address the magnitude of my loss. I didn't know the suffering I was experiencing would one day become a powerful resource, deepening and enriching my clinical work in medical music psychotherapy and beyond.

The Wounded Healer

Trauma does not invariably yield detrimental effects. Calhoun and Tedeschi identify the concept of "post-traumatic growth," suggesting this can lead to "greater appreciation of life and changed sense of priorities; warmer, more intimate relationships with others; a greater sense of personal strength; recognition of new possibilities or paths for one's life; and spiritual development."[6] I experienced all of these during my recovery. "Post-traumatic growth" is clearly a favorable, and quite likely necessary, precondition for the transformation of the trauma survivor into the "wounded healer."

The concept of the "wounded healer" in modern psychology can be understood as a form of "countertransference." While the term "countertransference" has been defined in various ways since originated by Freud[7], Gelso and Hayes offer a useful definition: "the therapist's internal or external reactions that are shaped by the therapist's past or present emotional conflicts and vulnerabilities".[8] Suggesting that "all therapists are wounded healers," Gelso and Hayes describe the wounded healer phenomenon in terms of "therapists drawing from their own experiences of working through painful personal incidents to better understand, offer hope to, and work therapeutically with patients."[8] Jackson elucidates the concept:

> Healers whose personal experiences of illness have left lingering effects on them – in the form of lessons learned that later serve constructive purposes, in the form of attitudes and sensitivities that recurrently serve them in ministering to those whom they treat, or in the form of symptoms or characteristics that stay with them and usefully influence their therapeutic endeavors. [9]

Austin succinctly describes a wounded healer as "someone who doesn't just 'talk the talk' but who 'walks the walk'". [10] Zerubavel and O'Dougherty Wright emphasize the need for wounded healers to have adequately processed their traumatic material to avoid adversely impacting the therapist-client relationship.[11]

Kirmayer traced the ancient roots of the concept, pointing out that "shamanism and other elementary systems of medicine are built on an ethos that identifies healers' calling, authority and effectiveness with their own initiatory illness experiences". [12] Examining the Greek myth of Asklepios, [12] (identified by Jung as the basis for his conception of the wounded healer "archetype")[1] Kirmayer points out that "In mythic thought, healing power and woundedness are inseparable" and suggests that "there is an intuitive logic in the notion that someone who has been afflicted and survived possesses intimate knowledge of the nature of illness and its cure". [12] Kirmayer holds that the client's ability to heal is often projected by both parties onto the therapist, disempowering the client. The therapist thus "pathologizes the patient. The alternative is for the healer to acknowledge his own wounds as a way of reconnecting woundedness and healing. This allows the patient to acknowledge his own wounds and mobilize his own 'inner healer'". [12] Just as facilitating the patient's capacity to recognize and integrate her own healing ability is essential, also integral to this process is the therapist's acceptance of his own wounds, of the "patient within." Maintaining this connection with his own "wounded side" facilitates the therapist's capacity for empathy. Wounded healers walk a fine line, however, for "when we align with patients through empathy and advocacy we face the danger of over-identification with their wounds".[12]

Kirmayer envisions the wounded healer's growth and development (internally and as an agent in the external world) as a five-step process: [12] 1) Initial attraction to the role of healer (often expressed in early attempts to repair dysfunctional family situations) and subsequent total identification as "healer," eliciting a feeling of distance – and difference – from clients; 2) Early clinical experiences that re-activate the trainee's psychological wounds, coupled with an initial period of supervision in which the trainee begins to acknowledge and explore his "woundedness" (akin to "the first trials of initiation" [12] in shamanic traditions; 3) Identification with clients and doubt about one's ability to successfully take on the responsibilities of a healer, leading to a period of feeling lost within and defined by one's wounded status 4) Implementation of the role of healer, acceptance of one's pathologies and vulnerabilities, and the ability to contain this paradox; and 5) Full assumption of the role of "wounded healer," including the ability to maintain an ongoing fruitful connection with one's wounds – understanding one's "strengths and limitations to be *one and the same,*" [12] – and recognizing the client's innate capacity for healing. Paradoxically, it is the healer's woundedness – and his continuing, purposeful engagement with it – which fuels his ability to facilitate the client's healing process.

Understanding and drawing upon the healer and patient elements within both therapist and client may activate healing more effectively than a top-down hierarchical approach. The respective elements in each individual resonate, amplifying their impact. The wounded healer approach relies on mutuality and reciprocity, while acknowledging the stewardship, experience and skillset of the therapist.

From Trauma Survivor to Wounded Healer

My movement towards the role of "wounded healer" can be understood through Kirmayer's steps [12]. I experienced "initial attraction to the role of healer" a few years after my accident. My discovery of body-mind integration practices, including mindfulness meditation, yogic "pranayama" breathwork and shamanic journeying, helped drive this process. These tools facilitated a sense of safety. I was unknowingly tapping into the ventral vagal response described by Porges: "If we feel safe…we have access to a myelinated vagal circuit that is capable of down-regulating the…fight/flight and stress responses. [4] Pranayama yoga activates this response because both the breathing apparatus and the facial muscles are connected to this vagal circuit," … "embedded in mindfulness is being in a state of safety…[as] long as we are in that state of safety, it is difficult to recruit our defense systems."[4] Propelled by these interests, I engaged my "initial attraction to the role of healer" through a certificate program in sound and music healing. This decision was partly motivated by my father's protracted illness (which reactivated both my developmental and shock trauma); I used music as a healing tool for him and for myself, and my studies enabled me to deepen this exploration, and to better process his eventual death. Through this program, I discovered music therapy, leading to my application and admission to a master's degree program.

My music therapy field work practicum was spent working with children, teens and adults with developmental disabilities. It was a valuable experience and an unparalleled opportunity to learn a rich music-centered music therapy approach informed by humanistic psychology. Although I'd long hoped to work with patients in medical rehabilitation who'd become permanently disabled through physical trauma, such an opportunity had not arisen. In retrospect, given my history, I wasn't ready to take on such intense work while still learning the basics of music therapy practice. In Kirmayer's terms[12], I was experiencing total identification with the healer construct and a feeling of distance – and difference – from clients. The nature of the population encouraged this tendency – it was easy to disidentify with clients so different from myself and to view my clinical work in a benevolently paternalistic manner. I gained confidence during my year of field work and felt readier to move into medical work for my clinical internship.

Music therapy internship is challenging under the best of circumstances[13], and for me, working at a highly stressful office job, dealing with a suicide in the family, and faced with the physical and emotional demands of my disability, I already faced a heavy load of stressors before even considering my history. Nonetheless, as I began my internship at a large, well-known teaching hospital, I already understood that my unique experiences had instilled a refined sense of empathy, particularly for those experiencing medical trauma. I didn't know how challenging it would prove to access this potential, nor how much resistance my history would bring up while working with oncology, rehabilitation and hospice patients affected by life-threatening illnesses, disabling and degenerative conditions, and violent trauma. I experienced Kirmayer's second step[12]: early clinical experiences which re-activated my psychological wounds, coupled with an initial period of supervision during which I began to acknowledge and explore my own "woundedness." I struggled to understand my vulnerabilities, temporarily feeling lost within and defined by my own wounded status. Despite reassuring external feedback, I had an exaggerated view of my own psychopathology, and despaired of ever becoming a competent clinician. Reflecting Kirmayer's third step,[12] this led to overidentification with my patients. The final months of internship involved great strides of inner and outer development, facilitated by on-site and off-site supervision, training seminars, and personal therapy. I was eventually able to accept my own woundedness and contain the paradox of being both wounded and a healer (Kirmayer's fourth step)[12]. Many clinicians remain stuck at this point.[12] However, as my internship concluded, I began a continuing process (Kirmayer's fifth step) [12] of mature acceptance, fuller integration of the dichotomous roles, acknowledgement of the healer element within my patients, and, importantly, understanding that I will need to regularly access this vital aspect of my professional identity in order to realize my full potential as a clinician. In my current work with Alzheimer's and dementia sufferers, I find my history of trauma enables me to relate to clients' experiences of isolation and loss. Having learned to do what I can with what I have, I help such clients focus on realizing their full potential in the present moment, while accepting the limitations imposed by irreversible degenerative conditions.

Disclosure

Disclosure of a clinician's wounded status remains controversial. It is worth noting that the wounded healer model is an essential premise in common approaches to substance abuse, serving, for example, as a model for sponsorship in 12-step programs. Many substance abuse counselors have a history of addiction and recovery, which is seen to add to their credibility. [11] This has become increasingly common in counseling for eating disorders as well. [11] Well-known clinicians have publicly revealed their status as wounded healers, notably including Dr. Marsha Linehan, developer of Dialectical Behavior Therapy, who in

2011 came out as a sufferer of borderline personality disorder, revealing her history of self-harm, suicidal thoughts and institutionalization. [14] Public disclosure of woundedness via online and print media or educational seminars can be an empowering and effective tool. Wounded healers may become activists and advocates. Disclosure can encourage members of the public facing similar challenges to access their own healing capacity and can inform their choice of therapist and encourage participation in support groups. [11]

Disclosure poses significant risks however, including "stigma, judgment, or overt hostility from other professionals". [11]. The pressure this places on clinicians to maintain silence is a major impediment to optimal delivery of service. Acknowledging and addressing this issue would best serve the needs of clients and practitioners, and would help reconcile implicit hypocrisies. As Zerubavel and O'Dougherty Wright point out:

> With wounded clients…We encourage the unshrouding of silence and offer responses of empathy and support. Yet, we do not approach our wounded colleagues with the same warmth and support…This silence must be broken in order to support the wounded healer in navigating issues of recovery, management of countertransference, and seeking help when necessary. This includes questioning the incongruence between how our profession regards woundedness in its clients and its practitioners. [11]

I view my status as a "wounded healer" as a hard-won victory which required strength, courage and perseverance. I'm proud of my "scars" and of the extensive work I've done to activate this transformation. I believe my capacity to help others exists not in spite of my history, but largely *because* of it. Sharing my story seems to me the wise and compassionate choice, offering the greatest benefit for me and for my audience. When wounded healers "break the silence," it presents an opportunity to dismantle the stigma and shame for others who suffer similarly.

My ongoing journey as a "wounded healer" has helped me develop an effective professional identity which allows me to provide my clients and patients with a quality and depth of care I might not otherwise be able to. It has also catalyzed my own healing. While most trauma survivors do not go on to enter a healing profession, all victims of trauma can potentially benefit from accessing their "inner healer," in whatever ways they are inclined and able, whether through volunteering, mentoring, through the fellowship of peer support programs, or even in the simple daily acts of caring for family, friends, and community members.

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Biographical Statements

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