

Research Article

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Wounded but Now Well: Family-of-Origin Dysfunction and Later Functioning in Mental Health Practitioners

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Abstract

This study examined the wounded healer concept, asking whether the family-of-origin dysfunction it describes is accompanied by impaired later functioning among mental health practitioners. The mental health practitioners (34 healers) were compared with other professionals (34 non-healers) on family-of-origin, self-esteem, stress, Type A behavior, wellness, reason for career choice, alcohol consumption, somatic complaints, medication use, and involvement in self-improvement activities. Healers reported significantly less healthy families of origin, consistent with the wounded healer concept. They did not differ from non-healers in self-esteem, stress, or Type A behavior, indicating that this early woundedness was not accompanied by poorer present functioning. Healers reported significantly greater wellness, more often cited altruistic reasons for their career choice, consumed less alcohol, and engaged more actively in self-improvement, including personal counseling and self-help reading. These findings suggest that the wounds associated with the wounded healer lie in the family-of-origin rather than in present functioning, and that practitioners, as a group, appear to have moved toward wellness through active personal and professional development.

Keywords: Wounded Healer, Family of Origin, Mental Health Practitioners, Therapist Wellness, Psychopathology of Therapists, Psychotherapist Altruism, Childhood Trauma of Therapists

1. Introduction

This exploratory study examined the wounded healer concept, focusing on whether therapists' early woundedness persists in later functioning. It has been widely theorized, though not so well researched, that psychologists, therapists, counselors, and other professionals who treat personal and emotional problems often grow up in dysfunctional families and suffer childhood emotional trauma. They subsequently develop psychopathology that draws them into the healing professions, where they can meet their own needs vicariously by helping others. Such individuals have come to be known as wounded healers, a term used by Maeder [1].

The concept has deep historical and cross-cultural roots, tracing back to the ancient Greek myth of Chiron and extending into contemporary clinical frameworks [2-4]. While the underlying theme is ancient, Carl G. Jung introduced the term into psychology as an archetypal dynamic describing the interaction between therapist and client, which he termed a dialectical exchange [5].

Within this framework, practitioners must consciously examine their own psychological wounds, because a client's struggles that mirror the therapist's own can reactivate them. A growing body of research connects these reactivated wounds directly to the therapist's early background.

Based on interviews with over 50 therapists and 200 children of therapists, Maeder [1] found that childhood emotional trauma was not only prevalent among therapists but was often a decisive factor in their choice of therapy as a career. In a study of 40 psychoanalysts and psychotherapists, Burton [6] found a high incidence of psychopathology among family-of-origin members, including schizophrenia, psychotic depression, and personality disorders. In one of the few empirical studies comparing helpers with non-helpers, Marsh found that social work students had a significantly higher incidence of addictive and compulsive behaviors in their families of origin than business students; alcoholism, in particular, was twice as prevalent [7]. Their motives differed as well: social

work students chose their major “to work with people, help people, and understand myself better,” whereas business students cited “interest in the field” or “high income potential” (p. 97). Other studies have also supported the dysfunctionality of helping professionals’ families of origin [8-10], and a recent systematic review also confirmed that adverse childhood experiences were associated with the choice of a helping career [8-11].

Much has been written on the psychopathology of helping professionals [2,12-14]. In a nationwide survey of 263 psychiatrists, Looney et al. found serious depression among 58% of respondents and moderate to incapacitating anxiety among 73% [15]. In a similar survey, Bermak found mental illness among 90% of psychiatrists. Boxley et al. reported significant impairment among clinical trainees in American Psychological Association accredited internship programs: 35% reported personality disorders, 31% depression, and 31% emotional problems [16,17].

Different motives have also been assigned to therapists for choosing their profession, such as altruism, narcissism, voyeurism, power, reduction of psychic tension, an unconscious desire to eliminate childhood fears of going crazy [23], and an attempt to prove that one is not alone in one’s own strangeness [18-24]. Kopp presents an interpretation aligned with the wounded healer concept, suggesting that contemporary therapists often endure a “tortured pilgrimage as a deeply troubled misfit youth” (p. 13) before becoming successful healers in later life. This journey is not straightforward or linear; rather, it involves a process in which therapists redefine their perspectives and integrate their past struggles into their professional identities [25,26].

This exploratory study addressed three questions. First, do mental health practitioners report greater family-of-origin dysfunction than other professionals? Second, if such early woundedness is present, is it accompanied by poorer later functioning, as reflected in self-esteem, stress, and Type A behavior? Third, how do the two groups compare on wellness, reasons for career choice, alcohol use, involvement in self-improvement activities, and educational level? A comparison group of non-healers and a multivariate approach were used to address these questions.

2. Method

2.1 Participants

A healing professional was defined as one currently engaged in active, paid employment to assist others in resolution of their personal and emotional problems. The sample consisted of 18 licensed psychologists (doctoral healers) and 16 master’s-level psychological associates, counselors, and social workers (sub-doctoral healers) employed in western Texas. Non-healers consisted of 18 doctoral-level professors of math, hard sciences, and business (doctoral non-healers) and 16 master’s-level instructors in mathematics, hard sciences, and business (sub-doctoral non-healers) from a western Texas university. In this sample, men comprised a majority, accounting for 59% of healers and 65% of non-healers. The average age of the healers was 47 years, while the average age of the non-healers was 48

years. Nearly all participants identified as Caucasian, with 97% of healers and 100% of non-healers belonging to this demographic. Additionally, a large portion of the sample was married, with 73% of healers and 79% of non-healers.

2.2 Instruments

The following instruments were used in the present study.

Family-of-Origin Scale (FOS) measures levels of perceived health in one’s family of origin. It uses a 5-point Likert scale across 40 items. The least healthy response is scored 1 and the most healthy is scored 5. Thus, the score range is between 40 and 200; lower scores indicate less healthy family functioning. Internal consistency reliability of the FOS for our current study yielded a Cronbach’s alpha of .96, which is consistent with the original scale [27].

Rosenberg Self-Esteem Scale (RSES), is a brief yet reliable 10-item assessment tool. Responses are made on a 5-point Likert scale, with the lowest self-esteem at 10 points and the highest at 50 points [28].

Social Readjustment Rating Scale (SRRS) measures daily life stress. Forty-three items were numerically ranked according to Life Change Units (LCU). An LCU score of 150-199 indicates mild life crisis, 200-299 a moderate life crisis, and over 300 a major crisis [29].

Type A Behavior Checklist measures Type A behavior or “hurry sickness” and its connection to coronary thrombosis and competitive, aggressive behavior patterns. The 13-point, yes/no scale used in this study was obtained from the work by Rice [30]. In the present study, a score of 7 or more yes responses was considered indicative of an unhealthy Type A behavior pattern, and internal consistency of the scale was found to be .87.

Wellness Scale was developed for the present study as a screening tool. The items were derived from a review of the relevant literature and two existing measures: Lifestyle Assessment Questionnaire and the Self-Assessment Quiz [30-34]. Twelve questions were created to represent the following health categories: sleep pattern, satisfaction with weight and body image, smoking, exercise, diet, leisure activity, sex life, self-actualizing experience, group affiliation, alcohol usage, caffeine usage, and deep relaxation. Items were scored dichotomously (yes or no). Although the Cronbach’s alpha of .53 was low in the present sample, we retained the Wellness Scale results due to the clinical interest, pending further test development and research with a larger sample.

A psychosocial questionnaire provided demographic data of the sample, as well as data on several additional psychosocial factors, such as reasons for career choice, frequency of alcohol consumption, medication usage, somatic complaints, and self-improvement activities.

3. Procedure

Survey packets, each with a self-addressed, stamped return envelope, were mailed to 55 healers: 33 licensed psychologists and 22 sub-doctoral-level healers. They were identified from the telephone directories of the three medium-sized West Texas cities. Non-healers were recruited from the Colleges of Science and Business at a regional university in the same area and matched the number of healers who returned the questionnaires based on the educational level. Of the 55 healers, 34 healers returned the completed surveys, resulting in 18 doctoral and 16 sub-doctoral level healers. The non-healers were recruited until 18 doctoral and 16 sub-doctoral level professionals responded.

3.1 Design

A 2×2 factorial design was used, with profession (healers vs. non-healers) and educational level (doctoral vs. master's) as the independent variables. The five primary dependent variables were family-of-origin functioning, self-esteem, stress, Type A behavior, and wellness. These variables were analyzed using a multivariate analysis of variance (MANOVA). Additional outcomes, including individual wellness items, alcohol consumption, medication use, somatic complaints, self-improvement activities, and reasons for career choice, were analyzed using chi-square tests or Fisher's exact tests, as appropriate.

4. Results

Before the primary analysis, the five dependent variables were examined for intercorrelation. Family-of-origin scores were significantly correlated with self-esteem ($r = .27, p < .01$) and with stress ($r = -.22, p < .05$), and Type A behavior was significantly correlated with wellness ($r = -.20, p < .05$); the remaining intercorrelations were small and non-significant. Because the measures were intercorrelated, a multivariate analysis of variance (MANOVA) was used to assess the overall effect.

The MANOVA, using family-of-origin dysfunction, self-esteem, stress, Type A behavior, and wellness as dependent variables, revealed a significant multivariate effect for profession, $F(5, 60) = 5.35, p < .001$. Univariate analyses showed that healers reported significantly less healthy families of origin than non-healers, $F(1, 64) = 5.75, p = .02$, and significantly higher wellness, $F(1, 64) = 13.85, p < .001$. Healers and non-healers did not differ significantly on self-esteem, $F(1, 64) = 0.77, p = .38$; on stress, $F(1, 64) = 0.03, p = .86$; or on Type A behavior, $F(1, 64) = 2.45, p = .12$. Means and standard deviations for all five measures are presented in Table 1.

Variable	Healer M	Healer SD	Non-healer M	Non-healer SD	F	p
Family-of-origin	127.7	34.7	147.0	31.3	5.75	.02
Self-esteem	43.9	4.6	42.6	6.9	0.77	.38
Stress	122.1	93.0	120.7	95.1	0.03	.86
Type A behavior	3.2	2.5	4.2	2.9	2.45	.12
Wellness	7.5	1.7	5.8	1.8	13.85	< .001

* $N = 68$. The multivariate effect for profession was significant, $F(5, 60) = 5.35, p < .001$.

Table 1: Dependent Variable Scores by Profession

There was a significant difference between healers and non-healers in the proportion who scored in the "mild life crisis" range on the SRRS, $\chi^2(1, N = 68) = 8.74, p < .01$. Healers and non-healers also differed significantly in their selection of an altruistic reason for career choice, $\chi^2(1, N = 68) = 12.62, p < .001$. There were no significant differences by educational level, although the doctoral group tended to give more varied responses.

Healers tended to consume alcohol less frequently than non-healers, $\chi^2(3, N = 68) = 12.07, p < .01$. Most healers drank less than once a month, whereas the largest proportion of non-healers drank more than once a week. There were no significant differences by educational level.

There were no significant differences between healers and non-healers in medication use or somatic complaints by profession or education. Less than one-third of each group had ever used prescription drugs on a regular basis. Over half of each group used analgesics regularly (usually aspirin, Tylenol, or ibuprofen), and

over three-fourths of each group had experienced one or more minor stress-related somatic difficulties in the previous six months (mainly migraine and tension headaches and allergies). Overall, 35% reported experiencing stress or burnout in the previous six months. Although stress was not significantly related to medication use, it was significantly correlated with the number of somatic complaints, $r = .28, p < .01$.

Healers reported greater participation in self-improvement activities than non-healers. They differed significantly from non-healers in receiving counseling or therapy for their own personal and emotional problems, $\chi^2(1, N = 68) = 9.22, p < .01$, and in reading self-help books, Fisher's exact $p = .047$. There was no significant difference between the groups in church attendance or participation in 12-step recovery programs; three healers reported 12-step involvement, but none of the non-healers did. The groups did not differ in participation in outpatient or inpatient treatment programs. Overall, healers differed significantly from non-healers in participation in any of the self-improvement activities, $\chi^2(1, N$

= 68) = 8.14, $p < .01$.

5. Discussion

The MANOVA results did not reveal differences by educational level or an interaction between education and profession. The clearest finding concerned family-of-origin: healers reported their families of origin as significantly less healthy than did non-healers, which supports the central premise of the wounded healer concept. Within psychodynamic theory, such early family deficiencies may be understood as the wounds of the wounded healer, which persist unless therapy or other life experiences resolve them.

The finding that healers reported significantly greater wellness suggests that many may have worked toward resolution of woundedness. Although the two groups also differed in the proportion who fell in the mild life crisis range on the SRRS, their nearly identical mean stress scores indicate that healers were not generally more stressed than non-healers. Their greater wellness suggests that they manage life stress more actively. During their training, healers often disclose and work through their own past difficulties. That process, together with the training itself, may help heal their wounds. Such a view is consistent with Greenberg and Stone's [35] finding that health improves through the disclosure of past trauma.

Beyond family-of-origin and wellness, healers and non-healers did not differ significantly on self-esteem, stress, or Type A behavior. The pattern of means was nonetheless generally consistent with the view that healers were not impaired in their present functioning: they scored slightly higher on self-esteem and lower on Type A behavior than non-healers, though neither difference was significant, and the two groups were nearly identical on stress. The absence of a self-esteem difference is itself informative. It runs counter to the prevailing view that family-of-origin dysfunction results in lowered self-esteem, a view popularized by therapists such as Satir and Bradshaw [36, 37]. Despite reporting less healthy families of origin, healers did not show the diminished self-esteem this view would predict. One explanation is that healers have compensated for their family-of-origin deficits through participation in counseling and other self-improvement activities. This fits the pattern observed by Zosky, who found that many graduate trainees enter the field having experienced family violence, and that when students revisit these experiences during training, that background becomes a source of empathy rather than a professional disadvantage [38].

Consistent with the pattern seen on the other present-day measures, healers and non-healers did not differ in medication use or in stress-related somatic complaints. These data were gathered to use the body as an index of the effects of repressed emotional trauma, as occurs in psychosomatic disorders. A correlational analysis offered partial support for this idea: although stress was unrelated to medication use, higher stress was significantly associated with a greater number of somatic complaints.

Healers and non-healers differed most clearly in their involvement in self-improvement activities. Church attendance was virtually identical, with about one-third of each group attending regularly, and the two groups did not differ in participation in outpatient or inpatient treatment programs. The clearest contrast was in personal therapy: 62% of healers had received counseling or therapy for their own personal or emotional problems, compared with only 17% of non-healers. Healers also read self-help books more often. This pattern of active self-improvement fits Shuler et al.'s view that counselor development involves reflection on one's own experience [26].

The largest difference between healers and non-healers was in their motive for career choice: healers were far more likely than non-healers to report an altruistic reason for entering their field (56% versus 9%). This strong altruistic orientation is consistent with the wounded healer concept. Practitioners who have confronted and worked through their own early difficulties may be especially drawn to helping others, their own experience of woundedness and recovery serving as a source of empathy and motivation rather than a liability.

The present findings, in which healers reported more troubled family origins yet greater wellness and far more active engagement in personal therapy and self-improvement, strengthen the case for personal psychotherapy in the preparation of mental health practitioners. Several traditions already reflect this value. Jungian analysts undergo a lengthy personal analysis in preparation for practice. In some disciplines, such as substance abuse counseling, professional counselors are often expected to be recovering alcoholics or addicts, and in some settings personal recovery has been required (e.g., the historical Hazelden-modeled treatment community). Self-help groups patterned after the 12-step model use a peer counseling method called sponsoring, whereby seasoned members assist newcomers with recovery. The American Psychological Association's ethics code requires psychologists to refrain from treating clients when they are unable to function professionally, and to suspend practice until they regain the required level of functioning. Although this principle is generally applied retrospectively, we propose that it be considered as a prospective policy. Why not require all counselors to receive counseling before being licensed? After all, the Bible tells us, "Physician, heal thyself."

6. Limitations

The findings of this study should be considered within the methodological limitations of a small and non-random sample; all subjects were volunteers, raising the possibility that the best or worst on woundedness in the family of origin might not have volunteered. Some therapists may have felt that their family-of-origin issues were no longer a major focus in their lives, and some therapists may have not wanted to risk opening up to anyone besides their therapist. Self-reporting and retrospective reporting were also limitations of the present study. Retrospective recall may distort perceptions of relationships and negative events of childhood. Given the low internal consistency of the newly

developed Wellness Scale (Cronbach's $\alpha = .53$), the wellness findings should be considered preliminary; however, they serve as a foundation for future research focusing on refining and formally validating this scale.

7. Conclusions

This exploratory comparison of healers and non-healers yielded the following principal findings:

1. Healers reported significantly less healthy families of origin than non-healers, consistent with the central premise of the wounded healer concept.
2. Despite their more troubled family origins, healers did not differ from non-healers in self-esteem, stress, or Type A behavior, indicating that early woundedness was not accompanied by poorer later functioning.
3. Healers reported significantly greater wellness than non-healers.
4. Healers were far more likely to affirm an altruistic motive for their career choice than the non-healers.
5. Healers consumed alcohol less frequently than non-healers.
6. Healers engaged in significantly more self-improvement activity, including personal counseling and the reading of self-help books, than non-healers.
7. Educational level (doctoral vs. master's) was not significantly related to any of the differences between healers and non-healers.

These findings suggest that the wounds associated with the wounded healer may be rooted in the family of origin rather than in present functioning, and that mental health practitioners, as a group, appear to have moved toward wellness through active personal and professional development. However, further longitudinal research is needed to establish how these processes unfold over time

Conflicts of Interest

The authors declare that there are no conflicts of interest.

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