THERAPISTS’ EXPERIENCES WITH ILLNESS, INJURY, AND DISABILITY:
EFFECTS ON THE THERAPIST’S SUBJECTIVITY AND THE THERAPEUTIC
RELATIONSHIP

A DISSERTATION
SUBMITTED TO THE FACULTY
OF
THE GRADUATE SCHOOL OF APPLIED AND PROFESSIONAL PSYCHOLOGY
OF
RUTGERS,
THE STATE UNIVERSITY OF NEW JERSEY

BY
JOSHUA ROMERO, M.A.
IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE
OF
DOCTOR OF PSYCHOLOGY

NEW BRUNSWICK, NEW JERSEY OCTOBER, 2018

APPROVED:
______________________________
Nancy Boyd-Franklin, Ph.D. (Chair)

______________________________
Karen Riggs-Skean, Psy.D.

DEAN:
______________________________
Francine Conway, Ph.D.
This exploratory study investigated the impact of a mental health professional’s illness, injury, or disability on the therapeutic relationship. Primary issues, as identified in the literature, included: (a) disclosure; (b) alteration in the therapist/patient dyad, e.g., transference, countertransference, and a change of focus from patient health to include patient concerns for the therapist; (c) influences on therapist subjectivity; and (d) ethical and training implications. Thirteen clinicians who had faced an illness, injury, or disability while treating patients were interviewed in-person or by phone. A qualitative analysis of the interviews was conducted using a grounded theory approach (Corbin & Strauss, 2014). Study results identified themes consistent with the literature in multiple domains. Themes relating to disclosure of the therapist’s illness included: (a) the trend towards a more relational understanding and acceptance of a therapist’s self-disclosure of illness; (b) disclosing the illness out of necessity; (c) disclosure enhancing treatment progress; and (d) selective disclosure, e.g., disclosing to some patients, but not to others.

Themes related to patients’ reactions to disclosure included transference responses elicited by the therapist’s illness, and the positive effect on treatment resulting from patient concern for the therapist. Themes identified in exploring therapists’ reactions included positive and negative emotional and countertransference responses to the illness, and positive and negative changes to the therapist’s subjectivity. The finding of ethical challenges arising from a therapist’s illness was consistent with the literature. Additional themes expanded upon current knowledge, such as: (a) how illness alters a therapist’s conceptualization of patient treatment; (b) how patient concern for the therapist might be utilized to promote treatment progress; (c) adherence to ethical guidelines; and (d) how enhanced training might prepare therapists for future personal crises. Implications for
research indicated the need for more systematic qualitative and quantitative investigations. Implications for clinicians and the mental health field were identified as pertaining to: (a) issues of disclosure; (b) patient and therapist reactions; and (c) the need for training programs and professional organizations to better prepare clinicians for potential crises, such as illness, and to revise ethical guidelines to incorporate current research findings.
Acknowledgments

There are so many people to thank in this journey of writing this dissertation. Firstly, I would like to express an infinite amount of thanks to my dissertation committee members. To Dr. Nancy Boyd-Franklin, you are an inspiration and a role model. Not only as a professional clinician, but as a person as well. You got me into graduate school, helped me get through graduate school, and most certainly have helped me complete graduate school. There are not enough thank yous in the world to express how grateful I am for your guidance. To Dr. Karen Riggs-Skean, another excellent example of a personal and professional role model, I appreciate your nurturance, guidance and continuous encouragement throughout my early and later days as a young clinician. Thank you both for believing in me!

I would like to take some time to thank the “MasterMinds,” a group of my three closest friends, Frank Jackson, Jeremy Sus, and Jon Guerrera, for their encouragement and support during the initial stages of writing this dissertation study. When I first started, it was a tough year for me since I had to take a year off to recover from a serious medical condition. You guys kept me motivated with the recovery process and on track with the work I had to complete for this dissertation. I am infinitely grateful to have friends like you by my side. To my best childhood friends, Pedro Marquez and Emmanuel Olivo, you guys have been with me since the beginning. Can you believe I am finally going to be a doctor!?? Thank you for being there for me through thick and thin and for always believing in me and pushing me to strive for better. To my girlfriend, Maricela Lares, you deserve a significant degree of gratitude as well for your encouragement and support during the later stages of writing this study. I know that it has been challenging hearing
I complain about how burdensome it is to write a dissertation, but your patience and understanding kept me going through. I am grateful to have you by my side.

To my GSAPP cohort, I am finally going to make it to the finish line! And I would not have done it without your support and all of you sending me well wishes, words of encouragement and just willing me through with positive vibes. I am so grateful to have gone through graduate school with you guys. To my internship cohort, I am really blessed to have met all of you. I would not have chosen anyone else to go through internship with. I sincerely appreciate all of your support and words of encouragement.

To my homeopathic doctor, Joseph Giacona, thank you for saving my life! When I was really sick and hit rock-bottom, your guidance and advice restored me back to health. I have gotten this far because of your efforts.

To my parents, Luis and Maritza Romero, there really are no words that can describe the amount of gratitude that I feel for your love, support, compassion, patience, words of encouragement, and guidance. You made me who I am today and without you, I would not have gotten this far. In my professional opinion, you are the best parents in the world! To my family, I would like to say something in Spanish. Gracias para todo su apoyo, su amor, y su creencia en mí. Estoy orgulloso de ser parte de esta familia y para honrar a esta familia dondequiera que vaya. Ustedes no saben cuánto te amo. ¡Te amo mucho!

Lastly, I would like to thank God. You have been a constant companion and a source of refuge in my life. When I was down, You brought me back up. I may not have always sought You out, but You were always there. I thank You for Your mercy and grace. Thank You for allowing me to do what I love. I pray that You continue to be by
my side and that my work as a clinical psychologist will be pleasing to You and bring glory to Your name. Amen.

Y para todos los Puertorriqueños que sepan, ¡Sí, se puede! Sí, podemos lograr cualquiera cosa nos queremos lograr.
# THERAPISTS’ EXPERIENCES WITH ILLNESS

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Chapter I: Statement of the Problem

“Psychologists are human. At some point during his or her career, nearly every mental health professional will confront a significant health problem” (Johnson & Barnett, 2011, p. 285). Phillip (1993) indicated that young mental health professionals are susceptible to suffering from a serious illness early in their careers, and Johnson and Barnett (2011), along with other scholars (Guy, Stark, Poelstra, & Souder, 1987; Junkers, 2013), have pointed out the substantial likelihood of mental health professionals experiencing a range of illnesses, injuries, and disabilities due to the tendency of therapists to work well beyond a traditional retirement age. Many examples detailing a clinician’s experiences with illness, injury or disability can be found in the literature, such as Cooper (2017) (cancer); Pizer (2016) (blindness); Madonna (2014) (cardiac condition); Brody (2013) (cancer); and Linna (2002) (foot injury). The current study will explore the commonalities in the experiences of mental health professionals who have suffered either from an illness, injury, or disability. (Throughout this study, the term “illness” will include illness, injury, and disability.)

Illnesses, injuries, and disabilities vary in their nature and how they manifest. Illnesses may exist along a spectrum of acute and temporary, or gradual and chronic; critical and life-threatening, or treatable and curable; symptoms that are observable by others, or with no visible symptoms. Injuries can be healed or leave permanent damage. Disabilities, according to Pizer (2016), can be “life-threatening, sudden, progressive, or stable over time” (p. 217). Pizer stressed that illness and disability often have disparate impacts on individuals “Illness is usually accompanied by a change in one’s feelings about health status, whereas disability may be integrated into one’s ongoing identity, with little effect in one’s perception of wellness or well-being” (Pizer, 2016, p. 217).
A serious illness, injury, or disability can be a jarring and terrifying experience that provokes intense emotional responses. When mental health professionals become ill, the ability to manage the emotions elicited by the illness is essential to continuing to function effectively as a therapist. Thus, it is very important for clinicians in this situation to be knowledgeable about how the issue of their illness should be navigated within the therapeutic relationship, as patients may be harmed if the situation is not addressed appropriately by the therapist. Unfortunately, this task is complicated by the following factors: (a) the reluctance of the profession to discuss the topic, (b) the insufficiency of relevant current literature, and (c) the profession’s failure to issue clear ethical guidelines that might help clinicians dealing with a complex situation to have more assurance that they are not putting patients at risk of harm.

**The First Problem: Reluctance To Address the Issue**

Despite the potential for therapists to experience a serious medical illness, injury, or disability, and the impact this potentially transformative event often has on therapists, their ability to treat patients, and the therapeutic relationship itself, this topic has received surprisingly little attention (Barbanel, Dattner, Fieldsteel, Simon, & Ziman-Tobin, 1989; Dewald & Schwartz, 1993; Junkers, 2013; Monaco & Palombo, 2012; Pinsky, 2002; Pizer, 2016; Robutti, 2010; Torrigiani & Marzi, 2005; Vlachos, 2011). Prior to 1982, only five articles had been published on this subject (Chernin, 1976; Cottle, 1980; Dahlberg, 1980; Grunebaum, 1973; Little, 1967). This is especially surprising given the origins of the profession. Many of the pioneering psychoanalysts of the early twentieth century suffered from long-term illnesses, e.g., the father of psychoanalysis, Sigmund Freud, experienced a painful 17-year battle with cancer of the jaw (Barbanel et al., 1989; Frommer, 2005; Junkers, 2013; Pinsky, 2002; Schur, 1972; Silver, 2002; Vlachos, 2011);
Heinz Kohut, a major force in the development of self psychology, suffered from lymphatic cancer which caused intense anxiety as well (Strozier, 2001); and Donald Winnicott, a leading object-relations theorist, had a long-term heart condition (McDougall, 2003; Monaco & Palombo, 2012; Rodman, 2003; Winnicott, 1977). Despite their painful and debilitating illnesses, none of these men—each of whom was a prodigious writer—ever addressed the impact of his illness on his ability to treat patients or whether it had any influence on the therapeutic relationship.

Avoidance of this issue by prominent figures in the field has continued with more contemporary figures in the field such as Emmanuel Ghent who, according to Pizer (2016), never spoke about his vision disability with colleagues or with patients (Bass, Black, & Dimen, 2005; Black, 2003; Pizer, 2016; Zindel, 2014), and leading relational analyst, Stephen A. Mitchell (Goode, 2000), who never indicated whether his chronic heart condition influenced his work with patients.

The Second Problem: Potential Harm to the Patient

Patients are at risk of harm and possible trauma when a therapist with a poor prognosis fails to inform them of this situation. The literature has offered a multitude of examples of the harm caused by therapists when patients were not emotionally prepared for the therapist’s death and/or when no provisions had been made for continuity of care, e.g., referrals (Bruns, 2014; Firestein, 1990; Friedman, 1991; Galatzer-Levy, 2004; Paul, 2014; Pinsky, 2014; Shwed, 1980; Tallmer, 1989; Traesdal, 2005; Vlachos, 2011). Not surprisingly, most patients react with a host of intense negative feelings when this situation occurs (Barbanel et al., 1989; Bruns, 2014; Deutsch, 2011; Garcia-Lawson, Lane & Koetting, 2000; Gurtman, 1990; Kaplan & Rothman, 1986; Lord, Ritvo, & Solnit, 1978; McWilliams, 2017; Paul, 2014; J. Simon, 1990; N. Simon, 1989; Tallmer,
1989; Tauber, 1989; Tiemann, 2012; Traesdal, 2005; Van Raalte, 1984). Tauber (1989), for example, stated that two of her patients experienced “acute depression” after the death of their previous therapists (p. 174).

Given that mental health professionals are expected to uphold the American Psychological Association’s ethical principle of nonmaleficence towards patients (American Psychological Association, 2010), it is important to address the issue of whether therapists should tell patients about their illness, particularly in the case of terminal illness, and understand the ramifications of this decision.

**The Third Problem: Lack of Methodological and Theoretical Foundations**

Despite the reluctance of some prominent psychoanalysts to talk about the issue of an illness, injury, or disability, as discussed above, the literature on the topic has exponentially expanded with Dewald’s (1982) seminal article identifying major issues that can arise from a therapist’s experience with illness, such as: (a) whether a therapist should disclose information about his or her illness and, if so, how much information should be given; (b) what effects might the therapist’s illness have on the patient’s immediate and long-term transference distortions towards the therapist; (c) what effects would the therapist’s illness have on the therapist’s immediate and long-term countertransference (feelings towards the patient) reactions; and (d) what effects would the illness have on the subjectivity of the therapist (Dewald, 1982, pp. 77-87). Additional issues that have been identified by other authors include: (a) the patient’s concern for the ill therapist; (b) ethical dilemmas that arise when a therapist has to work with patients while simultaneously dealing with an illness; and (c) whether training programs and professional organizations can better help prepare mental health professionals to deal
with personal crises, such as an illness. (See Chapter II below for a more detailed discussion of the literature on this topic.)

Most of the current literature exists in the form of self-reported information and subjective opinion deriving from therapists’ (mostly psychoanalysts’) personal experiences with illness. Clinical vignettes incorporated into these articles regarding how therapists and patients are affected by a therapist’s struggle with illness, injury, or disability often are limited in scope, addressing the impact of one individual’s illness on the therapeutic process with patients and/or certain aspects of the therapist-patient relationship (e.g., transference/countertransference). The lack of objective, systematic, qualitative or quantitative research offering a wider perspective has resulted in researchers’ agreement that current theoretical models do not adequately address themes of aging, illness, and death (Cohen, 2002; Frommer, 2005, 2013, 2016; McWilliams, 2017; Pinsky, 2002, 2014; Silver, 2002).

Other than three investigations conducted by Counselman and Alonso (1993), Grunebaum (1993), and Grefenson (2012), the author of the current study could locate no research exploring the significant issues elicited by a therapist’s experience of illness, injury, or disability, and the commonalities among therapists who have experienced physical illnesses. (For detailed discussions of study findings by Counselman and Alonso (1993), Grunebaum (1993), and Grefenson (2012). (See Chapter II.)

It would be beneficial for therapists dealing with an illness, injury, or disability to be able to access professional guidelines, designed to help them navigate questions of whether or not to disclose to the patient, how to respond to the patient’s concern, what to do with countertransference feelings, how to address patients’ transference reactions in
response to the therapist’s illness, how to cope with changes in the therapist’s subjectivity, and how to adequately address ethical dilemmas.

Research Questions

The purpose of the current study was to address the gaps in the literature and explore common themes present in therapists’ experiences of illness, injury, or disability. Issues addressed included: (a) disclosure; (b) the patient’s concern for the therapist; (c) the patient’s transference reactions towards the therapist’s illness; (d) the therapist’s countertransference reactions; (e) the therapist’s subjectivity; (f) ethics; and (g) training and preparation. The issues listed above corresponded to the following seven questions that served as the structure of the interview:

1. Should therapists disclose their illness, injury, or disability to patients?
2. Is the patient’s concern for the therapist, in response to the therapist’s illness, a barrier or beneficial for the patient’s treatment?
3. What are the characteristic transference reactions in response to the therapist’s illness, and how should therapists address them?
4. What are the therapists’ reactions to their individual illness and do such reactions interfere with their ability to work with patients?
5. How is the therapist’s subjectivity affected by the illness experience, and how does an illness experience change the way each thinks about treating patients?
6. What are the ethical dilemmas that can arise when a therapist has to work with patients while dealing with an illness?
7. Are training programs preparing future clinicians to respond to personal crises? What can be done to help prepare future clinicians?
It is this author’s hope that the themes identified in this study can become the basis for further hypothesis testing and lay the foundation for theory.
Chapter II: Review of the Literature

Harm to Patients

Therapists who mishandle the issue of their illness put their patients at considerable risk of harm, particularly if the illness is severe. The literature contains many examples of the harm caused by therapists who have not prepared their patients for their death. Patients may be emotionally devastated and left without any support, particularly when a therapist has not provided for continuity of care (e.g., referrals) (Bruns, 2014; Firestein, 1990; Friedman, 1991; Galatzer-Levy, 2004; Paul, 2014; Pinsky, 2014; Shwed, 1980; Tallmer, 1989; Traesdal, 2005; Vlachos, 2011).

In reviewing the findings of a study investigating the responses to a therapist’s death by Lord, Ritvo, and Solnit (1978), Galatzer-Levy (2004), stressed the severe impact on ten participants who had been described by Lord et al. as “bogged down in mourning [for more than a year,] or warding it off in ways that interfered with personal development or subsequent analytic progress” (Galatzer-Levy, 2004, p. 1000). These patients, who “tended to be older” and had been “in analysis longer than the average patient in the study,” suffered significant symptoms, including “anguish and helplessness, profuse crying, recurrent dreams, and imagined glimpses of the analyst” (p. 1000).

Traesdal (2005) related how one patient reacted to the sudden death of the patient’s analyst: “During the first couple of months my body ached as if I had been severely beaten up physically, and I felt as if I were living two completely different existences simultaneously” (p. 1242). Deutsch (2011) expressed the devastating loss she felt after her analyst died: “I missed not just my analyst, but also my analysis. I had lost contact with that part of me that [could] access fleeting thoughts and feelings and share them with another” (p. 526).
Even when informed of a therapist’s critical illness, patients may still undergo extreme emotional turmoil. For example, Rendely (1999) described her response to the death of her analyst:

I was overwhelmed with anxiety and fear. In an attempt to quell the terror, I began a frantic search for contact. I spoke with my children, with friends and colleagues, with one of my…supervisors….Every time I hung up the telephone I was utterly alone in a frightening and unpredictable world, cut off and isolated. (p. 133)

Given the primacy of the therapeutic relationship, treatment interruption due to a therapist’s illness may often cause patients to experience severe emotional distress. According to Tiemann (2012): “Eventually, I moved into…‘survival mode’ in which I…am simply ‘going through the motions’ in a world that feels colorless and devoid of understanding…..I…felt as if I had lost my only ally” (p. 554).

Rizq and Voller (2013) offered a first-person phenomenological account of a patient’s reaction to her analyst as his illness progressed. Without disclosing his illness, the analyst indicated his intention to decrease his practice and no longer accept new patients. The patient’s reaction was negative and self-focused: “I was feeling no concern for him at all, but just feeling totally shut out and abandoned and angry and cross that he was holding in something” (p. 153). Eventually she learned of his terminal cancer diagnosis and described her feelings during his hospitalization as “very weird and disconnected” (p. 151).

Brothers (2012) described her experience as a therapist whose bout of Bell’s Palsy and the resultant paralysis of her facial expressions provoked a negative transference reaction from a patient and served to re-traumatize her:
My patient usually took pains to avoid injuring the feelings of others.

[However], on seeing my lopsided face for the first time, she said, “Oh dear, you used to be so pretty. You look the way my grandmother did after she had a stroke. She died two days later.”

The therapist was too stunned to respond at first but was then able to ask what prompted the comments:

[The patient] immediately broke into tears. “I’m so mad at you,” she said, “but I know it’s unfair to feel angry when you’re obviously suffering.” I asked her what might be making her angry. After a long pause, she described how her grandmother had turned on [her] in the months before she died, accusing her of stealing her jewelry. A large measure of what had made [that incident] so devastating was that her grandmother had been the one person who had seemed reliably stable in a relational world punctuated by shocking and unanticipated violence. (p. 7)

The therapist first helped the patient put her feelings into words and then worked through the transference with the patient.

Together we realized that...my consistency and predictability had enabled her to develop some small measure of trust that I would not betray her in a similar way....Not only had she been unprepared for my changed appearance—in itself a reminder of the sudden and traumatic change in [her] grandmother—she could no longer guard herself against potential traumas at my hands. We could then understand the lengths to which she had gone to insure that she would not be caught off-guard by others in her life. (p. 7)
The age of the therapist can also add to a patient’s feelings of apprehension. According to Chessick (2013), patients of elderly analysts may become fearful of the analyst becoming ill and/or dying. Additional age-related fears among patients include the analyst developing cognitive impairment, e.g., senility or dementia, or other degenerative diseases. Such patients often become hypervigilant to indications of such conditions.

Therapists often have to navigate complex decisions about how much information, if any, they should tell patients about their illness. Researchers (Galatzer-Levy, 2004; McWilliams, 2017; Pinsky, 2002, 2014; Vlachos, 2011) have stressed the vulnerability of patients to harm when this is mishandled. Ginsburg and Cohn (2007) presented an example of a therapist who not only was unable to properly handle his feelings towards his illness, he had a critically ill wife as well:

[Given the therapist’s] heightened need and distress, he became increasingly frustrated and disappointed…that after more than three years [of treatment] they had reached a stalemate….The analyst began to repetitively address [the patient’s] reluctance to associate, and to pressure her to lie down on the couch. [This] coercive enactment was intensifying [and] in retrospect [was] related at least in part to his personal fear of helplessness (Strean 2002). This fear was being expressed through coercion of the patient. (p. 65)

**Commonalities Among Therapists who Have Experienced Illnesses**

Three studies have been conducted with multiple subjects exploring the issue of the impact of illnesses on therapists. Counselman and Alonso (1993), assessing the impact of their illness on the therapists themselves, their patients, and the therapeutic relationship, distributed questionnaires to nine psychoanalysts who were colleagues and
close friends of the researchers. The surveys included questions related to (a) how much information was given to patients about the therapist’s illness, (b) the aspects of dealing with an illness as a therapist that each found difficult, and (c) patient reactions towards the therapist’s illness. Most respondents indicated that: (a) they provided patients with a minimal amount of information regarding their illness; (b) various countertransference responses were experienced, including anxiety about returning to work, the difficulty of being absent from the work as a therapist, denial of the severity of the illness, and the urge to reassure patients about his or her illness; and (c) patient reactions, including patients expressing concern that the therapist minimized the severity of the illness and patients feeling guilty about their angry feelings towards the therapist.

Grunebaum (1993) conducted interviews with 12 mental health professionals regarding their illness and their experiences providing therapy services during the duration of and recovery from their illness. He identified certain common concerns among the interviewees, such as (a) the suddenness of illness onset; (b) the seriousness of the illness or injury; (c) the unpredictability of the outcome; (d) not knowing how long recovery would take, and thus being unable to determine when they would be able to return to work; (e) how the therapist’s absence would affect the patient; (f) the point at which therapists should inform the patient of the therapist’s illness, and the appropriate method of conveying that information; and (g) identifying the noticeable sequelae of the illness and assessing patient reaction to such sequelae. Grunebaum (1993) also identified several common intrapersonal variables and concerns with his participants. These included: (a) a significant desire and need to work, (b) the need to work with patients while experiencing pain and discomfort, (c) patient work as a means to cope with social isolation experienced in response to dealing with an illness, (d) parallels in the therapist’s
and patient’s social network, (e) the emotional state of the therapist, (f) making judgments on what to tell the patient about the illness, (g) patients’ idiosyncratic reactions to the therapist’s illness, (h) whether the therapist serves as a role model to the patient, and (i) does the illness adversely affects the therapist’s work with patients.

Grefenson’s (2012) study explored how experiencing breast cancer elicited changes for seven female therapists in terms of (a) themselves, as individuals; (b) as therapists treating patients; and (c) how they conceptualized their work with patients. Participants reported both positive and negative changes. As individuals, they experienced the following positive changes: (a) more self-awareness, (b) greater efforts at self-care, (c) greater comfort with themselves as therapists, and (d) increased awareness of their capacity to grow through adversity. Positive changes they experienced when working with patients included the following: (a) significant increases in patience, compassion, empathy and attunement; (b) increases in noticing and pointing out to patients that it was possible to grow through adversity; (c) an increased focus on a patient’s strengths; (d) an enhanced ability to simply listen without feeling compelled to suggest solutions; and (e) they were more real and vulnerable with patients.

While some positive changes may have manifested exclusively for participants in their capacity as individuals, some negative aspects often shared both a personal and professional component, e.g., decreased energy, feeling tired and physically ill during sessions with patients, and memory problems. Other negative manifestations were exclusive to patient treatment, e.g., decreases in patience with a patient’s self-defeating behaviors, an increased difficulty with listening to some patients’ complaints, and difficulties with focus and concentration during sessions. Finally, participants reported that their experiences with cancer were so profound that it caused them to rethink and
expands their theoretical orientations regarding their work with patients. Most of these participants reported that they became more existential and humanistic in their orientation due to their increased awareness of their own mortality and fragility (Fischer, 2001; Slattery & Park, 2007).

**Issues of Disclosure**

Whether therapists disclose serious medical conditions to patients has been a key focus of the literature and the subject of debate within the field. According to reviews conducted by Fajardo (2001), Goldstein (1997), Kahn (2003), and Monaco and Palombo (2012), most therapists’ views of disclosure can be characterized as adhering to one of two categories. The first perspective, based in classical psychoanalysis, holds that a therapist should not provide any information about the illness so that the patient’s transference reactions may be uncontaminated by knowledge of the therapist’s personal life. Additionally, arguments against disclosure include its potential to disrupt the treatment and create an unnecessary burden on patients (Abend, 1982; Clark, 1995; Cooper, 2017; Dewald, 1982; Friedman, 1991; Gervais, 1994; Lasky, 1990; Lindner, 1984; Madonna, 2014; Meissner, 1996, 2002; Schwaber, 1998; Schwartz, 1987; Simon, 1990; Van Dam, 1987; Wong, 1990).

The second perspective, based in the relational psychoanalytic approach, views disclosure in a positive manner. Rather than disruptive of the treatment process, proponents of this position perceive disclosure as having the potential to: (a) promote the evolution and development of the patient’s transference reactions, (b) enhance the treatment process by fostering authenticity and intimacy in the therapeutic relationship, and (c) encourage patients to talk about their inner-most anxieties (Brody, 2013; Brothers, 2012; Davoine, 1990; Engels, 2001; Frommer, 2009, 2013, 2016; Grunbaum,

A third school of thought, advocated by Moses and McGarty (1995) and others (Friedman, 1991; Kahn, 2003; Kuchuck, 2009; Pizer, 2016; Weinberg, 1988), takes the middle ground and argues against restrictive positions that either mandate disclosure or forbid it. They hold that disclosure decisions are made by individual therapists based on reasoning that is personal and idiosyncratic to each clinician, and that the context of the therapeutic situation should also be considered in the disclosure decision. For example, Dewald (1982), who was otherwise opposed to disclosure of one’s illness to patients, stated that there were circumstances in which disclosure was appropriate, such as with patients in supportive psychotherapy when the working through of transference is not a focus, and at the start of psychoanalytic treatment with patients who have not had enough time to develop a regressive transference.

An additional factor may arise from the serious nature of a particular illness and the responsibility to consider the best interest of patients. For example, Phillip (1993), who had been diagnosed with a life-threatening blood cancer, decided to disclose her health situation to her patients to prepare them for the possibility that she would have to close her practice. (It should be noted that not all mental health professionals prioritize their responsibility to patients, as discussed above.)

A decision not to disclose may also be subject to reconsideration for a number of reasons often unique to the clinician (Cooper, 2017; Friedman, 1991; Schwaber, 1998). For example, Schwaber (1998), who had initially chosen not to disclose her illness based on her belief that disclosure would elevate her anxiety, found that nondisclosure was
creating a sense of emotional distance in her work with her patient and thus was harmful to the therapeutic relationship. Friedman’s (1991) original decision not to disclose was rendered moot when some of her patients learned about her illness from others. Cooper (2017), whose near-death experience caused a significant interruption in his practice, felt that he had to explain his absence to patients.

Once therapists make the decision to disclose, the content of the disclosure needs to be considered. Grunebaum (1993) found that all of the therapists he interviewed were straightforward with their patients, giving them an honest recitation of the facts of their illness. Despite the uniformity among Grunebaum’s (1993) sample, and further research (Morrison, 1997) supporting the position that comprehensive disclosure is indicated, others have argued for a more conservative approach, e.g., providing minimal information, not revealing the exact diagnosis (Cooper, 2017). Consensus in the field has not been reached and therapists hold divergent views as to what to tell patients, often dependent on the individual therapist’s own attitudes.

While clinical vignettes illustrating therapists’ disclosures to diverse patients are abundant in the literature, these individual examples, by themselves and in the aggregate, do not reveal the types of patients for whom disclosure is indicated and those for whom it is not. A few authors did, however, attempt to offer guidance. For example, Monaco and Palombo (2012) suggested that a patient’s level of functioning inform a therapist’s disclosure decision:

Most therapists, who believe in disclosing the nature of their illness, caution that therapists should tailor their disclosures to the patients’ psychodynamics and diagnosis. The more disturbed the patient the less detailed the disclosure; the healthier the patients, the more detailed answers to satisfy the patients’ need to
know. The consensus is that how much to disclose should always be titrated to match the patients’ capacity to tolerate the anxieties produced by the information.

(p. 319)

Goldstein (1997) advised that the developmental needs of the patient should serve as the basis for the disclosure decision and that therapists assess a patient’s capacity to cope with disruptions prior to disclosure. Thus, patients who could be negatively impacted and traumatized by the therapist’s disclosures should not be told anything about the therapist’s illness. Conversely, some authors hold that the severity of a patient’s mental health should not preclude disclosure, and that it may be more harmful for individuals with psychosis not to be informed as there would be an increased potential for trauma in such patients (Davoine, 1990; Searles, 1975; Silver 1982, 2001). Regarding disclosure to children, Monaco and Palombo (2012) recommended that disclosure “should be titrated to match the level of the children’s cognitive maturity” (p. 324).

Despite the efforts of the authors above to offer guidance, the conclusion remains that disclosure decisions be made on a case-by-case basis.

Some literature has suggested, consistent with the relational psychoanalytic approach discussed above, that disclosure of an illness can be helpful to patients. Van Raalte’s (1984) dissertation study found that when clinicians had been honest with patients about their illness prior to their death, these patients tended to have better outcomes than patients to whom therapists had not disclosed. Conversely, when analysts had not been honest with patients about their illness, patients had difficulty trusting other therapists and engaged in self-blame for the analyst’s death (McWilliams, 2017; Van Raalte, 1984). Cooper (2017), who had originally advocated for nondisclosure and later reconsidered this position, noted that disclosure of his medical condition to his patients
prompted patients to open up more about their own death anxieties—conversations he characterized as fruitful.

Pizer (2016) associated disclosure with resulting in a greater sense of intimacy in the therapeutic relationship. Frommer (2009; 2013) suggested that disclosure would be helpful in the treatment process as it would relieve the burden of having to withhold information from patients about their therapists. Frommer (2013) elaborated on the need for contemporary relational theory to be revised so that therapists might be allowed to be vulnerable in ways that are beneficial to the patient, but would not compromise the integrity of the therapist. The issue of how a therapist’s vulnerability may be utilized as part of the treatment frame has not received sufficient attention in the psychoanalytic literature, according to Pizer (2016) and Pinsky (2014).

Although the issue of whether therapists should disclose the facts of their illness has been discussed in the literature, such discussions have not yielded consensus nor produced a theoretical basis from which therapists might be guided to make their own decisions in the best interests of patients. Rather than the existing emphasis on the process of disclosure as highly idiosyncratic and based on the personal attitudes of the individual therapist, it would be useful to identify themes that can provide a rationale for: (a) a therapist choosing whether to disclose or not to disclose, (b) the amount of information a therapist should disclose, (c) the patients who are proper recipients of disclosure and those who are not, and (d) the likely impact of disclosure on different types of patients.

Patient’s Reactions to the Therapist’s Illness

Patient’s Awareness of Therapist’s Illness. The literature has documented that a patient can become aware of a therapist’s illness through methods other than therapist
disclosure, such as the patient finding out this information from others, drawing conclusions from a therapist’s extended leave of absence (Cooper, 2017), or observation of a therapist’s visible symptoms or bodily changes (Wong, 1990). Additionally, some authors have acknowledged a patient’s ability to intuit a therapist’s illness in the absence of disclosure or visible symptoms (Davoine, 1990; Searles, 1975; Silver, 1982). Fajardo (2001) expanded on Silver’s thesis of an “unconscious communication” transpiring between patients and therapists which Fajardo attributes to Silver’s work with “many borderline and psychotic patients in her practice” (p. 573): “[Silver] believes that many patients, regardless of diagnostic category, perceive subtle changes in the analyst’s bodily and emotional states, including those associated with serious, even life-threatening illness” (p. 573). Fajardo’s analysis of Silver’s work extends to the need of therapists to gauge patients’ attitudes and react accordingly: “[Silver] recommends that the analyst stay alert to themes in the material that suggest the patient’s awareness of the illness and respond openly with appropriate factual information and exploration of transference wishes and fears” (p. 573).

Davoine (1990) offered a clinical vignette illustrating a patient’s unconscious awareness of a therapist’s illness that took the therapist totally off guard:

[During the first session after returning to work, the therapist] greeted [the patient] with the words: “So we were both in a hospital. And here we are, looking as if we had to survive.” He asserted right away: “Your operation was in the belly.” “Yes, it was. How did you guess?” “Before your departure I knew it.” What kind of knowledge was that? Telepathy? Had he looked into my soul? Was it a mere chance of guess? He then told me how anxious he had been [when he saw me] deteriorate before his very eyes. He had not said anything for fear of
scaring me and making things worse. Then he added: “You were acting like a robot, only moved by duty.” Shamefully, I had to acknowledge that none of this psychical as well as physical distress had reached my awareness. (pp. 57-58)

If patients have some awareness of the therapist’s illness despite a lack of disclosure, the idea that therapists can truly hide their illness and maintain a neutral analytic attitude in treatment may need to be reconsidered. Further exploration of whether a therapist’s knowledge of a patient’s unconscious awareness is an additional factor in the disclosure decision is indicated.

**Effects on patients’ transference reactions.** The consensus in the field is that a therapist’s experiences with a serious medical condition can have a significant impact on the development of a patient’s transference reactions towards the therapist, and the ways in which the illness, injury, or disability can effect a patient’s transference reactions has received considerable attention in the literature (Brody, 2013; Brothers, 2012; Chaudhuri, 1999; Cole, 2001; Cottle, 1980; Cristy, 2001; Davies, 2004; Dewald, 1982; Elliott, 1996; Engels, 2001; Fajardo, 2001; Feinsilver, 1998; Frank, 1975; Friedman, 1991; Frommer, 2013; Goldstein, 1997; Grunebaum, 1973; Guy & Souder, 1986; Halpert, 1982; Hoffman, 2000; Kahn, 2003; Lindner, 1984; Linna, 2002; Little, 1967; Meloche, 1984; Monaco & Palombo, 2012; Morrison, 1997; Oesterheld & Buckman, 1989; Pinsky, 2014; Pizer, 2009a; Schwaber, 1998; Silver, 1982; Strean, 2002; Torrigiani & Marzi, 2005; Woods, 2013). Interestingly, Levy (1968-1969) suggested that the transference reactions of one of Freud’s famous patients, the “Wolf-man”, may have been influenced by Freud’s cancer symptoms that, despite Freud’s unwillingness to address them in session, were apparent.

Although patients’ reactions are often idiosyncratic, varied, and dependent upon the nature of the therapist’s illness and the patient’s character style and life history, many
authors have agreed that certain reactions, such as anger, are commonplace among patients (Brody, 2013; Brothers, 2012; Dewald, 1982; Fajardo, 2001; Frank, 1975; Friedman, 1991; Goldstein, 1997; Guy & Souder, 1986; Hoffman, 2000; Kahn, 2003; Lindner, 1984; Monaco & Palombo, 2012; Silver, 1982; Torrigiani & Marzi, 2005).

Dewald (1982) reported that many patients react to the therapist’s illness with “hostile, aggressive, disappointed, or depressive feelings regarding the separation and what they experienced as sudden abandonment (p. 82).” Guy and Souder (1986) highlighted that patients can react with guilt since they feel that they have either contributed to the therapist’s illness or survived the therapist by maintaining their own good health (Cottle, 1980; Halpert, 1982; Kahn, 2003; Monaco & Palombo, 2012; Pinsky, 2014). Other reactions include their expressing concern towards the therapist and even wishing to care for the therapist (Feinsilver, 1998; Kahn, 2003; Lindner, 1984; Linna, 2002; Pizer, 2009a; Searles, 1975; Silver, 1982; Singer, 1971). Conversely, patients can react with resentment that they are being treated by someone who is weak and vulnerable (Chaudhuri, 1999; Cottle, 1980; Elliott, 1996; Engels, 2001; Feinsilver, 1998; Kahn, 2003). Some patients adopt a stance of denial, refusing to acknowledge that the therapist is ill or injured (Cristy, 2001; Friedman, 1991; Guy & Souder, 1986; Halpert, 1982; Linna, 2002; Meloche, 1984; Torrigiani & Marzi, 2005; Woods, 2013).

Oesterheld and Buckman (1989) identified four facets of the therapist’s experiences with illness that elicit transference reactions from the patient by stimulating feelings, impulses, wishes, fears, beliefs, fantasies, and defenses from within the patient that correspond to previous events that have occurred in the patient’s life history. These include: (a) the absence of the therapist due to illness or injury, (b) the perceived vulnerability of the therapist, (c) manifestations of the therapist’s illness or injury, and
(d) particular symptoms of the therapist’s illness that prompt idiosyncratic reactions. They provided an example of how a therapist’s absence due to illness caused a transference reaction in a patient:

A graduate student came to therapy because he was blocked in writing a thesis on the subject of psychological adaptations to chronic disease. Four months into therapy, the therapist developed an acute viral illness which necessitated cancellation of therapy for two weeks. Upon the therapist’s return, the patient became enraged at the therapist because the therapist had “deserted him.” Suddenly the patient began to weep and revealed that he had experienced similar feelings towards an older sister who had been hospitalized with arthritis when the patient was ten years old. The patient had previously denied any illness in the family. Following the working through of these feelings, the patient was able to resume work on his thesis. (p. 47)

Although the literature has offered some information regarding how different aspects of a therapist’s illness experience can elicit a transference reaction from a patient, and how transference reactions commonly manifest among patients, there is little analysis of how such transference reactions should be worked through in the context of the therapy. Such information would be useful to guide therapists in helping patients navigate through various emotional responses that may occur in response to the patient’s awareness of, or the therapist’s disclosure of, a serious medical condition.

**Patients’ Concern for the Therapist**

Although a patient’s response of concern to the therapist’s illness was considered characterized predominantly as a transference reaction in the literature, some authors characterized the patient’s concern differently. For example, Barker and Stern (1973)
considered that expressions of concern might be genuine and not the result of a transference reaction: “Patients may actually make suggestions to facilitate better health in the therapist, and [Barker and Stern] would take the suggestions as an expression of a real concern, rather than analyze it” (as stated in Flapan, 1986, p. 33).

Searles (1975) expanded the concept of patient concern for the therapist beyond that expressed by Barker and Stern (1973), stating that a patient’s concern for a therapist was a necessary requisite of a successful treatment (Sapountzis, 2009; Searles, 1975; Singer, 1971; Strean, 2002). Searles’s theory posited that psychopathology occurs in response to a patient’s failure in alleviating or resolving the problems of a parent, caregiver, or significant other. Thus, allowing the patient to demonstrate concern towards the therapist would be highly beneficial towards the patient’s progress in treatment, as long as such concern was appropriate in degree. His ideas were later confirmed by the experiences of Sapountzis (2009) and Strean (2002) who related that when each allowed patients in their practice to become aware of the difficulties and vulnerabilities that each faced both personally, and professionally as therapists, their patients made significant progress. Davies (2004) reported witnessing a positive insight her patient had as a result of the therapist’s acceptance of the patient’s expression of concern. When Davies was ill with a cold during a session, her patient prepared her a cup of hot tea. As Davies drank the tea, the patient reported that the gesture helped her realize that she, the patient, could be a caring and nurturing person. This insight led the patient to begin experiencing increases in her self-esteem.

Although the above examples revealed positive outcomes for patients as a result of their concern for the therapist, none of these were in the context of a therapist’s serious illness. Therefore, Searles’s (1975) original assertions about patients’ concern for
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therapists has not received significant attention in the literature regarding therapists experiencing a grave medical condition. It would be beneficial to understand, from a clinical and theoretical perspective, whether a patient’s concern for a seriously ill therapist would be helpful or have a negative impact on treatment. Such analysis could provide important implications for revising current relational theory.

**Effects on Countertransference and Subjectivity of the Therapist**

Just as a therapist’s experiences with a serious medical condition can affect a patient’s transference reactions to the therapist, various aspects of a therapist’s experience with illness can influence countertransference reactions that a therapist develops towards patients (Dewald, 1994). These variables include: (a) the onset of illness, ranging from acute and unexpected to gradual; (b) the characteristics of the illness; (c) aging; (d) recovery from an illness; (e) the professional issues that may result due to the illness; and (f) the positive therapeutic opportunities that can arise from an experience with illness. In a prior publication, Dewald (1982) identified common countertransference reactions of therapists toward their patients, including exhibitionistic and/or masochistic fantasies of wanting the patient to take care of them, and using patients as a source of gratification so that therapists might maintain a positive self-image related to his or her identity as a therapist (Coen, 2007; Counselman & Alonso, 1993; Torrigiani & Marzi, 2005; Van Dam, 1987; Wong, 1990). Other reactions include: (a) guilt for abandoning a patient; and (b) anxiety experienced towards the patient regarding the therapist’s ability to tolerate the patient’s intense negative affect, such as anger, aggression, and hostility (Durban, Lazar, & Ofer, 1993; Levin, 1998; Morrison, 1997; Torrigiani & Marzi, 2005; Wong, 1990); and (c) facing uncomfortable emotional experiences and aspects of self (Abend, 1982; Brothers, 2012; Chaudhuri, 1999; Chernin, 1976; Counselman & Alonso,
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In addition to research scholarship, the literature has provided a range of first-person accounts of how a serious medical condition impacted a therapist’s emotional experience and various aspects of his or her subjectivity. Most therapists reported an emotional experience during the course of their illness, injury, or disability that reflected its terrifying nature and generated a diverse range of intense emotions. For example, Monaco described his emotional reactions in response to a diagnosis of lung cancer as consisting of “sheer panic, to devastating depression, to intense anger” (Monaco & Palombo, 2012, p. 317). Elliott (1996) dealt with extreme feelings of fear, rage, shame, and depression when she learned of her diagnosis of Parkinson’s disease. Kahn (2003) reported that her potential diagnosis of breast cancer caused so much anxiety it interfered with her ability to focus during therapy sessions. Linna (2002), whose foot injury was visible, reported that she felt wounded and that it was difficult for her when patients mentioned her injury. With regard to her diagnosis of breast cancer, Engels (2001) stated, “I felt at times alone, helpless, terrified and convinced that I was dying. At other times I felt angry and resentful at having to go through what promised to be a major ordeal and upheaval” (p. 2). Schwaber (1998) reported experiencing intense emotional isolation as a consequence of her decision not to disclose her cancer diagnosis to patients. Brothers (2012), Counselman and Alonso (1993), Frommer (2009, 2013), and Morrison (2008)
reported that therapists can experience a sense of profound shame when dealing with an illness.

Fajardo (2001) identified three different stages of emotional reactions that therapists undergo while experiencing a life-threatening illness. The first stage involves a fear of death accompanied with feelings of dread and terror. The second stage involves regaining a sense of optimism once a therapist experiences a trajectory of healing from the illness and is able to resume therapeutic work with some semblance of normalcy. The third stage involves remission of, or recovery from, the illness and enables the therapist to establish a sense of emotional distance from the illness.

In contrast with the prevailing, more pessimistic attitude towards the onset of illness, as discussed above, Feinsilver (1998) reported that his diagnosis of metastatic cancer caused him to experience life with more pleasure and produced other positive consequences, e.g., provoking a reestablishment of his priorities and a rethinking of what was important for him, viewing his therapeutic work with more verve, and his belief that his patients significantly improved in their ability to explore their conflicts and emotional pain after he became ill.

Some therapists report that an illness experience can alter their subjectivity in various ways. Subjectivity is defined for the purposes of this review as consisting of the following: (a) the various self-states that the therapist uses to connect with and help patients throughout the process of therapy, e.g., a therapist uses the empathetic parts of himself to convey understanding towards patients; (b) a therapist’s self-perception and confidence level towards his or her ability to provide effective therapy, which includes the therapist’s ability to provide a holding function for a patient’s subjectivity and his or her intense negative emotions; (c) a therapist’s ego and superego functioning, which
includes the use of defense mechanisms that help the therapist to self-regulate against the uncomfortable self-states and realities of dealing with an illness while working with patients; and (d) the individual’s professional identity as a therapist.

With reference to alterations in the therapist’s self-state, Pizer (2009a) described how an emergency medical crisis with perforated diverticulitis changed his therapist self-state from a rational, intellectual, “left-brained” self-state to a more intuitive, emotionally-attuned, “right-brained” self-state:

Within me, some profound shifts were occurring. My heightened body experience, my posttraumatic psychic readjustments, my management of shame and vulnerability, my gradual absorption of my exposure to near-death, and my physical hyperawareness, all shifted me to a more right-brain mode of being. I experienced an acute intuitiveness, impatience with surface words, a sense of immersion in conditions of risk and a surprising daring about taking risks of clinical response that felt to me both different and notable….I…generally think of myself as heartfelt and affectively available, playful and open, but I also know myself as wordy and certainly leaning toward the left-brain and the use of language to connect. (p. 52)

Shernoff (1991, 1996) also experienced a shift in his self-state as a therapist. He stated that he developed a “special empathy (Cole, 2001, p. 116)” for his HIV positive patients after he was diagnosed as HIV positive. Cole (2001) stated that his diagnosis of HIV positive forced him to redefine himself and create a “new narrative of self” (p. 118), which included an awareness of, and empathy for, the social stigma that he and others face as individuals diagnosed with HIV.
In the study by Grefenson (2012), as discussed more fully above, participants reported that their experiences with breast cancer elicited changes that manifested in both professional and personal aspects of their lives, including (a) changes in their subjective capacities for patience and empathy displayed towards patients, (b) shifts in their levels of self-awareness, and (c) changes in their theoretical orientation. Fischer (2001) found that her experience with breast cancer resulted in her developing a “greater empathy for and understanding of my own patients’ struggles” (p. 101), made her “more sensitive to others” and “heightened [her] sense of compassion” (p. 107). Brody (2013) described how her struggles with cancer caused a “sudden change of course that became part of my work and life” (p. 46), while Brothers (2012) remarked that her bout of Bell’s palsy affected her “embodied self” (p. 3), and that she began to become more attuned with the creative and vital aspects of herself as a therapist.

Some therapists have expressed the view that an illness experience compromises their therapeutic efficacy, specifically in the ability to use their subjectivity in providing a holding function for patients, i.e., helping patients feel soothed, helping them sort out their thoughts and feelings. For example, Rytöhonka (2015) interviewed a colleague who had experienced a life-threatening illness and reported that working with patients at that time was a “constant burden.” Linna (2002) declared that it was difficult for her to maintain an “internal therapeutic frame” (p. 33) of being able to endure and contain a patient’s intense negative feelings, such as terror, rage, jealousy, and hatred. Ulman (2001) reported the case of a therapist who found it difficult to contain his patients’ fears of mortality—both of their own and the therapist’s—while simultaneously confronting his own feelings on his mortality. These therapists’ difficulties in enduring the patient’s intense fears and negative affect comports with Durban, Lazar, and Ofer’s (1993)
metaphor of the ill or injured therapist as a “cracked container.” They explained the concept as follows:

We describe a “cracked container” in two senses of the term. Firstly, the body, which was supposed to be an unobtrusive partner in our work, has, literally, become an irritant and a saboteur. Secondly, this difficult and painful confrontation with the limits of our ability will be experienced as a crack in the therapeutic function of containing. The therapist’s private contents, which should have remained self-contained, have leaked out uncontrollably. The illness, an excess of reality, permeates the therapeutic space. (p. 708)

Illness can also have an effect on the therapist’s use of defenses and superego functioning. A therapist’s use of defenses can be viewed as both necessary and inevitable as a means to cope and come to terms with uncomfortable aspects of his or her illness experience. Denial is a frequent response towards dealing with a medical condition (Arlow, 1990; Clark, 1995; Counselman & Alonso, 1993; Dewald, 1982, 1994; Edwards, 2004; Guy & Souder, 1986; Rosner, 1986; Silver, 1982, 2001). Cole (2001), who had been diagnosed HIV positive, used denial so that he could continue to rationalize his decision to proceed with his psychoanalytic training. Similarly, when Cristy (2001) was diagnosed with multiple sclerosis, her use of denial and dissociation allowed her to push the painful intense feelings associated with her illness out of awareness, especially when she was in session with patients. Although some authors (Arlow, 1990; Counselman & Alonso, 1993; Dewald, 1982, 1994; Edwards, 2004) have claimed that denial is disruptive to the treatment process, Cole (2001) deemed denial to be critical to moving forward in his professional training, and Cristy (2001) considered the use of denial as a
defense to be adaptive and necessary in order to continue effective treatment with patients.

Researchers, such as Abend (1982), Chaudhuri, (1999) Chernin (1976), Counselman and Alonso (1993), Dewald (1982), Edwards (2004), Frommer (2009), Torrigiani and Marzi (2005), and Wong (1990), have suggested that most therapists utilize idealization of self in believing that they possess, in Kreichman’s (1984) term, a “personal specialness” (p. 384) that makes them invulnerable to illness and personal crises because of their role as healers. An experience of illness or injury, however, forces the therapist to grapple with a self-image of being delicate, feeble, and needy, and thus can shatter any illusions of omnipotence and fracture the therapist’s idealization of self (Coen, 2007; Dewald, 1982; Ulman, 2001). Edwards (2004), for example, considered that a cancer diagnosis caused her to mourn for her idealized, healthier former self and forced her to adjust to a new reality:

Since I’ve had cancer, my whole way of thinking about myself has changed. I am no longer that healthy person who could run to catch a bus or plan a schedule without allowing for the scary incursions of doctors’ checkups. I have had to come to terms with the person I have become and to accept the loss of aspects of my former self so long taken for granted. (p. 315)

Lasky (1992) focused on how the therapist’s superego functioning is affected by illness. He identified six superego processes impacted by illness, including: (a) problems of self-esteem regulation, (b) regression regarding one’s object-relationships, (c) the awakening of formerly inhibited instincts (e.g., the need to be taken care of), (d) an alteration from being idealistic to being personally motivated by one’s needs and
interests, (e) disruptions in healthy narcissistic strivings, and (f) relegation of autonomous ego functioning and reality testing to meet the more unrealistic demands of the superego.

Relatively little research has been conducted examining how a serious medical condition might affect the therapist’s professional identity. In response to Frommer’s (2009) question concerning how the changes caused by Pizer’s illness experience “endured over time” (p. 78), Pizer (2009b) reported that even after his recovery, the changes he experienced in his therapist self-state due to his struggle with his illness became embedded within his identity as a therapist. DeMarce (2007) stated that her diagnosis with Hodgkin’s lymphoma altered her beliefs in a just world and resulted in her becoming more accepting and nonjudgmental towards patients. Grefenson (2012) found that her participants’ identities as therapists shifted significantly because of their experiences with breast cancer, exemplified by their theoretical orientations expanding or becoming more eclectic. A dissertation study conducted by Stilgenbauer (2007) also suggested the potential for an illness experience to cause shifts in a therapist’s theoretical orientation as well as how therapists conceptualized their work with patients. Van den Brink’s (2013) illness experience had a transformative impact on his identity. His illness caused him to reconsider his worldview on how one should think about and treat patients, and prompted his career switch from being a medical doctor to becoming a therapist.

While Van den Brink (2013) might offer an extreme example of an illness experience influencing professional development, it is unclear to what extent changes in self-state brought about by illness endure for mental health professionals. The ability of a therapist to self-regulate when working with patients during the duration of a serious medical condition is not well-understood. While some therapists have stated that they were still able to provide “good enough” therapy during their illness (Grunebaum, 1993,
Woods, 2013), there is some evidence suggesting a connection between a therapist’s personal distress and impairments in the process of therapy (Johnson & Barnett, 2011; Sherman & Thelen, 1998). Many therapists have reported the potential for an illness to compromise their ability to hold the patient’s intense affect effectively (Durban, Lazar, & Ofer, 1993; Linna, 2002; Rytöhonka, 2015; Torrigiani & Marzi, 2005; Ulman, 2001).

Additionally, there is debate within the field as to whether a therapist’s use of defenses is healthy and adaptive (Cole, 2001; Cristy, 2001), or disruptive towards the therapist’s ability to provide therapy (Arlow, 1990; Dewald, 1982, 1994; Edwards, 2004; Lasky, 1992; Torrigiani & Marzi, 2005).

Ethical Dilemmas and Therapists’ Preparedness for Dealing With Personal Crises

When therapists become ill, injured or disabled, ethical dilemmas arise concerning the decision of whether to continue their practice. The American Psychological Association’s Code of Ethics sought to provide guidelines to therapists facing an illness, injury, or disability through Ethical Standard 2.06b and Ethical Standard 3.12. Ethical Standard 2.06b advises therapists in this situation to seek guidance or make a decision to discontinue or reduce one’s workload. Ethical Standard 3.12 sets forth the responsibility of therapists to assist with the continuity of treatment for their patients when therapists interrupt their practice due to illness, among other factors (American Psychological Association, 2010).

There has been little scholarly attention devoted to the ethical concerns inherent in a therapist’s becoming ill, injured, or disabled. Bram (1995), in the one article that discussed this topic at length, elucidated three primary ethical dilemmas present in this situation: (a) self-disclosure of the illness and deciding whether it is more important to act in the patient’s interests (beneficence) versus telling the truth regardless of the potential
consequences (fidelity); (b) the risk of abandonment of the patient and the responsibility to act in an ethical manner when complications exist by reason of the illness, e.g., providing patients with referrals; and (c) the decision to return to work and the conflicts of interest that such a decision entails for the therapist and patient if the illness has the potential for continued impairment. Cole (2001), for example, grappled with ethical issues surrounding the timing of disclosure: Did he have a responsibility to disclose his HIV positive diagnosis to patients before his illness would become evident to them through an obvious deterioration of his health or visible symptoms?

An additional complication arises as a result of financial considerations. A therapist’s need to earn a living, support a family, and maintain his or her livelihood, may be prominent concerns. For example, Henry (2009) returned to work after a diagnosis of breast cancer out of “necessity” (p. 294). She would have been unable to pay for her living expenses without the income from her private practice. Morrison (2008) similarly didn’t consider that he had the option to retire, despite being placed on dialysis, given his need for the income generated by his private practice. A method some authors (Henry, 2009, Morrison, 1997, Shernoff, 2009) suggested as crucial to their ability to meet their financial obligations when they had to take a leave of absence or were no longer able to work was having disability insurance policies in place before the onset of illness.

Potential loss of income may operate as a factor in disclosure as well (Morrison, 1997). Phillip (1993) asserted the financial incentive to remain silent about the illness out of concern that patients could leave treatment upon disclosure. Morrison (1997) corroborated the connection between disclosure and loss of income: she received fewer referrals for new patients after being diagnosed with breast cancer.
While both Henry (2009) and Morrison (2008) stressed that their decision to continue working was strictly out of financial necessity, the issue has psychological as well as practical implications. According to Morrison (2008), reductions in income can cause therapists to experience a sense of “personal humiliation” (p. 75). When therapists rely on their work for a sense of productivity and meaning, curtailing a practice or retirement may not be considered conceivable irrespective of financial considerations. An additional ethical issue complicating therapists’ decisions whether to retire due to illness is whether they can fulfill their responsibility to patients to provide competent treatment. Shernoff (2009) described experiencing “deep sadness” (p.109) upon his realization that he no longer was competent enough to continue his practice and had to make the “painful” (p. 109) decision to retire.

Although little, if any, literature exists exploring the issue of adequate training of therapists to deal with potential illness, injury, or disability, recent efforts have been undertaken in the profession to prepare therapists to plan for future crises. Steiner (2011) and others (Bradley, Hendricks, & Kabell, 2012; O’Neil, Yanchyshyn, & Freebury, 2014; Pope & Vasquez, 2005; Steiner, 2011) have stressed the necessity for mental health professionals to contemplate the eventuality of ending their practices, and that “having a plan in place ahead of time may drastically reduce the stress of dealing with the complex issues that often arise when we are most vulnerable” (Steiner, 2011, p. 34). One example of such a plan is the preparation of a professional will (Bradley, Hendricks, & Kabell, 2012; O’Neil, Yanchyshyn, & Freebury, 2014; Pope & Vasquez, 2005; Steiner, 2011), which Steiner (2011) described as follows:

[A professional will] details your wishes for the treatment of your patients in your absence, planned or unplanned, whether due to serious illness, relocation,
retirement, or death. It is designed to reduce the trauma and impact on your patients, colleagues, and you when you are unavailable. (p. 35)

Unfortunately, there are some therapists who remain unwilling to accept the reality that they are no longer able to offer competent treatment to patients. Nass (2015) addressed the “major problem” that arises when a refusal to recognize the need to retire outweighs the responsibility to patients:

[There are analysts who] apparently plan to keep working until they are no longer able to function….There are isolated stories of their continuing to work past the age of one hundred. More frequent are stories of elderly analysts…falling asleep, forgetting important material about the patient, and keeping the focus of these errors on the patient. Confrontation by the patient often results in the analyst’s getting angry. (pp. 1013-1014)

Nass ends this statement with questions anyone troubled by a therapist’s failure to provide effective treatment to patients would want answered: “What procedures are available to monitor an analyst’s quality of work,…and how should [they] be enforced?” (p. 1014).
Chapter III: Methodology

For the current study, a qualitative exploratory design, in the form of detailed interviews, was utilized to identify common experiences among therapists who have contracted, sustained, or suffered from an illness, injury, or disability. As common experiences were found, themes emerged that would contribute to the growing body of literature on the subject, and help to provide knowledge for clinicians on how to deal with an illness situation.

Participants

The current study utilized a network sample of 13 mental health professionals who had experienced a serious medical condition, which included a physical illness, physical injury, or physical disability, during the course of providing psychotherapy services for patients. The medical condition, which could vary in nature (acute or chronic, gradual or sudden), was required to be of a severity that had either (a) caused the therapist to interrupt patient treatment for a period of time, or (b) had significantly impacted or hindered the clinician’s ability to function as a mental health professional. Thus, commonplace illnesses, e.g., cold or flu, did not meet the criteria of the study. All participants (100%) experienced an illness, injury, or disability necessitating a leave of absence from seeing patients, with the majority of participants (eight, or 62%) taking more than two weeks off. All participants (100%) also reported experiencing an additional recovery period, which varied in time from a few months to a few years.

Participants included five clinical psychologists (38%), three social workers (23%), two school psychologists (15%), two psychoanalysts (15%), and one (8%) doctoral student currently training to become a clinical psychologist. Their experience working with patients ranged from three years of doctoral training, to over 38 years in the
field (comprised of training and practice), with a mean of 28.1 years and a median of 32 years. Twelve participants identified as Caucasian (92%), and one participant identified as Latino (8%). There were nine female (69%) and four male (31%) participants.

As the interview questions required familiarity with psychoanalytic concepts and theory, participants were required to identify the theoretical model which guided their work with patients, e.g., classical psychoanalysis, object-relations, relational psychoanalysis. All participants (100%) identified as eclectic, drawing from various traditions of psychoanalytic theory, including: (a) interpersonal psychoanalysis, (b) self-psychology, (c) object-relations, (d) classical psychoanalysis, (e) modern psychoanalysis, (f) relational psychoanalysis, (g) intersubjective psychoanalytic theory, and (h) attachment theory.

Recruitment of Participants

Twelve participants (92%) were recruited through the online list-serves of an educational institution and professional organizations, including the alumni of the graduate school the investigator attends, members of local and state-wide professional organizations in New York and New Jersey, and the national membership of the American Psychological Association. An electronic-mail (email) advertisement message was posted to these list-serves that described: (a) the procedures and rationale of the study, (b) the contact information for the investigator, and (c) the inclusive criteria for participation in the study (see Appendix A). An additional source of recruitment was through the identification of potential participants by networking with professional colleagues. Such potential participants were then informed that they had been recommended as someone who might qualify as a participant in a dissertation study and then asked for their permission to be sent an email message. Once permission was
obtained, the investigator emailed the message to them that had been sent to participants who had responded to the online list-serve postings, as described above. One participant (8%) was recruited in this manner.

**Procedures**

The email advertisement message informed participants that: (a) they could choose between an interview format conducted either in person or by phone; (b) interviews were expected to last from 90-120 minutes; and (c) an additional written interview would be made available if answers to the interview questions had not been completed within the time frame of the initial interview (see Appendix A). One participant (8%) agreed to the latter option so that the interview might be completed in full.

Regarding the inclusive criteria and eligibility for the current study contained within the email advertisement, three questions which required “yes” or “no” answers formed the basis for prescreening potential participants. Those potential participants who answered yes to all three questions (see Appendix A) were informed that they met the criteria and were invited to participate in an in-person or phone interview, after which a mutually determined time and place was established through email communication for the interview.

Seven participants (54%) participated in an in-person interview, and five participants (38%) participated in a phone interview. One subject (8%) who was unavailable for either a phone or in-person interview answered questions through submission of a Microsoft Word document. The location chosen for in-person interviews was either the participant’s workplace or home office. For phone interviews, both the
participants and the investigator selected private locations where the interview could be conducted.

Prior to the start of in-person interviews, participants were asked to read, review, and sign two documents: a consent form and a demographic questionnaire. A week prior to phone interviews, electronic versions of the consent form and demographic questionnaire were emailed to the participant in the form of a Microsoft Word document file. Participants were instructed to provide an electronic signature to the consent form and to fill out the questionnaire and then to send the files via email attachment to the investigator.

For both formats of the interview, participants were read an opening prompt (see Appendix D) prior to interview commencement that: (a) explained the rationale and purpose of the study, (b) requested permission to continue, and (c) informed subjects that participation was voluntary and that they had the option of declining to participate or withdrawing from the study at any time without penalty. Participants were also notified of the procedures in place to protect their confidentiality, i.e., that their responses would not be linked to any personal or identifying information, and that the investigator would create a code key in order to mask their personal identity and or any other personal information. All participants were also provided with copies of a consent form for their records (paper-based documents for in-person interviews, and electronic-based documents for phone interviews). For the subject who participated entirely through written responses communicated via email, consent procedures were followed as if this participant participated in a phone interview.

After the completion of the interview, subjects were read a statement thanking them for their participation (see Appendix D). The duration of in-person and phone
interviews ranged from a minimum of 40 minutes to a maximum of 93 minutes. In-
person and phone interviews were audio recorded so that participants’ responses could be
transcribed for data analysis.

**Consent procedures.** Qualified subjects who agreed to participate in the study
were asked to review and sign a consent form (see Appendix B) that explained the
purpose, procedures, and treatment of data for the study, as well as the subject’s rights for
participating in the research. Subjects who participated in an in-person interview received
a paper-based document and were asked to review and sign the form prior to the start of
the interview. Subjects who participated in a phone interview and the one subject who
participated in a written interview were sent electronic versions of the consent form via
email and indicated consent by providing an electronic signature on the form and sending
it as an email attachment to the author.

**Measures**

In addition to responses to the open-ended interview questions (consisting of 33
primary and 16 follow-up questions) (see Appendix D), a demographic questionnaire
consisting of eight questions was also administered (see Appendix C). This document
provided supplemental information about participants, including: (a) age, (b) gender,
(c) ethnic background, (d) job title, (e) years in clinical practice, (f) institutions in which
the subjects received clinical and/or psychoanalytic training, (g) year when training was
completed, and (h) the participants’ psychoanalytic orientation. The consent form (see
Appendix B), as described above, was administered as well.

The open-ended interview questions were grouped and divided into different
themes (see Appendix D), so that data analysis might be facilitated. The themes included:
(a) participants’ description of their experience with a serious medical condition; (b) self-
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disclosure of a serious medical condition; (c) their patients’ expressions of concern
towards the ill therapist, if any; (d) transference and countertransference reactions that
were affected by a therapist’s serious medical condition; (e) how a therapist’s subjectivity
was affected by a serious medical condition; (f) ethical dilemmas that arise when a
therapist with a serious medical condition decides to continue to work with patients; and
(g) whether therapists are prepared, or can be adequately prepared, to deal with crises
such as a serious medical condition in the future. Participants were not informed that the
questions were divided according to themes.

Treatment of Data

A participant’s personal identity and/or contact information was known only to
the investigator who created pseudonyms and a code key as a means to ensure that any
identifying information was not linked to interview or demographic questionnaire
responses. After completion of each interview, the investigator deleted all email
interchanges between the participants and the investigator. Paper-based documents, such
as interview data and notes, demographic questionnaires, and consent forms, were stored
in a locked file cabinet within the investigator’s private residence. Audio recordings were
stored electronically in a dedicated password-protected folder on the investigator’s
firewall-protected personal laptop. The password was only known to the investigator.
Once audio recordings were transferred onto the laptop they were immediately erased
from the audio recorder. Participant’s responses on written interviews and signed
electronic consent forms were saved in password-protected Microsoft Word files and
stored on the investigator’s firewall-protected personal laptop in the dedicated password-
protected folder. All correspondence via electronic mail between participants and this
author were wiped from the investigator’s electronic mail browser history. All phone
numbers of participants whose interviews were conducted by phone were deleted from the investigator’s phone call history upon interview completion. If the study is published or presented at a professional conference, all information will be further disguised to eliminate any identifiable information. Three years after the date of completion of research, all hard copies of data, including interview notes, paper-based demographic questionnaires and consent forms will be shredded via the investigator’s personal paper shredder and disposed of at a private location. At the same date, electronic materials including audio recording files, the code key file, electronic consent form files and written interview files will be wiped from the hard drive of the investigator’s personal laptop.

Data Analysis

The primary goal of data analysis was to identify common themes among the participants. Data collected from interviews and surveys were analyzed utilizing a modified grounded theory approach (Corbin & Strauss, 2014). The modified grounded theory approach was utilized to identify core variables and develop a theory of how experiences with a serious medical condition impacted the person of the therapist, aspects of the therapist-patient relationship, and the psychotherapy process. The data analytics of grounded theory consist of three stages: open coding, axial coding, and selective coding. The process of open coding consists of developing categories from the raw data by labeling the data and grouping similar concepts, phrases, words, and patterns together. The relevance of certain data sets is determined by identifying whether data is (a) consistent with the literature or previous theoretical constructs, (b) contradictory to what is expected, or (c) particularly emphasized by participants. The data obtained is continuously compared to the emergent categories in order to determine reliability in data
coding, and the process is continued until there are no more emerging categories to be identified.

The process of axial coding consists of identifying relationships between the categories that had been previously identified via open coding. Once data are collapsed into more inclusive and complex categories, relationships between categories can be created by identifying: (a) the causal conditions that give rise to certain categories, (b) the context of particular categories, (c) the intervening conditions or the broader context of a particular category, (d) the action or interaction strategies that people take regarding a certain category, and (e) the consequences of such strategies. Selective coding involves refining the data to a number of central core themes so that a narrative can be constructed that provides an adequate and sufficient description of that core category. In the final phases of selective coding, the characteristics of the core themes are outlined, compared to other categories, and then compared against the overall data.
Chapter IV: Results

Participants’ responses in their semi-structured interviews pertained to six primary categories, each of which included subcategories as well. The primary categories included: (a) types of therapist illness; (b) issues related to therapists’ disclosure of their illness to patients; (c) patients’ reactions to their therapist’s illness; (d) how the illness affected therapists; (e) ethical issues that can arise when a therapist is ill; and (f) how therapists might be better prepared to deal with illness in the future through enhanced training, guidance from professional organizations, and learning from the experiences of others who had dealt with this issue.

Types of Therapists’ Illness

Participants were asked about their illness experience in terms of: (a) the nature of their illness, injury, or disability; (b) the duration of their recovery period; and (c) whether the illness necessitated a leave of absence from patient treatment.

Participants’ responses indicated that they had experienced a range of illnesses, injuries, or disabilities, with six (46%) reporting multiple illnesses, injuries, or disabilities as having occurred throughout their career. Eight participants (62%) identified cancer as the illness they experienced. Types of cancer included breast, lung, skin, prostate, and uterine cancer.

Four participants (31%) experienced neurological issues, attributed to concussion, vertigo, mild stroke, brain tumor, and seizures. One of these participants had a history of blacking out and losing consciousness. Another four participants (31%) presented with some type of disability, which included hearing loss, vision loss, and difficulty walking because of hip replacement surgery. Four other participants (31%) presented with one of two types of degenerative disease, either arthritis or macular degeneration. Two
participants (15%) suffered from digestive conditions, which included irritable bowel syndrome and gastroesophageal reflux disease. Two other participants (15%) had a severe respiratory illness, which included Acute Respiratory Distress Syndrome and asthma attacks. Another two (15%) suffered from an injury, one a broken ankle and the other a slip and fall injury.

Although all participants (100%) reported an extensive convalescence period, ranging from a few months to a few years, all were able to return to work before full recovery. Five participants (38%) reported a leave of absence of two weeks or less, and eight participants (62%) reported a leave longer than two weeks. The participant whose leave was the longest stated that after his 14-month hospitalization, he was still unable to return to work for four additional months.

**Issues Related to Therapists’ Disclosure of Their Illness to Patients**

Participants were asked about aspects of their disclosure decisions, including:

(a) whether they made the decision to disclose their illness to patients, (b) whether they distinguished between types of patients they chose to disclose to and those they chose not to disclose to, (c) the factors that influenced their disclosure decision, and (d) the effects on patients and the treatment process by the disclosure decision.

**Decision to disclose.** When asked whether they decided to disclose to patients, 12 participants (92%) reported that they disclosed some information about their illness to at least one of their patients. Three participants (23%) decided to disclose to all of their patients, six participants (46%), decided to disclose selectively to patients, and the remaining three (23%) reconsidered their initial decision not to disclose when they first became ill, but disclosed to some of their patients at a later time. Only one participant
(8%) decided not to disclose any information about her illness to her patients and never wavered from that decision.

When the 12 participants who disclosed were asked the type of information they provided to their patients, six (46%) chose to be “honest and forthright” and informed their patients of the diagnosis. The other six participants (46%) chose to disclose some, but not all, information about the illness. For example, one participant who told his patients of his prospective surgery did not reveal the underlying cause—a serious heart condition that required open-heart surgery: “I decided that I would tell…people the minimum.” Once he returned, his plan was “just say I was out, I had to have some surgery, and I’m happy to be back now.” He left open the possibility that patients might ask for more information: “I would kind of leave it up to them to see whether they had any further questions.” Some participants referenced “minor medical issues” when they felt it necessary to acknowledge the situation but not reveal their diagnosis.

When making a decision to disclose, nine participants (69%) mentioned the importance of evaluating whether a patient was appropriate for disclosure on an individual basis. According to one participant:

I think [disclosure] really depends [on] know[ing] the people you are dealing with….I think being able to show your vulnerability and share that in a way…can be helpful with people. [It] makes the work much more productive. But, on the other hand, some people can feel very frightened by a therapist’s vulnerability….One particular patient…is also schizophrenic, and she’s just very frightened of everything….I cannot see how it would help her to share very much….There’s…assessment going on [whether this is] a useful thing to share.
Another participant articulated a similar concern for how a patient might be affected by the therapist’s disclosure: “We really should know…patients’ histories from our own transference and countertransference with them, and…think about what might be the effects of disclosing this on the patient.” One participant considered aspects of the therapeutic relationship as influencing the decision: “I decided to disclose based on my judgment of the level of intimacy…between me and that particular patient, because some of the patients I had felt less connected [to] than others.” Other participants’ responses stressed the importance that disclosure “not be done impulsively,” but that it be done “carefully,” and that a therapist should be deliberate about “what is disclosed, when to disclose, and how it is disclosed.”

**Who was disclosed to?** When participants were asked to reflect on the types of patients they deemed appropriate for disclosure and the types for whom disclosure was not indicated, six participants (46%) referred to the patient’s level of functioning as the determinant. Although these participants agreed on disclosure to “high functioning” patients, they offered different definitions as to what constituted a high-functioning patient. One participant defined high-functioning as: “somebody who is more toward the neurotic end of the spectrum and can tolerate relational work,” and added that with that type of patient, disclosure “could enhance the work.” Other participants’ definitions of high-functioning patients included those who are “resilient,” possessing “strong enough egos,” are “well-related to others,” and those with “good careers, good self-images, and…who are able to create a strong working alliance with the therapist.” Length of treatment was a factor identified by five participants (38%) who held that patients in long-term treatment were appropriate for disclosure.
Six participants (46%) stated that they did not disclose their illness to “lower-functioning” patients. As one participant stated: “I have a number of people who are lower-functioning and… I don’t feel in that situation it is necessary or helpful to do much disclosure.” Descriptions of what constituted lower-functioning varied among participants, with terms such as “mentally fragile,” “vulnerable,” “self-absorbed in their mental illness,” and “on the periphery of the human life and activity” offered as illustrations.

When asked for additional classifications of patients for whom disclosure is not advisable, responses included patients: (a) in crisis or those who “have hit rock-bottom” (two participants, or 15%); (b) with schizophrenia, psychosis, or delusional disorder (two participants, or 15%); (c) with bipolar disorder (one participant, or 8%); (d) with substance abuse issues (one participant, or 8%); and (e) with personality disorders (four participants, or 31%), including narcissism (two participants, or 15%) and dependent personality disorder (one participant, or 8%). One participant each, mentioned patients not suitable for disclosure as (a) patients with a “diffuse sense of boundaries” (8%), (b) those in short-term treatment (8%), (c) patients who are terminating from therapy (8%), and (d) patients who are just starting treatment (8%).

**Influential factors in the decision to disclose.** When asked to reflect on the factors that influenced their decision, participants often responded similarly to the answers they had given about what types of patients for whom disclosure was indicated. Six participants (46%) chose to disclose in response to patient questions related to the therapist’s illness. As with the prior interview question, participants cited patients’ level of functioning, with five participants (38%) stating that it would be suitable to disclose to high-functioning patients as such patients were thought to be sufficiently resilient not to
be negatively affected. Six participants (46%) cited intimacy in the therapeutic relationship as allowing for disclosure.

Eight participants (62%) offered positive views of providing honest information, cautioning therapists not to be “vague,” as not disclosing the illness would be harmful to the patient. One participant highlighted the benefit of being straightforward with patients when preparing them for an absence due to illness:

Most people wanted to be reassured that you are going to be okay….It was helpful for them to have…clear information rather than a vague, unclear and indirect answer that would leave them wondering if something more significant was going on.

Another participant felt uneasiness at the prospect of nondisclosure: “I had to tell the patient, because [my illness] felt like a secret which did not feel right.” The same participant further highlighted patients’ family history as a further impetus for honest disclosure: “It would be unfair for [patients] not to know [about my cancer diagnosis] because they had people close to them who died of cancer.” One participant also referenced patients’ painful family histories as a rationale for disclosure:

There’s the [example] of parents who did not tell their children that they were sick, and how hurt the children [became] when the parent die[d]….Then [the children] find out later because it was kept a secret….I did not really think too much about that [beforehand], but…it came to mind that if things had gone really poorly,…then somebody [would have] to say, “Oh, well, she is closing her practice.” That would not have been good for my patients.

Six participants (46%) stated that they needed to disclose to patients because the symptoms, or the effects, of the illness were visible. They felt that it was important to be
honest with their patients about their symptoms, e.g., labored breathing, difficulty
walking due to hip surgery, excessive redness in eyes, rather than deny them and risk
invalidating the patient’s observations. Five participants (38%) stated that disclosure was
necessary because they didn’t want to leave their patients “in the dark” during leaves of
absence. One participant felt her multiple leaves of absence warranted acknowledgment:

[I told] people that I’ve been seeing…longer and [who were] in better
condition,…especially since they have seen the pattern of me going out for a long
time initially, and then go[ing] out every once in a while for a couple of weeks.
I…felt…I needed to be honest with them because they [could] see that something
was going on.

One participant (8%) mentioned that he needed for patients to know because he was on
immunosuppressant medication and needed to take extra precautions when patients
attended sessions while ill, even with a cold.

Participants also provided many reasons for why not to disclose to patients. Four
participants (31%) implemented a “don’t ask, don’t tell” policy, i.e., not revealing any
details about their illness unless patients asked. Eleven participants (85%) reported that
they did not disclose their illness to some patients out of concern that disclosure would be
harmful to them. Eight participants (62%) reported their misgivings about the potential
impact disclosure might have in taking the focus away from the patient or otherwise
interfering with the treatment process. As one participant stated: “I do not want
[disclosure] to affect the clinical relationship, or [patients’] problems, or have [patients]
feel like they have to take care of me, because that’s not what [therapy] is about.”
Another participant expressed the view that disclosure might inhibit patients’ ability to be
honest about their own circumstances: “If I had disclosed [my illness, patients might not
want] to tell me as many details” about their own health problems. One participant cautioned that disclosure was not advisable with particularly vulnerable patients:

I try not to tell clients…in crisis [about my illness] because I…feel like [it] would add more stress to [their] situation….When [people are] in crisis, they really don’t need more stress, especially [from] the person [who] is supposed to be helping them with the crisis.

Another participant stressed that disclosure might have the impact of “retraumatizing” traumatized patients:

Who knows what people could have in their history? [They might have had] family members who had gone through terrible serious illnesses, and [disclosure] might bring up all sorts of feelings that they…have been defending against….From an analytic point of view, [this] might be [a situation] where you do not want to take people’s defenses away.

**How patients’ treatment process was affected by disclosure.** When participants were asked how the treatment process was affected by their disclosure, nine (69%) stated that disclosure had a positive impact. One participant noted that disclosure prompted important conversations among her patients in a group therapy setting: “In that group, my illnesses and absences…led to very fruitful discussions of mortality, dependency, and feelings people had when other therapists or loved ones…were ill, or died, and more.”

Another participant reported that a patient’s subsequent experience of the same illness as the therapist enhanced treatment:

I have one patient who’s in his mid-70s….After I recovered from my stroke, he had a stroke….When he came back from his recuperation…a couple of months [later], he was very interested in comparing notes with me….He was pleased to
know that we had shared such similar experiences….I felt that brought us closer together, and it helped him feel that I understood him even better.

Five participants (38%) felt that their disclosure was helpful for the treatment process as it allowed patients to see therapists as “more human” and “more real.” One participant reported how her illness took her off the pedestal the patient had put her on and allowed the dyad to become more balanced:

I did have [a] female client in her 50s that [I’d] been seeing for a long time, and she was very stable….I did tell her during my initial illness and she was very supportive….I think…that before I told her about my illness, she kind of idealized me and my life, [which she seemed to conceptualize as a reproach to] herself and her life….It was kind of a negative dynamic and [had a] negative impact on her treatment….Once I told her about my illness [and] a little detail about the treatment, [she] realized that everyone has struggles that they have to deal with, and…her transference to me [allowed her to] perceive me more like herself than she realized….I struggle too, and I have difficulties too, and…then she started to see me as someone that can help her with her difficulties, because I have my own difficulties. [The patient’s feelings] seem[ed] to change from [an] idealized [view of my having] this perfect life, to seeing [me] more as someone who has difficulties, who’s trying to deal with them, and [who can serve] as an inspiration for her own treatment and her own progress.

Some participants reported negative reactions from patients after disclosure. For example, four participants (31%) experienced their patients leaving treatment after notification. One participant’s comments referenced the decisive impact a patient’s family history can have on treatment when a therapist discloses:

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I had been working with someone who…has…inner stuff, but externally [is] a very high-functioning person. I'[d] been working with him [for around] four years [by] the time that this happened….He was very engaged, really consistent, and a hard-working patient. He was one of the [patients] who asked me what had happened, and I told him….I knew from this patient’s history early on [that] he had had a father who had been very ill during his childhood [and] my patient had to do a lot of caretaking….He never talked about [his father experiencing vertigo] because the father had much more serious conditions, [but when I described the nature of my illness as vertigo], he said something like, “Oh my father had that too. I remember…how debilitating it could be.”….I do not remember exactly how I responded, but [I was] trying to explore, [asking him if he wanted] to say more about that….At the time he minimized it, but subsequently…ended up…terminat[ing] prematurely….I am sure that something got kicked up for him about dependency, and feeling he needed to protect himself from getting dependent on me….He had not been talking about terminating at all before,…and then suddenly…he thought he was ready to stop coming….I tried to…make the link [between my illness and that of his father, but] he did not feel that [it] was connected for him. So, in the end, [disclosure] destroyed the treatment.

She expressed her doubts as to whether her disclosure decision, which had been based on the patient’s current level of functioning, but had not taken into account an element of the patient’s family history of which she was unaware, turned out to be in her patient’s best interest: “I don’t know what it would have been like for him…had I not told him.”
Patients’ Reactions to Therapist’s Illness

For this section, participants were asked questions about patients’ reactions to disclosure of the therapist’s illness and how they dealt with those reactions, including (a) patients’ awareness of the therapist’s illness in the absence of disclosure; (b) whether patients demonstrated concern for the therapist, and, if so whether that concern was considered by therapists as useful in treatment; (c) patients’ transference reactions to the therapist’s illness; and (d) how participants addressed patients’ transference reactions in treatment.

Patients’ awareness of the therapist’s illness. When participants were asked whether they felt their patients were aware of their illness despite nondisclosure, four participants (31%) stated their belief that some of their patients could have been “unconsciously aware” of the illness without the therapist informing them directly. One participant’s patient, whose diagnosis of “severe schizoaffective” disorder “with psychosis” led the therapist to believe that disclosure was not indicated, nonetheless communicated to the therapist that she had some awareness of the illness:

I…did not share [disclosure] with [my patient. Given her diagnosis, she was] not my first choice of someone who I would…want to talk to a lot about myself, and what I’m going through. I’ve been seeing her for many years [and] she’s doing extremely well in her treatment….She said to me, “Is everything okay with you?” And she gets a little psychotic about it, and says, “Do you want to retire or something?”….I think she just picked up on some disruption in our schedule,…but [she may have also noticed] that I was bruised. I can’t remember exactly…but…it was like she has this sixth sense.
Interestingly, another participant reported a similar experience with a schizophrenic patient intuiting the therapist’s illness:

After I was diagnosed, but before I told anyone of my plan to take a leave, one of my schizophrenic patients said, seemingly out of the blue: “What happens to us if you get sick or something and have to go to the hospital?”

The participant described the question as “unnerving,” and an opportunity to “witness…the power of the unconscious.” The therapist’s response was that the patient “would have another therapist to speak to [and that the patient] would be in good hands.” To further allay the patient’s fears, the therapist added that she “would keep everyone informed of when [she] might return.”

**Patients’ transference reactions in response to the therapist’s illness.** When asked about patient transference reactions, one participant (8%) stated that there were no transference reactions for him; however, twelve participants (92%) stated that their illness affected their patients’ transference reactions in some way. Eight participants (62%) characterized their patients’ transference-related reactions as negative in nature. The negative feelings ranged from five participants (38%) who reported patients’ expressing a fear of losing the therapist or fear of abandonment; four participants (31%) who reported patients’ expressing anger; and one participant (8%) who reported patients’ expressing feelings of dependency on the therapist. Nine participants (69%) stated that the transference-related feelings might have evoked memories of family members who died after becoming ill. For example, one participant related his experience with a patient who did not want to face another devastating loss of someone important to him:

One patient, whose mother had died of AIDS,…when [informed of my illness, immediately decided] to flee….He didn’t want to come back….He told
Another participant’s patient’s strong negative reaction toward his mother’s illness was elicited by his therapist when she disclosed her illness:

One [patient] was highly narcissistic….He had a mother much older than me, a very elderly mother, and he was an only child….She was somewhat infirm, and he was very athletic….He was dismayed by her aging and by her infirmity. He was angry about it, and angry at her. So I knew he was going to be narcissistic…and experience my illness as an affront to him….The nature of his narcissism was that [when] confront[ed, he would] acknowledge it….“Yeah, right….It is an affront to me, you’re right. I don’t deserve to have a sick mother, and I don’t deserve to have a sick analyst, and it does affect me.” So [his perspective was not] “I wish this weren’t happening to you,” it was…a matter of “I wish this wasn’t happening to me.”

Three participants (23%) had patients who had previously been treated by therapists who had died during the course of the patients’ treatment. Thus, it was not surprising for patients to be reminded of the prior experience when informed of their current therapist’s illness. For one participant, the only information that the patient had of the therapist’s illness was upon notification of the therapist’s death:

I have [a] patient…who’s a physician….He had a…male therapist who [was] very sick,…never told him anything, [and died]. It’s come up more than once in his
treatment….He’s a pretty narcissistic guy….but he was very aware….He’s [picking up that something is] wrong….He was aware of the black eye, and then later when I had a bracelet on, he [asked], “What’s going on?”…He really wanted to run down my treatment, [asking], “Who are you seeing?” and “What medication do you have?”…I gave him….an outline generally of what was wrong, and validated that I had a health issue.

**How therapists addressed patients’ transference reactions.** When participants were asked how they addressed patients’ transference reactions in response to the therapist’s illness, eleven participants (85%) stated that they helped patients to explore their transference-related feelings and put those feelings into words. The participant whose patient’s mother had died of AIDS, as discussed below, was assisted by the therapist to become more aware of his reactions toward negative experiences: “We looked at his reaction to stress as pulling away, and his reaction to loss is leaving before the loss happens. [Then we explored] how he hadn’t really completely processed his mother’s loss.” One participant described the difficulty of a patient working through the complex feelings she had toward her ill mother while simultaneously dealing with the therapist’s illness as well, and distinguishing between the two important people in her life:

Part of [the process involved] working on the [patient’s] defenses and getting her to contact more of her unconscious anger at receiving subpar parenting and care because of her mother’s health habits….She was always worried about her mother dying because of how poorly the mother took care of her own health….Sometimes the mother’s health would get in the way of what, in both of our opinions, was adequate parenting….On a defense level, [I] helped her get
through that. On the transference-relational level, it was a mixture of eliciting…what she was thinking and feeling about the fact that I was going through [my illness] while I was taking care of her. [I] also explain[ed] that I…take care of myself, and I go to the doctor quite often. [I tried] to juxtapose the ways in which these two figures,…me and her mother, are different. But [I could validate her] being worried, and…the possible unconscious frustration of another person who is not in great health…taking care of [her], and…maybe [causing] problems for [her].

One participant helped her patient bring awareness to the ambivalence he was experiencing upon learning that his therapist had the same illness as the patient’s father:

[With] the man whose father had died of lung cancer,…I had to address things that he was afraid to address, [such as] “Why did my father die, but [the therapist is] still alive?” I had to bring that up for him to process, and to let him know that it was okay to talk about it with me….He was very afraid it was going to hurt me….I said I’m the one who thought of [his choosing whether to save his father or me] because I understand that this is how our minds work….It became extremely easy for him eventually, not right away, to talk about it….When he finally realized he didn’t have to protect me and he could resent me, [it enabled] working through…a very tacit underlying transference.

**Addressing patients’ reactions based on the therapeutic relationship.** Some participants reported that patients had reactions based on the “real” relationship between the therapist and the patient. Four participants (31%) mentioned that patients’ reactions towards the therapist’s illness were related to the patients dealing with illnesses of their own. They agreed that self-disclosure of their experiences with illness would help
patients come to terms with, and normalize their feelings towards, a comparable situation.

For example, one participant expressed the view that in opening up about her illness to her patient, the therapist was able to model disclosure, thus facilitating the patient’s disclosure of her illness to others as well:

I have a very long-term case, a patient who is schizotypal. She’s…extremely avoidant, kind of a hoarder, and she’s been seeing me…for years….Because she comes twice a week, she would know if something was wrong….So…I shared with her what was happening, but…a year and a half ago, almost the same time I had my seizure, she was diagnosed with lung cancer. We really went through this at the same time, my diagnosis and her lung cancer diagnosis…We spent a lot of time talking about medication side effects. She’d ask me about mine, and I’d ask her about hers, and…I think it really helped her connect. She has a lot of trouble opening up and sharing with people. I can’t say whether it’s her health issue, or my health issue, or both together, but we’ve used it very strongly to help her open up and tell people. I think because I was open, it helped her be open. She told everyone she knew at work she had cancer. She told her family….This person…would never tell anybody anything, and she finally felt like she had something to tell….I think that the transference…is [that] she saw how I did it….I think she really looks up to me,…and I think she wants to emulate that….We really bonded over the health stuff, even though I didn’t have the same thing….We talked about our tests, and how we got through an MRI—being in that thing and the hammering—and it…really helped the therapy….I can’t even say enough about [how] useful…it was.
**Patients’ concern for the therapist.** When participants were asked whether patients had expressed any form of concern towards them, eleven participants (85%) reported that one or more of their patients had expressed such concern. Demonstrations of concern took various forms, such as: (a) simple inquiries about the therapist’s well-being, (b) patients giving therapists items that represented their support, e.g., a “breast cancer keychain and bracelet”; and (c) sending the therapist a thoughtful gift, as illustrated by one participant:

I’ve been seeing…two patients…in their mid to late 20s who are both teachers in the same school….One had referred the other to me….After about four or five weeks of being out, they together sent me a gift basket of fruits and foods. They signed it with a card that said from your two favorite patients.

When asked whether they felt that expressing concern was helpful to the patient’s progress in treatment, nine participants (69%) described it as helpful, although it manifested in different ways. A few participants spoke of how this behavior allowed the patient’s character dynamics to be displayed and dealt with in treatment. One participant stated:

I do think having them show concern would be helpful [as long as it wouldn’t] entail them being a caretaker or over functioning. It would need to be treated very carefully because [otherwise it] could easily slip back into [negative] dynamics, and repetition with us as their therapist. [Handled carefully], it’s good [and] can definitely open up truthful avenues upon which to do clinical work.

Another participant elaborated on how an opportunity to express concern can enable patients to bring personal qualities into therapy that had not been elicited at any prior point:
Patients don’t always know how to show their gratitude or give back other than through pay[ment]. Once I simply had a cold, and a borderline patient said, “I like when you are sick.” That [initial portion of her statement reflected] the part of her that felt aggression towards me. [Then she continued.] “You are softer, less on your ‘therapy’ game, and more human. It makes me feel closer to you.” That [part of her statement reflected] her loving side. It helped me allow myself to be more myself, and in the therapeutic process rather than trying to stoically transcend my own humanity. It helps the patient feel validated too, [when] seeing the therapist’s vulnerability.

A few other participants mentioned one patient population—those who are narcissistic and self-centered—for whom concern may be significantly helpful. One participant reflected that it could provide an opportunity for such patients to be able to relate to others in the form of the therapist:

Client[s who are] very self-centered, self-focused, and…have trouble relating to others empathically, or focus[ing] on other people [are] just very caught up in their own situation or emotional difficulties. In that case, it can be helpful to their treatment [for them] to deal with asking someone how they’re doing and caring about someone in that way, especially if they haven’t really done that, or haven’t done it in a relationship, or [haven’t] had a positive outcome [in prior attempts].

Four participants (31%), however, perceived patient concern for the therapist to be unhelpful to the patient in that it created a burden for the patient and interfered with the treatment process. As one participant stated: “If [patients] were to show concern, I…didn’t…think it would be helpful to them. I…thought of it as [a burden or] an interruption [of] what they were doing, and…felt like I wanted to minimize that.”
How the Illness Affected Therapists

In surveying participants’ thoughts and feelings about how the illness experience affected them as therapists, questions related to the therapist’s subjectivity included: (a) the therapist’s countertransference reactions to patients, (b) the range of feelings therapists experienced in response to the illness, (c) the illness’s effects on the therapist’s subjectivity, (d) defense mechanisms and other types of coping skills used, (e) the illness’s effects on how therapists conceptualize their work with patients, and (f) the illness’s effects on the therapist’s livelihood.

Countertransference reactions. When asked about what types of countertransference responses they attributed to their illness, all 13 participants (100%) mentioned that they were distracted by or preoccupied with concerns about whether their illness and/or the associated symptoms would interfere with their ability to be present with patients, and compromise their ability to handle the patient’s problems and feelings. All participants indicated that seeing patients during the duration of their illness could present a burden at times. One participant expressed concern about her illness manifesting while in session with patients:

My main countertransference is my fear that I’m going to impose my health issues on my patients….Specifically [if I] have a seizure, [I fear that] someone is going to have to take care of me….I’ve been scared sometimes when I’m feeling a little woozy from the [seizure medication], and I’m thinking to myself, “Should I even be here working right now?”…I think my countertransference mainly [involves my questioning whether] I [am] able to be here doing this right now.

The therapist persevered with patient work notwithstanding her fears of her illness compromising her ability to provide effective treatment: “I push through things mostly,
which is a good quality, but I don’t know if people got the best session if I’m a little woozy and dizzy.”

Another participant stated that treating patients during her illness gave rise to unrelated emotions:

My feelings ran the gamut of guilt at times, for not being steady and completely available, and being forced to introduce my own situation onto theirs; to feeling like it was good and healthy to have an opportunity to experience a more “real” relationship with the patient and see how that might affect me and them.

One participant explained how distracted he could be when his respiratory symptoms manifested during sessions:

It can be a struggle to make sure I’m focusing on what the patients are…telling me if I’m having a particularly hard day….If I’m coughing more,…if I’m breathing hard, if I’m more tired than usual,…it’s made it harder to work.

Six participants (46%) expressed a desire for the patient to take care of them or to convey the message to patients that the therapist was suffering more than the patients. One participant had to exercise restraint so that she wouldn’t disclose to a patient in order to receive what she expected to be a nurturing response:

I…have a patient who’s a nurse, and I had sort of a craving to disclose to her and be taken care of. [Although] I wanted her to take care of me,…I didn’t yield to that. I just made myself aware that I was feeling that.

The same participant further elaborated that at times she wished to interrupt her patients when they were expressing their pain with statements indicating that the therapist was experiencing greater suffering:
Sometimes…if I was feeling particularly put upon, I was tempted to say, “Oh, you think you’re sick? Oh, I was really sick, and you didn’t even know about it. You neglected me. You don’t pay attention to how sick I was.” But I never said that…The treatment is about them, not about me.

One participant could not help herself from exhibiting her countertransference feelings when she compared her illness experience to that of the patient:

I had [an OCD patient] who…was so caught up in the minutia of her life [that] she spent an entire session discussing [her difficulties with] Invisalign….You have to take it out and brush your teeth every time you eat, and put it back in….If you have a cup of coffee, you have to take it out again, [and] put it back in….She went on and on about how stressful this Invisalign was. And she [then asked], “How are you? How’s the chemo going?”, and I said, “It’s almost as bad as Invisalign.”…That was definitely my countertransference going [on]. But she was somebody I knew would laugh, and she did laugh, and I think there was a part of me that wanted her to get a little perspective. So I kind of acted out a little bit.

**Therapists’ feelings.** When asked to reflect on the feelings they experienced when they first found out about their illness and then during recovery, participants offered a wide variety of answers. Twelve participants (92%) mentioned experiencing some sort of anxiety or fear, six (46%) characterized the fear as terror. Three participants (23%) expressed a fear of dying. One participant described her reaction to receiving her diagnosis in particularly vivid terms:

I went to my gynecologist, and they did some tests, and I got a phone call one day when I was driving home that I have cancer. [I had] the most terrible dark feeling
of falling into an abyss….I thought I was going to die….It was like you just see darkness in front of your eyes, like you’re falling into a pit.

Other reactions upon learning of their illness diagnosis included: (a) shock, expressed by six participants (46%); (b) guilt, expressed by five participants (38%); (c) anger, expressed by four participants (31%); (d) depression or sadness, expressed by four participants (31%); (e) fears that were work related, expressed by four participants (31%); (f) anxiety while waiting for test results, expressed by two participants (15%); and (g) concern about the prospect of a relapse, expressed by one participant (8%). In contrast, six participants (46%) were able to react with hope, optimism, joy, or gratitude at some point throughout their illness experience, four of whom (31%) expressed gratitude for their medical care as they were convalescing from their illness, one (8%) expressed gratitude for being able to return to work, while another participant (8%)—who used alternative healing methods as well as traditional medicine—characterized some aspects of her illness experience as “fun,” as discussed below.

**Effects on therapists’ subjectivity.** When asked whether they felt the illness experience had any effects on their subjectivity or self-as-a-therapist, participants reported both positive and negative impacts. Ten participants (77%) identified experiencing an “increased sense of empathy” for their patients as a positive impact. One participant stated:

> I feel more empathy…than I did before for my clients just [through] understanding how significantly life experiences…and/or emotional states can affect a person. I…think I’ve been…more sensitive to all kinds of distress, and I think I understand it…better than before.
Another participant articulated his belief that his illness experience acted to challenge the imbalance in the therapeutic relationship between the professional and the patient:

> It affected the treatment process for me because I became much more aware of people with illnesses….I think before this major series of events happened I was much more at a distance from people [when they were] telling me about their own crisis, especially [a] medical crisis. I was able to…feel myself… somehow protected. “I’m the doctor, and I’m okay, and they’re the ones who are vulnerable, who have a problem.” I think once I went through this, I became much more sympathetic and more empathic…and it affected me more….It sensitized me to what they were talking about, and it removed that distance that I had felt before,…like, “Oh yeah, this could happen to me.”…It’s also given me a sense of a stronger connection to people’s trials and tribulations. Whatever they are going through, I can sort of put myself in their place and sort of picture what it feels like because I’ve been through it myself.

Nine participants (69%) stated that they were better able to tolerate patients’ suffering, and that it became easier for them to discuss difficult topics with patients, e.g., mortality, loss, vulnerability, and feelings of dependency. One participant stated that his experience with cancer, along with facilitating conversations about mortality in general with patients, gave him the insight to help a young male patient talk to his children about his grave illness and the expected outcome:

> A couple of months ago, I went to see a patient who was terminally ill. I went to his house to do a home visit….He was…in his 40s. He had kidney cancer, which came back for the second time….I went to his home [because] he wanted to learn how to talk to his kids about cancer and about dying…..I think I was very
effective….I did share with him about my cancer journey too, and about being able to have that conversation with your kids, because I had to have that conversation with my kids.

Another participant stated that her illness has allowed her to engage more fully in discussions with patients on illness, death, and suffering, and not be dismissive of their concerns:

When people tell me about illness, I never say this is part of life, or that’s just to be expected, or everyone is going to get cancer, or anything else that would be, as far as I’m concerned, quite inappropriate, or try to dismiss it….I don’t…say, “Oh, everybody dies.”…I try to allow the patient to tell me about the[ir] suffering. I’ve [suffered through my own illness], and that helps me to tolerate the patient’s suffering.

Another participant stated that having come to terms with her own mortality, she might now be in a better position to help her patients talk about this and related difficult subjects:

There’s a way in which…I feel more realistic about myself….I am mortal and something could happen to me….Even if I’m not talking about that subject with a patient directly,…there’s a change in me that will make me more effective at helping them tolerate their own mortality,…their own fear of loss, and dependency issues.

Six participants (46%) stated that as a result of the illness experience, they were able to be “more authentic” with patients and were able to translate the vulnerability they experienced to their work with patients. One participant expressed that she could be
“more of herself” when treating patients, and another participant saw how her insight into her patients’ struggles increased in numerous ways as a result of her illness:

Having had an experience of vulnerability…yourself…allows you to help people differently….I’ve worked with people for years who are taking all kinds of medication, [but] never had the experience [myself] of [taking] a psych-related medicine until I went on Keppra. [Now] I…have a different feeling for people…being on meds….I listen and…I really understand….I’ve learned also to encourage people to push through side effects too, because it really did get better, but it took months….If you haven’t had some of those experiences,…how do you know?…I don’t think having an illness is a disadvantage. It just makes you think a little bit more about vulnerability,…what to share,…your humanness and the humanness of your patients.

With respect to negative effects on the therapist’s subjectivity, six participants (46%) reported that they experienced less tolerance or patience with some patients. For example, one participant spoke about how difficult it had become for her to work with patients whose presenting issues seemed unimportant:

I have a little less tolerance for superficial difficulties. Some of the clients…come in, especially families…with very low intensity, low-risk situations with parenting, or [a] parent-child relationship, or child behavior that [doesn’t qualify as] clinical. It’s…on a lower level. I just help with the extra stress….It’s…not a crisis….Sometimes I have a little less patience for those kinds of issues [when] compared to what I’ve been through. They just seem a little bit petty and insignificant.
Another participant stated how difficult it had become for her to maintain a stance of empathy and tolerance with clients who did little but voice the same grievances in every session:

I felt I was having less patience with patients…who had issues that were really very trivial, and [who] were…stuck on things week after week….I would try, [but] my tolerance was not as high as it [had been] prior to [my illness]. How can I stand, over and over again, the person who is a help-rejecting complainer?...I can reach and find some way to empathize with them….I would work to find a way to do it in session, but outside the session I would feel more burdened.

Defense mechanisms and coping skills. When asked whether they felt they were using any defense mechanisms or coping skills in order to deal with their illness, injury, or disability, eight participants (62%) reported being in denial during the beginning stages of their illness experience. According to one participant, “Initially, after I got the diagnosis, I…was kind of numb and in denial. I was…on autopilot, still doing everything the way I [had been] before, and…not respecting the diagnosis totally.” Another participant mentioned that his ability to tolerate discussions of his illness is so limited that even now, with his illness in the past, he’ll walk away if it is brought up by others:

I…tend to use defense mechanisms [such as] denial….With what I’ve been through, I’ve become much less comfortable talking about it….I guess I never was really comfortable….It’s funny, because my wife tends to tell people in detail what I went through, and what she went through at my side, and I get uncomfortable with that. I prefer to minimize those things, and…say, “Yeah, this terrible thing happened to me and it’s over.” That’s it. But, I think my way of defending against that sense of vulnerability is to just put it in the past, and
not…delve into it….If my wife is talking to someone who hasn’t heard my story yet, I’ll actually leave the room because I just don’t want to hear it again. It makes me too anxious….I just avoid it.

Four participants (31%) stated that they felt “invincible” and suggested that they were using some type of “omnipotent” defense. One participant felt that his relative youth would protect him from a cancer diagnosis: “I never thought I would get cancer at 42….As therapists, we want to think that we’re kind of invincible….We’re the therapist, we’re the psychologist, we don’t get sick.” Five participants (38%) mentioned their use of obsessional/intellectual defenses, such as compartmentalization, to try to not think about their illness when working with patients. One participant explained how this kind of defense, in conjunction with personal therapy, served to keep her anxiety under control so that she could continue to offer effective treatment:

Cancer made it necessary for me to continue with my own therapy so that I [could] deal with how I was at work, how I was at home. I had anxiety about waiting for results….If I had a CAT scan or an MRI, I had to be careful [to] compartmentalize and shut that out of my mind. [Otherwise I would be] worried about it when I was working in session with [patients].

Five other participants (38%) stated that they overcompensated for their illness with patients in order to reassure themselves, and their patients, that they were fine and capable of working. In fact, one participant felt that only by striving to achieve an unobtainable standard could she protect herself: “The absolute overarching concern that I had was that I maintain my practice, not [lose] patients, and be perfect….Since I was sick, I needed to maintain that secrecy….Therefore, I would be perfect.” Another
participant’s compulsiveness in trying to balance patient work with doctors’ appointments resulted in little time for herself despite the need:

I think I tend to be over-functioning, and always [feel] like I have to be super-present for people, and I’m very conscientious….I’ve had to really work on making more space…to first take care of myself, and not [jam] doctor appointments in between patients. I used to do that. I’d be running and…one of the things I was thinking about…was, “Is there [another eye doctor] I can see near, or closer to me, so I could fit in more work?”…My defense mechanisms are just [pile] everything in,…do as much as I can, and be there for my responsibilities….I’m…feeling like that’s not such a great thing.

In terms of coping skills, nine participants (69%) were able to view their work as a source of fulfillment and a necessary distraction from the stress of dealing with an illness. One participant described her private practice as a refuge which provided healing for her as well as for her patients:

My practice is a little bit of an escape for me, because when I’m with my clients, [I’m] not focused on me and my problems. [I’m] focused on other people’s problems and helping them….It gives me a sense of control and agency.

[Working as] a therapist and having my practice has actually been a coping skill for me….Being able to help other people, instead of always having to focus on my own illness, [is] helpful….Having…a sacred space….I always try to have it be that…for my clients, but…it’s become that for me also.

Five participants (38%) acknowledged support systems as helpful in coping with their illness, such as: (a) their social network of family members, friends, and colleagues (four, or 31%); (b) personal therapy (three, or 23%); and (c) supervision (two, 15%).
participants (31%) reported that making adjustments to their work routine helped them cope with their illness, such as taking 15-minute breaks in-between seeing patients (two, or 15%); reducing their caseload (one, or 8%); taking more frequent or longer vacations (one, or 8%); and implementing a mindfulness exercise between patient sessions (one, or 8%). One participant (8%) found a creative outlet, writing a blog about her illness, as a way to cope, and another participant’s (8%) consultations with a practitioner of alternative medicine—a relationship that continues to this day—encouraged her to view her illness and subsequent convalescence with a positive mental attitude and a sense of curiosity. For example, she learned how to “enjoy the chemotherapy” that she received, and she viewed the process of recovery as a game to play that progressed through different levels. She explained her process as: “Whatever I might have been feeling, it got converted into fun”:

What [the energy healer] did was fun, and whatever I might have been feeling…got converted into fun. For instance, he used a visualization technique [because] he [had] picked up…that I love imagery. I didn’t understand anything about the physiology of [my illness]. He explained [that] we have cells in our body that…had to get activated [before they eat cancer cells]. I don’t play video games, but I knew about Pac-man….I imagined little Pac-man images eating up all the cancer cells. It made me giggle. I had fun with the imagery, and I tended to turn things into a game….He would hum into my bones as a healing technique. I [could visualize myself as] a radio…receiving energy signals, either from the humming or from the universe at large. My entire attitude was…What happens next?
Effects on therapists’ conceptualization of patients. When participants were asked whether they felt that their experience with an illness changed their conceptualization of their work with patients, nine participants (69%) reported changes in the way they thought about patient treatment, and four participants (31%) stated that there were no changes. Those participants who viewed their work with patients as changing followed up with examples. One participant acknowledged a complete reversal in her beliefs regarding independence versus interdependence:

When I was a younger therapist [I felt that] independence, doing things on your own, [was so critical]. I don’t know if it was the training,…but [I saw] dependency…as more of a negative thing. I have completely changed my feeling on how interdependence, having close ties with people where you help each other through difficult things, seems…so much more important….Independence is a very useful thing to have,…but I don’t emphasize that as the sign of health in the way I would have when I was in my 20s and 30s….I truly think having various health [challenges which require] you [to] have to count on people, and share and disclose,…really changes your perspective….I think I’ve become more and more object-relations oriented….It’s definitely changed my view on how important…your network of relationships are to help you.

Another participant changed the emphasis of her work from “reducing negative symptoms” of her patients to helping enable them to visualize a positive image of their future and perform the actions that will facilitate its realization: “I focus more than I used to on supporting [patients] to imagine the life they would like to be living and then…helping them take the steps towards a more positive life for themselves.” Another
participant learned to appreciate living in the present after his struggles with a respiratory illness, a philosophy he has encouraged patients to adopt:

I’m not the same person I was….Help[ing] people be in the moment…is a very true experience for me. That’s…not just a theory. It’s…something I try to practice more, because you never know….Enjoy the moment. It is really all we have. The past is over and done with. You cannot redo that, and the future is yet to happen….That’s something I try to impart [to patients]. People have so many anxieties about what could or might happen to them,…they’re somewhere in a future state. [If you] live in a world where…something…might happen, you can miss out on your life a lot.

**Effects on therapists’ livelihood.** When participants were asked questions about whether their illness had an effect on their livelihood, nine participants (69%) reported that they lost some income as a result of needing to take time off from work. One participant explained that her leave of absence not only cost her income, it caused her to reorder her priorities as she realized how crucial it was for her to have a job that provided health benefits, whether she liked the job or not:

I…initially [took a] medical leave for about five months [which] reduced my income for that period….I wasn’t…doing my [private] practice full-time when I initially got sick. I was doing it part-time on evenings and weekends….The [full-time] job I [had] when I got sick…I didn’t really want. It was more…administrative [than patient treatment. But] because of my illness I needed the health care [insurance], and I needed the income. This was a position I had to [continue with], but I didn’t want to be doing.
Eight participants (62%) had to reduce their practice as a result of becoming ill. One participant described how her illness not only eliminated her aspirations of further developing her business, it forced her to make drastic changes in her then-existing practice:

I did not take any more patients after I was diagnosed. My income had gone down…I [had leased] a beautiful office that had fairly high rent. [My intention had been that] I would be able to grow my business from there, and I was thinking of ways that I might expand. I was going to add some testing and consulting services to my practice. [After] I got the cancer diagnosis,…my energy [kept] diminishing…over the year….I moved to a smaller office [that] was not as nice. It was sad because…it was not an office…where you could have…a conference, or [a meeting with] lawyers….Now I’m in a small office in an older building [practicing] therapy with the people that I already had a relationship with. [I] downsiz[ed] my business and [made] the eventual decision of being semi-retired,…working…four and a half days a week down to just working one day a week….Now [I’ve] closed that office, and I only see a few people in my home office….I don’t even have a regular office anymore.

Four participants (31%) expressed their concern that they would no longer receive new referrals. One participant stated:

One of the issues about being sick is that people think that they’re not going to get referrals, especially [with] a dire diagnosis like cancer. They’re afraid that you’ll die, and then the [patient] will be left high and dry. [This] happened [to] my friend….He didn’t want anyone to know [of his diagnosis] because he was afraid he wouldn’t get any referrals.
Another participant was having difficulties retaining new clients because the symptoms of his illness manifested in sessions, leading some potential patients to doubt his ability to offer effective treatment:

I used to be very successful bringing in and keeping a lot of [patients]. People would sort of feel engaged with me, at least well enough to start….I decided to say nothing [about the illness] in the beginning [with new patients]. That was a mistake, because [as] one guy said, “I felt like I should be taking care of you!” [I can’t hide] that something [has] happened to me because [rapid] breathing [is a] residual [symptom] of [my] illness….I decided that with new consultations, I would…try to help people feel comfortable to start talking [by acknowledging the issue], and it’s hard. I find that I’m dealing with more rejection than…before.

Ethical Issues That Can Arise When a Therapist is Ill

Participants were asked questions about ethical issues that therapists can potentially encounter when dealing with an illness and preparation for such crisis situations, such as the ethical dilemmas arising from a therapist working with patients while dealing with an illness, whether they had a professional will, and their knowledge of ethical guidelines advising therapists of their responsibilities to patients who are ill or in crisis.

Ethical dilemmas that arise when a therapist works with patients while ill.

When participants were asked about the ethical dilemmas they might encounter when working with patients while simultaneously dealing with an illness, 11 participants (85%) identified not informing patients of a condition rendering them incapacitated or posing a threat of imminent death. One participant presented a hypothetical for this situation:
[If] one [were] giving the impression that everything was the same as it always was, and that everything will continue that way,…that would be an ethical problem….If I wasn’t in complete control of my ego faculties of memory and [my] thinking, planning, [and] perspective taking [were] impaired, and I didn’t disclose [the illness], that would be a serious problem.

The same participant illustrated the above scenario with an example of a clinician who had been diagnosed with dementia yet continued to work with patients: “There was an issue in my local training institute, [an] analyst was demented and…because he spoke so rarely [the patient was unaware of his cognitive impairment. The] analyst should have resigned from that case but didn’t.” Another participant related an incident about an analyst who was so ill he could no longer work, but never informed any of his patients the reason for his absence:

I knew an analyst who got ill….He ended up dying….He was not…old….He was 63 or 64….It was the worst handled crisis. There [never] was…communication from his family to us….There was a rather bizarre message left on his answering machine, “Dr. M is out of the office indefinitely, but he does plan on returning.”…This went on for months. It…took some delving by people who found other[s] who knew him personally to figure out what was going on….That…served as a guideline as what not to do, because it really angered me.

Four participants (31%) described patients who had been significantly harmed by their therapist’s death, reinforcing the ethical issues raised when therapists continue to work when they are incapacitated or dying. Three participants (23%) questioned whether disclosure of an illness is always ethical, given the possibility that therapists might be disclosing the illness for their own benefit and not for the benefit of patients. Two
participants (15%) characterized not disclosing the illness as being dishonest with patients. Two participants (15%) described ethical dilemmas arising out of therapists taking advantage of patients when ill, such as charging patients for sessions the therapist cancelled because of illness, and asking patients to compensate for a therapist’s impairment, e.g., asking a patient to get the therapist a newspaper because of her difficulty walking. One participant (8%) offered an ethical dilemma arising from financial pressure: “Had I been more impaired, part of me would have wanted to come back too soon because I have to earn a living.”

**Professional will and ethical guidelines.** When asked about a professional will, nine participants (69%) stated that they had a procedure in place in the event they were not able to see patients because of a crisis, medical or otherwise. This took the form of a professional will (legal document containing explicit instructions), or a less formal emergency protocol established with colleagues or family members who would contact patients on the therapist’s behalf. The remaining four participants (31%) stated that they had neither a professional will nor informal emergency protocol.

When asked about whether they were aware of any ethical guidelines governing the situation of therapists dealing with an illness while treating patients, 10 participants (77%) reported having no knowledge of such ethical guidelines. Two participants (15%) stated that they consulted various professional sources to guide them in making ethical decisions in their situation, e.g., the code of ethics of the National Association of Social Workers (NASW) and the American Psychological Association’s (APA) ethical principles of psychologists and code of conduct. According to one participant:
I use the ethics handbook that the APA puts out. Every institute has its own code, every profession has its own code, and I think that the codes [provide] adequate [guidance in helping] to determine how to behave [in] extreme [circumstances].

Four participants (31%) stated that they consulted with their supervisors to help them with making decisions regarding disclosure, although a greater number of participants (five, or 38%) stressed the importance of relying on an internal thought process when deciding how to conduct treatment with patients while experiencing an illness in an ethical manner. One participant emphasized how therapists need to follow and trust their conscience when making ethical decisions while ill:

I think ethics in general is something you follow on an individual basis….I call it channeling the inner ethicist….How much do we share of an experience? Are we intruding if we acknowledge our experience? I think the same thing goes with the illness. You have to trust your ethical sense and be aware if you’re violating it, and [acknowledge it if you have] a real problem.

**Training Considerations To Prepare Therapists’ To Deal With Illness**

To assess whether therapists might be better prepared for potential illness in the future, participants were asked the following: (a) whether they felt that their training helped them prepare for dealing with crises, such as an illness experience; (b) advice they might have for other mental health professionals who may have to deal with a similar illness experience; and (c) advice for training programs helping to prepare future mental health professionals for dealing with illness and other crises.

**Did the training help to prepare therapists?** When asked whether they felt that their training was helpful or sufficient in working with patients during their illness experience, seven participants (54%) responded negatively. One participant mentioned
that training neglects matters not strictly connected to clinical treatment, e.g., finding referrals:

I think the training…mostly [concerned] how to work with people’s emotions and understanding the meanings of [them] versus the…practical things, like if I… have to transfer someone to another treater… That [information is] just hard to find. It takes time [and] it’s very difficult to do in real life.

Another participant felt that training helps individuals with the intellectual side of providing therapy and understanding patients, but the patient-centered focus seemed to often overlook the therapist as an individual:

What I think the training lacks is…talking about vulnerability as a therapist. I think we’re trained to be so intellectual and smart about understanding your patient, and to be able to write a really good treatment summary, and understanding everything about them, but I don’t really know [how] that addresses [a therapist’s issues] when you don’t feel well, or you go through anything [major] in your life, or any change….Is it okay to feel vulnerable, and how do you deal with it?

Conversely, four participants (31%) had a different perspective and expressed their view that the psychoanalytic training they received was helpful when they had to deal with their illness because of its emphasis on countertransference issues and the ways in which the therapist uses him or herself as the vehicle in treatment. One participant credited a specific approach for its helpfulness in dealing with illness:

I think a psychodynamic orientation prepares you to talk comfortably about transference and to be aware of how the therapist is a stimulator of feelings.
[Therefore] thinking about how my illness might affect patients is not a completely new thing.

Another participant also described the approach as helpful: “I think that the psychoanalytic [orientation] focuses a lot on transference and countertransference….There’s a lot of working with yourself in terms of what comes up with patients….Then the question of how…you handle these issues…flowed naturally.”

**Advice for mental health professionals.** Participants offered various suggestions when they were asked what advice they could impart to clinicians who might be facing an illness, injury, or disability during their lifetime. The greatest number of participants (10, or 77%) highlighted the importance of peer supervision. Nine participants (69%) emphasized the importance of self-care, with one also referencing self-care as necessary for effective patient work:

> We have to take care of ourselves first and foremost because if there’s nothing left in us…we’re not going to be able to give much to our patients….If we don’t practice what we preach, then any advice [or] interventions we give don’t really come from the heart—they just come from a textbook….If we don’t believe in [what we are communicating to patients], there’s a strong chance that patients will pick that up, and not…act on and…take in what we’re doing with them.

Seven participants (54%) stressed the importance of practical matters, specifically of having referrals available or drafting a professional will, as necessary to prepare for a crisis. Six participants (46%) emphasized the importance of being in personal therapy as helpful to a therapist undergoing an illness experience while working with patients.

Another six participants (46%) strongly advised the presence of a support group of family, friends, and colleagues. Four participants (31%) mentioned that preparation
should include a focus on how to deal with and address patients’ feelings and responses to the illness. Another four participants (31%) suggested that older therapists especially should consider slowing down and reducing their practice or caseload. One participant, recognizing how difficult coming to terms with the need to reduce their practice because of illness is for therapists, suggested that clinicians find alternatives for fulfillment other than work:

Nobody wants to…take time out of [a] career, but you have to take care of yourself first….In order to enjoy your work and do the best you can, you have to have a certain level of well-being….It doesn’t mean that your career is over, it just means that you won’t be able to do everything at once….Now I’m able to do more writing, and I’m back…to…reading more books,…which I couldn’t do when I was at work. You have to balance your life out. [You] might have to change the way you go about something. You may have to be realistic [and cut expenses. You might ask yourself], “How can I fulfill myself? How can I take care of myself financially and emotionally and still enjoy my career [to the extent I’m able]?” We all got into this because we love some part of it for ourselves, and [also] for helping others….You [may] have to…look at other choices, [such as being] willing to [see fewer] patients or [doing] other part-time work so that [you] can take care of [yourself], because it takes up a lot of time to take care of yourself.

Two participants (15%) advised that it is important to consider how one’s disclosure of illness to colleagues might result in fewer referrals as colleagues may be concerned about an ill therapist’s continued ability to treat patients.
Advice for training programs. Participants were asked about what types of advice they would give to training programs about helping mental health professionals deal with crisis situations, such as illness. Ten participants (77%) suggested that training programs should offer a program (class, seminar, or course) dedicated to issues surrounding a therapist’s becoming ill, including: (a) disclosure, (b) preparation of a professional will, and (c) ethical issues that arise for ill therapists working with patients. Three participants (23%) recommended that training programs bring in guest speakers, particularly therapists who have been through an illness experience, to discuss this topic with students. Two participants (15%) suggested that professional organizations issue clearer ethical guidelines establishing standards for therapists whose work with patients might be compromised due to illness. Lastly, one participant (8%) mentioned the difficulty in finding patients referrals to other practitioners if the therapist is no longer able to treat them, and suggested a nationwide service that could provide therapists with referrals:

What I really worry about is…if I couldn’t continue and had to transfer people. That would be very difficult…because I have [a diverse practice]. I have some Medicare, I have some kids, I have couples, I’ve got adults, women with trauma. I have a slew of anxious men [who found it] hard [to enter therapy], and are…very difficult to work with [in terms of] helping them adjust or change, or [altering behaviors to address their] anxiety….Sometimes I do imagine that…there was…a referral center, or something like [that, so] if you got sick, and you called, they could help you find someone [who] would cover your practice….My wish list [would include a] central place that you could [contact] for [well-trained] psychologists…able to cover for other psychologists, or help them make
transitions for their patients….I dread having to close a practice, because

[insuring that patients continue to receive effective treatment is] just going to be a lot of work.
Chapter V: Discussion

Themes

This chapter presents the themes that emerged from an investigation of therapists’ experiences of illness and how such experiences affected their work with patients, and the therapist as an individual. Participants’ responses were elicited from questions relating to the following: (a) identifying and describing the illness experience; (b) issues involving disclosure of a therapist’s illness to patients; (c) patients’ reactions to the therapist’s illness; (d) ways in which the illness affected therapists, and therapists’ reactions to their illness; (e) ethical issues arising from an ill therapist working with patients; and (f) training considerations and advice for helping therapists to prepare for crises, such as an illness, while continuing to work with patients. The limitations of the study, and implications of the study’s findings for future research, theory, mental health professionals, training programs, and professional organizations are also discussed.

Therapists’ Illness

Participants in this study presented with a wide range of illnesses, injuries, and/or disabilities, including: (a) cancer, (b) neurological issues, (c) impairments caused by disabilities, (d) degenerative diseases, (e) digestive tract conditions, (f) severe respiratory issues, and (g) injuries. The illnesses were not correlated with the aging process: one participant was diagnosed with prostate cancer—a disease that is diagnosed most often in men aged 65 or older—in his 40s; and another had been diagnosed with psoriasis—a chronic condition that persists to this day—as an adolescent. All participants (100%) experienced significant recovery periods, ranging from a few months to a few years, with some participants never having made a full recovery.
Many participants demonstrated a striking resilience in their efforts to work with patients despite having multiple health problems, or being diagnosed with a severe and life-threatening illness. For example, one participant with advanced stage lung cancer continued to see her psychoanalysis patients on a regular basis. Another participant experienced many health challenges during a year and a half, including suffering a stroke, having a cancerous tumor removed from one of his lungs, losing consciousness due to a chronic cardiac condition, and a severe slip-and-fall injury. After taking some time off to recover, he returned to his practice to see patients. As the themes discussed below demonstrate, an illness experience does not signify the end of clinical practice. The participants in the current study have demonstrated their ability to continue offering patients effective, competent treatment despite their health challenges.

**Issues of Disclosure**

When participants were asked whether they disclosed their illness to their patients, there was near unanimity—all but one (12, or 92%) disclosed their illness to one or more of their patients at some point in time. These results are consistent with research findings indicating that most therapists choose to disclose to at least some of their patients (Grunebaum, 1993). Even among clinicians who advocated for nondisclosure (Abend, 1982; Clark, 1995; Cooper, 2017; Dewald, 1982; Feinsilver, 1998; Lasky, 1990; Lindner, 1984; Madonna, 2014; Schwartz, 1987), a closer examination revealed that selective disclosure of some information about their illness had occurred. Despite the prevailing trend in the profession towards some degree of disclosure, there remain instances of clinicians never disclosing their illness to patients, as discussed below (see Chapter II), and further documented in the literature (Bruns, 2014; Firestein, 1990; Friedman, 1991; Galatzer-Levy, 2004; Paul, 2014; Pinsky, 2014; Traesdal, 2005;
Vlachos, 2011). The debate within the profession about whether or not to disclose has not been settled; however, and diametrically opposed views of the advisability of disclosure persist.

The Classical Psychoanalysis Versus the Relational Psychoanalytic Approach

In addition to individual therapists’ beliefs related to disclosure, the schism within the profession also has its derivation in opposing schools of thought. The classical psychoanalytic approach, as discussed below (see Chapter II), holds that disclosure of the therapist’s illness is unhelpful to the therapeutic process and thus should be avoided. The primary concern of this approach is to preserve the patient’s transference responses so that a clinician’s interpretations of the transference are not compromised (Fajardo, 2001; Kahn, 2003). Furthermore, Abend (1982) offered a strong rationale for nondisclosure arising from countertransference distorted by clinician illness:

The chief significance of the powerful countertransference elements mobilized by the analyst’s experience of serious illness is their tendency to influence analytic technique. This means, among other things, that the very clinical judgment relied upon to assess the specific needs of patients (with respect to how well they can maintain analytic productivity in the absence of factual information) is exactly what is under pressure from the countertransference; at no other time is the analyst’s judgment about this technical problem less likely to be objective and reliable. Countertransference reactions are liable to affect the analyst’s perception, understanding, capacity for instinctual control, and judgment in subtle, or sometimes not so subtle ways, and therefore may well color his opinion of his patients’ needs and capabilities. (p. 370)
In contrast to classical psychoanalysis, proponents of the relational psychoanalytic approach support disclosure. This approach views a therapist’s disclosure of illness not as presenting a negative influence on patient transference, but rather as having the potential to heighten and stimulate the patient’s transference reactions. This is accomplished by the value placed on honesty, authenticity, intimacy and the therapist’s use of subjectivity within the therapeutic relationship—qualities reinforced by disclosure that would ultimately prove beneficial for the patient.

The competing perspectives provided an important framework for exploration of the themes that emerged in the current study regarding issues of disclosure. The participants viewed disclosing some facts of the illness to patients as appropriate. Their adherence to the relational approach is consistent with the literature indicating that the classical psychoanalytic perspective is less prevalent in the profession today (Grunebaum, 1993). Furthermore, the author of the current study has found that there has been a significant shift in therapists’ attitudes regarding the two perspectives, with the relational approach gaining greater acceptance among contemporary authors at the expense of the classical psychoanalytic perspective. Although this observation has not been mentioned elsewhere in the literature, it is an important reminder that the nature of psychoanalytic theory reflects a trajectory of thought rather than remaining static over time.

**Importance of assessment.** Five general themes emerged regarding issues of disclosure. One theme, referenced by nine participants (69%), was the importance of making an assessment prior to patient disclosure. Assessment was described by participants as an active process that took into account multiple considerations: (a) a self-analysis by the therapist exploring the factors underlying a desire to disclose (or not),
(b) an analysis of the patient’s dynamics, and (c) possible impact on the therapeutic relationship. One participant characterized his decision to tell patients about his diagnosis of prostate cancer as not “impulsive,” but as a product of considerable thought as to how his patients would be affected by the disclosure. This theme corresponds to the relational approach, as discussed above, emphasizing disclosure as appropriate after a therapist’s analysis of the impact the disclosure might have on the patient. Abend (1982), a proponent of the classical psychoanalytic approach, argued conversely that a therapist should not disclose his or her illness as this decision is so heavily influenced by the therapist’s countertransference needs that it cannot be objective and deliberate.

Although the rigidity of the classical psychoanalytic approach precluding disclosure negates having to make a difficult decision, participants in the current study made the choice of whether or not to disclose on a case-by-case basis. One participant expressed it as follows: “I don’t know if I’m doing it right or wrong….It’s [based on] an assessment of my relationship with each person.”

Grunebaum (1993) and others (Friedman, 1991; Kahn, 2003; Kuchuck, 2009; Moses & McGarty, 1995; Pizer, 2016; Weinberg, 1988) suggested an additional component of decision making as to disclosure—the personal characteristics of the clinician: “An understanding of how much the therapist can comfortably reveal must take into account character. There are individuals who are inclined to be open about their personal experiences and those who value privacy more” (Grunebaum, 1993, p. 35). It may be the case that a therapist’s decision to disclose his or her illness is influenced more by his or her character rather than adherence to a particular perspective. For this theme, of paramount importance is the therapist’s thoughtful consideration of the potential consequences of the disclosure to individual patients.
**Disclose to high-functioning and long-term therapy patients.** A second general theme about disclosure that emerged concerned the types of patients for whom disclosure was or was not indicated. Level of functioning was identified as a major consideration and almost half of the participants in this study (six, or 46%) agreed that disclosure was appropriate for high-functioning patients as high-functioning patients had the resiliency to handle the information of the therapist’s illness without the risk of decompensating. This is consistent with Monaco and Palombo (2012), as discussed above (see Chapter II), who posited that proponents of disclosure viewed the amount of disclosure indicated to be proportional to the patient’s ability “to tolerate the anxieties produced by the information” (p. 319).

Various factors were mentioned by participants as constituting “high-functioning” patients, and thus good candidates for disclosure, including (a) patients in the neurotic end of the spectrum of psychological functioning (McWilliams, 2011); (b) patients with the capacity to tolerate relational work; (c) patients with certain positive personal attributes, e.g., strong-enough egos, good self-images, good careers; and (d) patients who are well-related and can create a strong alliance. These definitions offered by participants in this study are helpful since the literature does not reveal a consensus among scholars as to what should be considered a “high-functioning” patient.

Approximately a third of participants (five, or 38%), suggested that patients in long-term treatment were proper recipients of disclosure. This contrasts with the position of Dewald (1982) who, consistent with his adherence to the classical psychoanalytic approach, suggested that therapists not disclose to patients in long-term treatment because that would interfere with the “transference-inspired distortions and reactions to the event” (p. 354) that had developed over the course of the treatment.
Intimacy in the therapeutic relationship was cited by participants as the second factor influencing their decision to disclose. This was consistent with the emphasis placed on the primacy of intimacy in the therapeutic relationship by the relational psychoanalytic perspective of self-disclosure (Brody, 2013; Brothers, 2012; Frommer, 2009, 2013, 2016; Morrison, 1990; 1997; A. Pizer, 2016; B. Pizer, 1997; S. Pizer, 2009a). Participants in this study saw high-functioning patients as more able to foster intimacy in the therapeutic relationship because these patients tended to be more object-related and curious about others in general. The potential for intimate therapeutic relationships often correlated with the length of treatment as participants considered their relationships with long-term patients to be more intimate relationships and thus appropriate for disclosure.

In addition to high-functioning patients with whom they had a long-term relationship, participants identified patients who exhibited curiosity about the therapist’s illness, e.g., asking questions, as the third factor in an affirmative decision to disclose. Although the existence of patient curiosity is acknowledged in the literature (Brody, 2013; Goldberg, 1984; Monaco & Palombo, 2012; Morrison, 1990; Murphy, 2013), no connection between expressions of curiosity and a corresponding rationale for disclosure has been explicitly recognized. Participants suggested the logic: patients who were healthier and had been working with the therapist for longer were also more likely to inquire about the therapist’s well-being. In the end, decisions about the classifications of patients for whom disclosure is indicated may boil down to what an individual therapist places a greater value on—fostering intimacy in the therapeutic alliance or precluding distortions in transference.

**Do not disclose to lower-functioning patients.** A third general theme about disclosure that emerged involved patients for whom disclosure is not indicated, such as
lower-functioning patients who were mentioned by approximately half of the participants (six, or 46%). “Lower-functioning” patients were described as patients who were mentally fragile, vulnerable, and self-absorbed. This included patients in crisis, and those diagnosed with schizophrenia or psychotic-spectrum disorder, bipolar disorder, substance abuse, or personality disorder. When participants were asked to reflect on why they chose not to disclose to such patients, they offered three reasons. First, like Goldstein (1997) and Monaco and Palombo (2012), many participants stated that lower-functioning patients would be burdened or negatively impacted by knowledge of the therapist’s illness, and participants would be cautious about adding more stress to their lives. This opinion, however, does not have universal support in the profession. Researchers, such as Searles (1975), Silver (1982, 2001) and Davoine (1990), have posited that not disclosing to lower-functioning patients does more harm than good. As discussed more extensively above, these authors are of the view that lower-functioning patients might sense that something is wrong with the therapist and then become more anxious if they were not told about the illness. Silence on the part of the therapist might reinforce in the minds of these patients the idea that they are “crazy” for sensing—with no basis in reality—that something is wrong with the therapist.

Secondly, some participants were concerned that disclosure would take the focus of the treatment away from the patient. This reason is consistent with the argument of the classical psychoanalytic approach: that a therapist’s disclosure is based on the therapist’s own countertransference needs and not in the best interest of the patient (Abend, 1982). Third and lastly, four participants (31%) stated their belief that unless patients asked, they were under no obligation to tell, ascribing a level of self-absorption to lower-functioning patients that would often preclude their thinking to inquire about their therapists. That
lower-functioning patients might be too focused on their own problems to concern
themselves with any issues a therapist might have has not been addressed in the literature
concerning disclosure.

Additionally, three participants (23%) identified classifications of patients for
whom disclosure would have little value, e.g., those just starting treatment, patients who
are terminating treatment and those in short-term therapy. A few participants were
especially concerned not to take the focus away from short-term therapy patients who had
a limited time in which to work on their issues.

**Necessary self-disclosure.** A fourth general theme that emerged from the current
study was the necessity participants felt at times to disclose their illness to patients. This
was attributed to four main situations. Eight participants (62%) agreed that nondisclosure
could be harmful to patients in certain situations. The following examples were given by
participants: (a) participants were aware of a patient’s family history which included a
gravely ill family member whose illness was kept secret and were concerned that keeping
their illness from the patient would be harmful; and (b) concerns that a therapist’s
deceptiveness would leave the patient feeling confused and invalidated. This view is
consistent with the relational psychoanalytic approach, as discussed above.

The second reason, reported by six participants (46%), was that disclosure was
sometimes necessary because manifestations of their illness were visible and/or obvious,
and participants did not want to invalidate the patient’s perceptions or questions. Thus,
when these participants coughed, had a black eye, or had difficulty walking, etc., during a
session, they felt they needed to be honest with patients about their illness. Examples of
similar situations can be found in the literature. Pizer (1997) described disclosure in
response to the therapist’s visible symptoms as “unavoidable” (p. 51), e.g., Linna (2002)
working while in a cast, Pizer (2009a) working while attached to a colostomy bag. Under such circumstances, it is very common to choose to disclose an illness.

The third reason, offered by five participants (38%) was to not leave patients “in the dark” when therapists might need to take a leave of absence due to illness. Again, as with the first and second reasons, participants felt that nondisclosure would be more detrimental to patients. One participant (8%) offered a fourth reason for feeling it was necessary to disclose to his patients—self-protection. This participant had a chronic condition for which he was prescribed immunosuppressant medication. Thus, he would be highly susceptible to contracting patients’ illnesses if they attended sessions while sick. As with the others discussed above, he felt that disclosure was inescapable. His situation left him with additional unique ethical dilemmas: (a) Would it be ethical to cancel sessions if patients indicated they were sick?; and (b) a situation never addressed in the literature: Is it right to disclose because by advocating for his own self-care he is serving as a role model for patients to similarly protect themselves, or is it wrong because he is impinging on the treatment with his own problems?

**Disclosure was helpful to patients.** A fifth general theme regarding disclosure in the view of more than two-thirds of participants (nine, or 69%) was that disclosing their illness was helpful to patients and the treatment process. This theme was consistent with the relational perspective of disclosure as having the potential to enhance treatment. Five participants (38%) stated that they felt more “human” and “real” to patients, and that disclosure served as the impetus for conversations with patients about important themes in treatment. These findings are consistent with those of Van Raalte (1984), in which patients fared better when therapists had informed them of their illness because they were then better prepared for the therapist’s eventual death.
Approximately a third of participants (four, or 31%) reported that disclosure was specifically helpful for patients who were experiencing their own illness. The consistent idea expressed by these participants was that by serving as role models for their patients on how to cope with an illness, and by talking openly, freely, and honestly about their illness, patients would be encouraged to talk with others about their own illness.

This was exemplified in a clinical vignette presented by one participant, as discussed above (see Chapter IV), whose patient had been diagnosed with schizotypal disorder and struggled with connecting to others. When the patient was diagnosed with lung cancer, the therapist was open in sharing her own experiences with seizure disorder. After talking about the details of their illnesses, the patient who had been unable to engage openly with others for most of her life confided in co-workers and family members about her illness. Another participant who had disclosed about her eye surgery helped her patient build self-efficacy when dealing with a similar issue, and helped calm his fears about the surgery and recovery process. Thus, disclosure may also be indicated for patients with an illness of their own as the process of imparting information, serving as role models, and “comparing notes” with a therapist may prove beneficial to patients. These findings, again, are consistent with the relational approach viewing a therapist’s disclosure of an illness as helping to create an atmosphere of mutuality and authenticity in the therapeutic relationship and thus an enhancement to the treatment process.

Patients’ Reactions to the Therapist’s Illness

Patients’ unconscious awareness of therapist’s illness. During the interview, participants offered their thoughts on how they perceived their patients’ reactions to the therapist’s illness. Three general themes emerged from this line of inquiry, the first of which involved patients’ awareness of the therapist’s illness. When participants were
asked about whether they believed that their patients were aware of their illness in the absence of disclosure, about a third of participants (four, or 31%) reported such experiences.

This is consistent with reports in the literature. For example, Davoine (1990) discussed a case example concerning a psychotic patient who informed her that he had known about her illness prior to her diagnosis before she was even aware of it. A participant in the current study related a similar experience with a patient who had had an extensive trauma history. The patient reported experiencing pain in her genital area immediately after the participant had been diagnosed with uterine cancer. Both the timing of the incident and its specificity led the participant to interpret the situation as a synchronous moment in which the patient was unconsciously attuned with what the therapist was experiencing.

The above anecdotes elicit the following questions: Are these experiences a coincidence? Is there something to the idea of “synchronous moments?” Do psychotic patients or patients with trauma histories possess a “sixth sense” of awareness, allowing them to pick up on subtle changes in the therapist’s mental and bodily functioning and have an awareness of the therapist’s ailments without any indication? Silver (1982) suggested the existence of this ability in psychotic patients. If patients can have an implicit, preconscious awareness of the therapist’s illness, should it influence the view that patients who are lower-functioning, particularly psychotic patients, are not appropriate for disclosure? Based on the recommendations of Silver (1982) and Davoine (1990), it is best to be honest and straightforward with patients who are unconsciously aware of the therapist’s illness. Thus, the theme suggesting that lower-functioning patients are not appropriate for disclosure might be revised to suggest: “Do not disclose
to lower-functioning patients, unless they have some awareness of the therapist’s illness indicated by the questions they ask or themes they bring up in treatment.”

Patients’ transference-related feelings and reactions. Another general theme involved patients’ transference reactions. Consistent with the literature, which offers an abundance of examples about how patients’ transference reactions have been affected by the therapist’s illness, a significant majority of participants (12, or 92%) reported such occurrences with their patients. Participants identified three major sources of patients’ transference responses: (a) the patient’s transference-related feelings, (b) transference based on the death of a family member, and (c) transference based on the death of a former therapist.

Transference-related feelings that have been identified in the literature (Brody, 2013; Brothers, 2012; Chaudhuri, 1999; Cottle, 1980; Dewald, 1982; Elliott, 1996; Engels, 2001; Fajardo, 2001; Feinsilver, 1998; Frank, 1975; Friedman, 1991; Goldstein, 1997; Guy & Souder, 1986; Halpert, 1982; Hoffman, 2000; Kahn, 2003; Lindner, 1984; Monaco & Palombo, 2012; Pinsky, 2014; Silver, 1982; Torrigiani & Marzi, 2005), such as anger, fear of abandonment, and feelings of dependency on the therapist—often stemming from past experiences with someone close to them who is or was ill or has died—were also identified by participants as having occurred with their patients. Given the abundant references in the literature (Dewald, 1982; Fajardo, 2001; Pinsky, 2014; Silver, 1982; Torrigiani & Marzi, 2005), combined with the findings of the current study, it can be concluded that a therapist’s illness is likely to elicit a transference reaction from the patient.

Although patients react in idiosyncratic and unique ways, therapists can be attuned to and look out for common transference reactions listed above, e.g., anger, fear
of abandonment, and dependency feelings. For example, if a patient expresses anger towards an ill therapist, the therapist is advised to consider whether this reaction is based on the patient’s past experiences. Someone important to them becoming ill and/or passing away is an event likely to have been experienced by every patient given the ubiquity of illness and death.

Participants addressed the transference elicited by the therapist’s illness as they would with other instances of transference—by helping patients to confront their unconscious feelings and to put those feelings into words. One participant gave the example of how she helped her patient come to terms with his unconscious transference feelings that were related to his experiences with his mother. The patient saw his mother as the weaker of his parents and he felt overprotective of her. When the therapist became ill, he felt overprotective of her too as well. The process of working through the transference consisted of: (a) the patient becoming aware of the feelings of overprotectiveness towards the therapist, (b) the patient making the connection between how the feelings toward the therapist were similar to how he felt towards his mother, and (c) the patient’s realization that he could resent the therapist for becoming ill.

Although there is some discussion in the literature of patients’ responses to a previous therapist’s death during treatment with a subsequent therapist (Bruns, 2014; Firestein, 1990; Friedman, 1991; Galatzer-Levy, 2004; Lord, Ritvo, & Solnit, 1978; McWilliams, 2017; Paul, 2014; Pinsky, 2014; Tauber, 1989; Tiemann, 2012; Traesdal, 2005; Vlachos, 2011; Van Raalte, 1984), relatively few articles (Flapan, 1986) have been published addressing the situation of these patients learning that their current therapist is ill as well. This circumstance, identified by a number of participants in the current study, may become the basis for a unique type of transference response. In addition, awareness
of a current therapist’s illness would be particularly impactful if the original therapist’s
decision not to disclose had been mishandled, thus depriving the patient of the
opportunity to process the illness.

According to Lord, Rolnit, and Salvo (1978), as discussed below (see Chapter II),
the death of a therapist may have a devastating effect on patients in which they
experience prolonged periods of mourning that are counterproductive towards the
patients’ development and growth. The current therapist then faces a significant challenge
to handle the disclosure issue carefully or risk the re-traumatizing the patient. The current
therapist also has the opportunity to turn the situation into a positive by providing a
corrective emotional experience for the patient. For example, one participant in this study
was treating a patient whose former therapist had died without having disclosed the
illness. By keeping her patient informed about her illness and validating his concerns
regarding her health, she was able to provide a different, more corrective, experience for
the patient while also re-focusing the patient back to working through his anxiety and
past experiences.

Patients’ concern was helpful. A third theme that emerged with respect to
patients’ responses to the therapist’s illness was patients’ expressions of concern towards
the therapist when they became aware of the therapist’s illness. Some participants
mentioned their belief that patients who are highly self-centered and often lack empathy
for others should be encouraged to display concern for the therapist. Nine participants
(69%) reported the patient’s concern as helpful for the patient in two ways: (a) patients’
expressions of concern for the therapist brought their character dynamics into the
treatment which could then be worked on, enhancing treatment; and (b) patient concern
could be utilized by the therapist to work through or address the patients’ transferences.
This is consistent with the literature (Feinsilver, 1998; Kahn, 2003; Lindner, 1984; Linna, 2002; Pizer, 2009a; Searles, 1975; Silver, 1982; Singer, 1971), in which a patient’s concern is considered an element of a transference reaction that needs to be interpreted, analyzed, and linked to the patient’s past history. Participants viewed patient concern as more than a transference reaction. They also saw expressions of concern as a reflection of the patient’s personality style, an observation that has not received recognition in literature.

The idea that the therapist’s vulnerability, such as an illness experience, can be used in a therapeutic way to address the patient’s issues has not been addressed to any extent in clinical theory (Frommer, 2009, 2013, 2016), and the idea that patients who are self-centered should be encouraged to express concern towards aspects of the therapist’s vulnerability has not been discussed at all. This may be due to classical psychoanalytic theoretical approaches reducing a therapist’s request for the patient’s concern to the therapist’s countertransference reactions (Abend, 1982; Lasky, 1990). In addition, encouraging expressions of concern may violate the main principle of therapy which is to care for the patient, not for the patient to care for the therapist.

Alternate perspectives on patient concern for the therapist are also present in the literature. For example, Searles (1975) stated that patient concern should be considered as therapeutic not as an interference with treatment, and Kernberg (2014) expressed the view that therapy with narcissists may involve interpreting the defensive functions of the “pathological grandiose self,” and helping the patient to move towards more “object-related” transferences (pp. 867-869). One participant related an interchange with a narcissistic patient that served to illustrate Kernberg’s (2014) theory. The therapist confronted the patient directly in an attempt to get the patient to think about her as
another person by asking: “Are you concerned about me? You don’t register any concern for me?”

**Therapists’ Reactions to Their Illness and Consequences of the Illness to the Therapist**

**Wanting the patients’ concern as countertransference.** Six themes emerged from participants’ responses to interview questions regarding their reactions to their illness in terms of: (a) their countertransference responses towards patients, and (b) their subjectivity as a therapist. The first general theme involved the therapist’s countertransference reactions. This theme brings up an important question: whether the patients’ concern is being utilized therapeutically for the patient’s benefit, or whether it is being utilized in such a way that the roles are reversed and thus is detrimental to the patient. The answer by close to half of participants (six, or 46%) was that they had a desire for their patients to take care of them but, with the exception of one participant (who “acted out” her countertransference feelings by making arrangements with patients to take care of her in different ways), they acknowledged that acting on the desire would be potentially disruptive to the treatment process, and were careful not to disclose their illness in response to their countertransference feelings. While their decisions were consistent with the classical psychoanalytic approach viewing countertransference responses as an impediment to treatment, acknowledging the unacted-upon desire to be cared for by the patient is a reminder that therapists need to examine their feelings carefully prior to disclosure.

**Therapist resiliency in the face of illness.** A second general theme that emerged was the sense of resiliency some participants experienced in reaction to their illness. Consistent with prior findings in the literature (Feinsilver, 1998; Grefenson, 2012),
almost half of the participants (six, or 46%) were able to react towards their illness experience with optimism, hope, or gratitude. Gratitude took many forms. For example, some participants were grateful for their doctors and social supports, while others were grateful for recovering and being able to return to work. One participant, in particular, who had suffered a stroke which impaired his ability to speak, was grateful that speech therapy enabled him to return to the work he deemed a “privilege.” His illness could have caused him to lose “his speech completely,” and he realized that treating patients was not something you could “automatically assume that you can always do.”

Participants used various coping devices in response to their illness. Consistent with the literature (Cole, 2001; Cristy, 2001) holding that the use of denial and rationalization are necessary for therapists with an illness to continue patient treatment, five participants (38%) credited similar “intellectual” types of defenses to mitigate the amount of anxiety they experienced, especially during sessions. (For a discussion of one participant’s usage of compartmentalization, see Chapter IV above.) Other coping mechanisms mentioned by participants included: (a) finding support from others, e.g., therapists, supervisors, and family and friends (six, or 38%); (b) re-arranging their work routine, e.g., reducing the number of patients they were seeing, making adjustments to their workload and schedule, taking a vacation, scheduling short breaks in between sessions, and implementing a mindfulness exercise in-between seeing patients (five, or 38%); and (c) writing, e.g., creating an online blog documenting the illness experience (one, or 8%). One participant offered a particularly inspiring example of how she coped with a diagnosis of lung cancer. (See Chapter IV above for a discussion of how her utilization of an energy healer allowed her to reconceptualize incidents of her illness as
“fun.”) Her story is a unique contribution to this topic and it exemplifies the resiliency that can triumph over adversity in response to a life-threatening diagnosis.

**Therapists’ negative feelings and emotional avoidance.** A third general theme, participants’ experiencing a host of negative feelings, especially when first diagnosed, was mentioned by each participant (100%). This unanimity provides an interesting contrast with the fewer number of participants experiencing resiliency, six, as discussed above. One can conclude that positive emotions, such as hope, gratitude, and optimism, appear later for some and not at all for others.

Fear was a common response reported by almost all participants (12, or 92%). Fear took different forms for participants, from complete terror and fear of dying to not being able to work any longer. For example, one participant, as discussed above (see Chapter IV), compared her reaction to first learning about her diagnosis of uterine cancer to falling “into an abyss.” Others reported entering a state of shock, or experiencing anger, depression, and/or guilt. Feelings of guilt were attributable to the prospect of abandoning patients, or for a lessened capacity for empathy towards patients because of the illness. All of the feelings described by study participants have been reported in the literature as well (Brothers, 2012; Counselman & Alonso, 1993; Elliott, 1996; Engels, 2001; Frommer, 2009, 2013; Kahn, 2003; Linna, 2002; Monaco & Palombo, 2012; Morrison, 2008; Schwaber, 1998).

Some participants attempted to avoid uncomfortable feelings resulting from their diagnosis by viewing themselves as “invulnerable” (four, or 31%), or through the more widespread use among participants of denial (eight, or 62%). The literature is split between those who viewed a therapist’s use of denial as adaptive (Cole, 2001; Cristy, 2001), as discussed above, and those who view it as disruptive (Arlow, 1990;
Counselman & Alonso, 1993; Dewald, 1982, 1994; Edwards, 2004). As can be seen in the reactions expressed by participants, denial may manifest as both a (positive) coping device and a (negative) escape from a potentially devastating reality.

The use of denial may also influence the disclosure decision, a factor which may explain the decision by the only participant in the study who chose not to disclose to any of her patients:

Maybe part of my decision not to disclose anything was a defense, because I would not have to feel all the things that I was feeling. I would not have to feel the terror I went through with a patient….I [could] keep my feelings separate.

Another participant offered a view similar to what Kreichman (1984) described, as discussed below (see Chapter IV), as the sense of “personal specialness” (p. 384) therapists had because of their role as caregivers for others. Despite a diagnosis of prostate cancer, he stated that he felt “kind of invincible” and he rationalized to himself, as discussed above (see Chapter IV), that “We help people. We don’t get sick.”

When denial and feelings of invincibility prevent therapists from disclosing their illness to patients, patients may be harmed. It is not unusual for patients in this situation to only become aware of a therapist’s illness upon his or her death, a circumstance with significant ethical implications, as discussed below.

Positive changes on the subjectivity of the therapist. A fourth general theme that emerged was that participants experienced various positive effects on their subjectivity. Like the women in Grefenson’s (2012) study and authors from other studies (Cole, 2001; Fischer, 2001; Shernoff, 1991, 1996), most participants (10, or 77%) experienced increased empathy for patients. Having gone through a serious medical condition, they had greater understanding of patients’ emotional difficulties and could
relate to their patients’ suffering. Many participants (nine, or 69%) stated that they were able to tolerate their patients’ suffering more, and that discussions on difficult topics became easier. For example, one participant, who had received a cancer diagnosis himself, stated that he was now able to help his cancer patients prepare to talk with their children about their diagnosis and the possibility of their death from the disease. The finding of the current study—that participants’ therapeutic efficacy, specifically regarding the ability to have difficult conversations about painful existential themes that may come up in one’s life, was enhanced—is in stark contrast to the prevalent view espoused in the literature that working with patients becomes a burden, and that therapeutic efficacy is compromised when therapists are ill.

About half of participants (six, or 46%) stated that their illness experience allowed them to share more of themselves with patients, e.g., they were more “authentic” with patients, and they were able to use their vulnerability in ways that were helpful to patients. This finding is important because it helps address Frommer’s (2013) concern about the absence of guidelines advising therapists how their vulnerability can be used in treatment. The participants’ experiences of vulnerability during the course of their illness allowed them to have a more profound understanding of their patients’ vulnerability and consequently a more honest discussion about this subject. For example, after he experienced a life-threatening illness, one participant was able to “feel more connected with” his patients and talk about end of life concerns with them. Another participant reflected on how she was able to talk to patients about their prescribed medications once she had to take medications for seizures. She viewed vulnerability not as a “disadvantage,” but as a quality that could allow therapists to “help patients differently,” and share their “humanness” with patients.
Negative changes on the subjectivity of the therapist. The fifth general theme concerned participants’ perceptions of the negative changes to their subjectivity-as-a-therapist. Consistent with Durban, Lazar, and Ofer’s (1993) metaphorical description of the ill therapist as a “cracked container” (p. 708), as discussed above, all participants (100%) in the current study mentioned that as a consequence of their illness experience it was difficult to be emotionally present (or “containing”, p. 708) while working with patients. They expressed sometimes feeling distracted and preoccupied with their illness when working with patients, leading them to consider working with patients as a burden at those times. One participant illustrated Durban, Lazar, and Ofer’s (1993) depiction of a body dealing with an illness as an “irritant and a saboteur” (p. 708) when she described her experience of needing to continually refocus herself on listening to her patient because various elements of her illness, e.g., fatigue, anxiety about waiting for test results, physical pain, would serve as constant distractions.

Another negative effect mentioned by six participants (46%) was their diminished tolerance and patience for patients with “trivial” or “superficial” problems, or patients who talked about the same problems week after week. Participants offered various examples of what they defined as a “trivial” or “superficial” problem, including: (a) family therapy patients who wanted to discuss difficulties with parenting or interpersonal conflicts between the parent and the child that the participant considered as mild and not on a crisis level, (b) having difficulty “getting a date on Saturday,” (c) “help-rejecting complainers” who seemed stuck on the same issues and would refuse whatever interpretations or support the therapist would offer.

The above finding was consistent with the results in Grefenson’s (2012) study where the participants reported less patience with various clients, including clients: “who
do not show up for appointments” (p. 77); with trivial problems, e.g., “breaking up with a
guy after a month” (p. 78); and who behave “histrionically” (p. 78). The negative changes
on the therapist’s subjectivity, even when tempered by the positive changes, raise
questions about how an illness experience might affect a therapist’s competency. On the
one hand, when therapists utilize their own experiences and vulnerabilities to help
patients and become more attuned, more willing to have difficult conversations with
patients, and more authentic with patients, patients are likely to benefit. On the other
hand, therapists may become less attuned with some patients, less empathic, and less
tolerant of patients—a situation which presents a significant issue regarding patient care.

**Shifts in conceptualization.** The sixth general theme was that most participants
in this study (nine, or 69%) reported changes in the way they conceptualized their work
after their illness experience. This is consistent with Grefenson’s (2012) study where
participants reported that after being ill they either became more eclectic or they added
new orientations to their pre-existing perspectives regarding how they worked with
patients.

Four (31%) reported profound shifts in conceptualization. Their professional
identity-as-a-therapist changed in response to their illness in such a way that their
treatment focus with patients was transformed. For example, one participant’s diagnosis
of skin cancer changed her primary focus from helping her patients to reduce negative
symptoms to helping patients to build a better quality of life for themselves. Prior to a
second participant’s diagnosis of seizure disorder, and vision problems (e.g., macular
degeneration, blindness), she viewed dependency needs as negative, and worked to help
clients establish a sense of independence. After the illness she tended to emphasize inter-
dependence, as she helped her patients to foster closeness and intimacy with others and
have supportive relationships. She also stated that her theoretical orientation changed accordingly, and she became an adherent of the object-relations psychoanalytic approach which emphasizes the importance of relationships.

A third participant reported that as a result of his experience with a severe and chronic respiratory illness, he began focusing on helping his patients live more in the moment and “helping people to live the best life that they can.” The fourth participant stated that his illness experience taught him that people could look well on the surface but could be experiencing a lot of pain underneath. This caused him to challenge his assumptions about patients and approach them with a curious stance. Prior to his illness he perceived patients from an intellectual standpoint and had been more concerned with interpreting what was going on with them.

The findings reported above are unique contributions to the literature in that such changes in how therapists conceptualize their work with patients have never been documented in the literature before, and the existing literature leaves questions unanswered, such as: (a) whether the changes a therapist experienced endured over time, and (b) whether such experiences affected the therapist’s identity and how he or she conceptualized his or her work with patients.

Ethical Issues

Negative consequences on the therapist’s livelihood. Three general themes emerged from interview questions exploring the types of ethical issues participants encountered when working with patients while simultaneously dealing with an illness. One theme concerned the participants’ livelihood. Therapists need to continue working so that they can earn an income in order to survive; however, they also must be competent and provide “good enough” therapy to their patient. The ethical dilemma that arises from
this situation turns on whether the illness experience has compromised a therapist’s ability to render effective treatment.

The majority of participants (nine, or 69%) identified three areas in which their livelihood was impaired: (a) loss of income, (b) reduction in practice, and (c) loss of referrals. These findings were consistent with the literature (Henry, 2009; Morrison, 1997; Shernoff, 2009). Although therapists who work in a hospital or clinic setting may have employer-provided benefits that help to mitigate income loss, e.g., paid sick leave and/or vacation time and disability insurance, therapists in private practice often lack such benefits and thus are far more susceptible to losing income in response to an illness, injury, or disability.

One participant reported that she had just started working full-time in her private practice when an acute bout of vertigo resulted in her hospitalization. Although she was able to return to work a week later, this was the first time she fully relied on her practice for income, and she realized her financial vulnerability. A participant in private practice reported her needing to downsize after a diagnosis of breast cancer dramatically reduced her practice. Originally in an expensive office, she had to move to a smaller, less attractive office, and eventually she had to work out of a home office. Another participant’s severe respiratory illness required him to take a leave of over a year from his private practice, the financial effects of which were long-lasting. Not only was he deprived of income for that period, but once he returned to work he had fewer clients and thus could no longer generate the revenue he had prior to his illness. Two other participants mentioned that their loss of income necessitated a change from private practice to jobs they considered less desirable but that provided more financial security.

In contrast to the participants in private practice, one participant reported experiencing no
loss of income during her illness because she worked in a hospital and received compensation from employer-provided benefits, e.g., sick leave and disability insurance. While it is evident that therapists in private practice often suffer the greatest financial consequences, therapists in other settings can also experience reductions in practice. For example, Silver (1982), who worked in a psychiatric center, saw fewer patients when she returned to work.

Scholars have provided divergent views as to the impact of therapist illness on referrals. A dissertation study by Bressler (1990) found that a therapist’s illness had no effects on patients’ expectations for therapy because patients viewed therapists who were ill as having no problems performing in their role as therapists, suggesting that a therapist’s illness should not adversely impact referrals. In contrast with Bressler’s study, one participant in the current study reported that it was extremely difficult for him to obtain new therapy patients after returning from a 14-month absence. Although he conducted many initial consultations, most patients were reluctant to start working in long-term therapy with him. Unlike other participants whose illness was no longer detectible once they returned to work, this participant’s symptoms, e.g., coughing, difficulty breathing, were obvious.

Another example of the impact of illness on referrals was provided by Morrison (1997). Morrison found that she received increasingly fewer referrals after her diagnosis of breast cancer which she attributed to the attitudes of other therapists regarding her illness, as illustrated by the following: A patient related how another therapist, who the patient was seeing for couples therapy, encouraged the patient to stop seeing Morrison so that the patient would not have to suffer a loss. Consistent with Morrison’s experiences,
two participants (15%) brought up the issue of how colleagues might feel that the ill therapist is not competent enough to take on new patients, leading to a lack of referrals.

Loss of income, loss of existing therapy patients, and not having new patients due to a lack of referrals may present the ill therapist with the difficult, ethically challenging decision of whether they can keep working or have to retire. As was discussed in Chapter II, some therapists may rule out retirement because they need to work to survive (Henry, 2009; Morrison, 2008). Others may choose to continue working because their work as therapists gives them fulfillment and a sense of identity, the loss of which may be too difficult to contemplate (Nass, 2015; Shernoff, 2009). Unfortunately, those therapists may not consider that they may no longer have the capacity or competency to treat patients. Nass (2015), as discussed in Chapter II, has related incidents of elderly therapists, in particular, harming patients, e.g., falling asleep during sessions, blaming patients when confronted with evidence of memory loss.

An additional cause for concern expressed by Nass (2015) is the absence of professional or organizational procedures in place to assess and monitor for a therapist’s competency in providing treatment. The ethical challenge presented by therapists’ illness experience compromising their competency juxtaposed with therapists’ need to maintain their livelihood is not an easy one to resolve.

**Ethical dilemmas that can lead to harm to the patient.** Another major ethical dilemma identified by a majority of participants (11, or 85%) occurs when therapists do not disclose to patients when they are incapacitated by, or dying from, a serious illness. The harm that is done to patients in this situation has been well documented in the literature (Bruns, 2014; Lord, Ritvo, & Solnit, 1978; McWilliams, 2017; Paul, 2014;
Tauber, 1989; Tiemann, 2012; Traesdal, 2005; Van Raalte, 1984), and mentioned by several participants in their interviews.

Another ethical dilemma arising from non-disclosure, that a failure to disclose can be considered dishonest and thus conflicts with the ethical principle of maintaining integrity with patients, was reported by two participants (15%). In contrast, three participants (23%) expressed doubts as to whether disclosing an illness to patients was ethical, given that therapists’ disclosure decisions may be governed by their countertransference needs or a desire for reassurance from the patient. This conflict was characterized by Bram (1995) as between “beneficence and fidelity” (p. 570), as discussed above (see Chapter II).

Two participants (15%) mentioned situations in which ill therapists are tempted to take advantage of patients as posing an ethical dilemma. For example, one participant whose two hip replacement surgeries left her with difficulty walking asked a patient to buy her a newspaper during inclement weather. Another participant mentioned knowing of therapists who charged patients for sessions the therapist had canceled due to illness, a dilemma left undocumented in the literature.

**Adherence to ethics.** One general theme that emerged related to a subject that has received little attention in the literature, adherence to ethical guidelines. A majority of participants (10, or 77%) reported that they had no knowledge of the presence of, or were unaware of the contents of, guidelines issued by their profession, e.g., the APA for psychologists, the NASW for social workers, that could advise them on how to manage a crisis, such as an illness. In contrast, two participants (15%) reported adherence to their profession’s ethical guidelines. Four participants (31%) stated that consultation with their supervisors would help them to make ethical decisions, while five (38%) expressed the
view that they were capable of making ethical decisions without guidance from others or their professional organization. Implications of this finding will be discussed below.

Training and Preparation

Training was helpful in preparing therapists for crisis situations. During the interview, participants were asked questions related to preparation for crisis situations, both in terms of training, and efforts they could undertake to reduce the uncertainty that could result from a future crisis. The first general theme was that there were some participants who had made preparations to deal with future crises and some participants who felt that training was helpful. Regarding training, about a third of participants (four, or 31%) found their prior training to be helpful when they encountered a crisis. These participants specifically stressed their psychoanalytic training—in its emphasis on the subjectivity of the therapist and countertransference—as invaluable in overcoming their negative feelings in response to their illness and those on their subjectivity as a result of their illness. These expressions were consistent with general themes identified in the current study. The ability to self-reflect on subjectivity may confer an advantage for some therapists, an issue which the current study was one of the first to discuss.

Regarding preparation for the future, most participants (nine, or 69%) had contemplated the consequences to their patients if they were to face a crisis and took actions to be prepared in advance. These consisted of either a professional will (see Chapter IV), or an informal emergency procedure appointing colleagues or family members to intervene in a crisis situation. Not much attention has been accorded how therapists can be prepared to deal with crises, such as an illness, in the literature, although there have been discussions in the literature emphasizing the importance of a professional will (Bradley, Hendricks, & Kabell, 2012; O’Neil, Yanchyshyn, & Freebury, 2014; Pope
The prevalence of professional wills among therapists is unknown however.

**Training was not helpful in preparing therapists for crisis situations.** A second general theme, mentioned by more than half of the participants (seven, or 54%), was that the training they received was not helpful in dealing with crises, such as an illness, reinforcing Frommer’s (2013) critique of clinical theory as not addressing how therapists are supposed to handle their vulnerability with patients. Others emphasized the lack of attention paid to practical matters, such as finding referrals, in training. As discussed above, most participants in this study (ten, or 77%) were not aware of the existence of ethical guidelines regarding how to deal with an illness while working with patients, and thus were not prepared to act in accordance with professional standards in this circumstance.

**Therapists’ advice for others.** The theme discussed above indicates that mental health professionals are often insufficiently prepared to deal with crises. Participants were asked how they would advise other mental health professionals to help them to be prepared to deal with future crises and how training programs might be revised so that this topic receives the attention it warrants. Regarding advice for clinicians, participants encouraged them to address issues of self-care and to seek support from peer supervision, personal therapy, and family, friends, and colleagues.

In addition, therapists were advised to be prepared to deal with others’ reactions to their illness, specifically patients and colleagues. Regarding training, participants recommended that training programs offer a program dedicated to this issue and invite guest speakers to discuss various aspects related to the topic of the therapist’s illness, such as: (a) the appropriateness of disclosing the illness to patients, (b) ethical issues that
may arise from therapists working while ill, and (c) information concerning the
preparation of a professional will. A few participants stated that the professional
organizations, e.g., APA, NASW, should issue comprehensive ethical guidelines that set
clear standards regarding therapists’ responsibilities toward their patients, and how
therapists should handle situations such as an illness. One participant, as discussed above,
offered an innovative suggestion that a national referral center be established so that
therapists can access a database of local providers and their practice areas to facilitate
patient referrals. Implications for these suggestions, among others, will be discussed
below.

**Limitations**

In the process of interpreting, utilizing, and applying the results obtained in the
current study, certain limitations should be acknowledged. One limitation involves the
generalizability of the results due to the small, non-random sample size, and possible
selection bias in recruitment. The sample was recruited from a network of clinicians who:
(a) identified themselves as practicing from a psychodynamic orientation, (b) were
connected to an academic institution in the Northeast United States, and (c) were
affiliated with national and state (New Jersey and New York) professional organizations.

Given the small sample size of 13 participants, it can be difficult to generalize the
results to most, if not all, therapists who experience an illness, injury, or disability.
Moreover, as illnesses, injuries and disabilities manifest in ways that are often unique to
individuals, it is unlikely that generalized statements would apply to a large population of
professionals.

The effect of selection bias must also be considered to be a possible limitation.
Participants took the initiative to respond to the advertisement and volunteer, indicating
their comfort in discussing their illness experience. This attitude may have impacted some of their responses, especially regarding issues of disclosure, i.e., participants who were comfortable talking about their illness in a study may have been more comfortable disclosing to patients. Other related factors affecting the generalizability of the results of this study were that participants were selected from a relatively small geographic area. All of the participants were recruited from the Northeast region of the United States, with 12 participants from mid-Atlantic states, and one from the adjacent region of New England. The lack of geographical diversity may have influenced findings on dealing and coping with illness, and their expectations of others in a comparable situation. Another limitation affecting generalizability was that most participants identified as Caucasian. Therapists’ cultural and ethnic background may influence how comfortable they are in discussing their illness with patients based on varying perspectives on illness, death, and dying among different cultures.

Another variable affecting the generalizability of the study’s findings arises from the theoretical orientation of the participants in the current study. As questions concerning transference and countertransference were central to the study—concepts that would be well understood by clinicians with a psychodynamic or psychoanalytic orientation—participants were required to adhere to either of these perspectives in patient treatment. The potential for illness is unrelated to theoretical orientation; however, the current study does not explore how mental health professionals with other perspectives might be affected by their illness experience. Such individuals may hold differing views on issues investigated in the current study, such as: (a) disclosure (for example, therapists adhering to existential perspectives with a focus on death anxiety (Yalom, 1980) might
often be inclined to disclose their illness to patients); (b) how they were affected by their illness; and (c) how to respond to patients’ various reactions.

The qualitative nature of the current study also served as a limitation. The lack of a random sample or a control group affects the generalizability of the results. Other limitations of the study included: (a) the use of multiple interview methods, e.g., phone, written, and in-person, which may have influenced the types of information participants felt comfortable in providing; and (b) a reliance on therapists’ self-reports, which can be highly subjective and biased, concerning how their condition affected them as individuals and the responses of patients.

The hypotheses developed in this study were exploratory. Data analyzed and the theories resulting therefrom may not necessarily be used to support or challenge research conducted by others in this area. Furthermore, as no identifying information was provided on the participants’ patients, the results may not be generalizable to all patients, especially concerning patient responses to the therapists’ illness. Another limitation of this study involves possible investigator bias due to his significant degree of involvement in the conceptualization, design, implementation, and analysis of the results. All of the interviews and analysis of the data was conducted by the investigator whose interest in the topic should also be acknowledged when interpreting the findings of this study. Taking the above limitations into account, the current study identified important themes related to a therapist’s illness experience which can be explored further in subsequent qualitative and quantitative research studies.

**Implications**

**Implications for future research.** Most of the literature on the topic of therapist illness derives from therapists reporting personal experiences of illness, injury, or
disability, and how those experiences might have affected their patient work. The current study was an attempt to uncover general themes regarding issues previously identified in the literature among a sample of mental health professionals. One possible avenue of future research is to replicate this study with a larger number of participants to confirm and validate its findings. Additionally, replication of this study with a more diverse research team, rather than an individual investigator, would address the issue of possible investigator bias and thus may act to improve the generalizability of the findings.

A second avenue of future research is to quantitatively examine the themes identified by this study. A systematic analysis of the literature would be extremely helpful. Given the nature of much of the literature on this topic—subjective descriptions, case reports and other qualitative forms of inquiry—such an analysis would bring together each therapist’s experience of illness, injury, or disability, and find commonalities in their attitudes, opinions, and theories on how to deal with an illness, especially when interacting with patients. A manual or guidebook derived from the literature and research findings instructing clinicians on management of a crisis, such as an illness, would be a significant contribution.

There has been relatively little discussion in the literature about the ethical dilemmas therapists face in crisis situations, or whether ethical considerations are taken into account when ill therapists need to make decisions about taking a leave of absence from their practice for a period of time or completely retire. Given that therapists are responsible for the well-being of others, and the proclivity for therapists to act in their own self-interests when facing the intense and anxiety-provoking experiences of enduring an illness, it is important to investigate how therapists navigate through such ethical dilemmas during times of crisis.
Some topics that were raised, but not addressed, by the current study need further exploration. For example, many participants mentioned how important it is for a therapist who is ill to have adequate supervision; however, this concept needs further clarification, including: (a) what factors constitute adequate supervision?, (b) how should supervisors and colleagues respond to the ill therapist in terms of guidance and/or advice?, and (c) are there standards in place so that supervisors are in a position to assess therapist competence? (See Alexander, Kolodziejski, Sanville, and Shaw (1989) and Phillips and Stevens (1992) for extensive discussions on consultation and supervision with ill or dying therapists.)

There has been some suggestion that professionals tend to circle the wagons and protect their own. Given the sensitivity of the issue, some mental health professionals may find it difficult to encourage compromised colleagues to stop working with patients. Thus, another suggested topic for future research is how professional organizations, ethics committees, and governing bodies should handle the issue of therapists who are deemed incompetent to continue with practice. There is some discussion in the literature (Laliotis & Grayson, 1985) concerning the efforts of various state licensing boards and professional organizations, such as the APA, to address the issue of helping support impaired psychologists.

**Implications for theory.** Although the literature has offered some discussion on how an illness can impact the therapist’s subjectivity and countertransference responses towards patients, there remains a need for further clarification and revision of theory regarding these topics. For example, it is not clear if the changes a therapist experiences to his or her subjectivity as a result of an illness endure over time, or whether an illness affects a therapist’s self-state temporarily. This issue warrants further exploration.
Another implication for theory involves the therapist’s use of disclosure and the therapist’s use of vulnerability in the therapeutic relationship with patients. There needs to be an investigation of the factors that are necessary for the therapist to be able to work effectively while managing an illness, and a revision of theory that can provide guidelines for how a therapist can handle being in a vulnerable self-state with patients in this situation. This issue also arises in the context of current relational psychoanalytic theory. According to Frommer (2013): “Relational theory and practice need to develop a more fully articulated and elaborated existential framework that can hold the analyst and patient securely when the analyst inhabits the position of a suffering subject with the patient” (p. 59).

In the current study, some participants expressed the view that their illness experience prompted them to become more authentic with their patients which helped to deepen the treatment. Some participants reported that sharing their illness experience was especially helpful for patients who were dealing with an illness themselves. Thus, the potential implication for theory is that mutual authenticity arising out of the mutual sharing of vulnerability provides a holding space for both therapist and patient. This was characterized by one participant as therapist and patient inhabiting an “even playing field,” relying on one another to navigate through their mutual suffering. The experiences of participants in this study suggests that the presence of therapist vulnerability and its manifestation through self-disclosure does not impinge on the therapeutic process, rather it helps to create mutuality within the therapeutic relationship to the patient’s ultimate benefit.

Implications for mental health professionals. The results of the current study present many implications for mental health professionals who have experienced or will
Experience an illness, injury, or disability. As self-disclosure of the therapist’s illness may create more authenticity and intimacy within the therapeutic relationship, it may be beneficial to the patient and the therapeutic relationship. Nonetheless, there remains a lack of consensus in the field regarding this topic. Findings of the current study suggest three factors that might help guide therapists in making disclosure decisions: (a) an assessment of whether disclosure will be helpful or not helpful for an individual patient; (b) consideration of patients’ level of functioning, e.g., disclosing to higher-functioning patients may be indicated while disclosing to lower-functioning patients may not; and (c) a determination of whether disclosure is indicated when certain circumstances exist, e.g., when a patient observes symptoms and questions the therapist about them. Ultimately, the decision whether to disclose is a personal one each therapist must make.

It is important for therapists to consider how much a patient knows about them and how the patient’s knowledge may affect the therapy and therapeutic relationship. Patients’ reactions towards the therapist’s illness may not always result from direct communication. Thus, mental health professionals should be alert to patients’ demonstrating unconscious awareness of their therapist’s illness. A therapist’s illness may engender expressions of concern by patients which may lead to beneficial effects for the patient and may provide useful opportunities in the treatment, indicating that therapists can try to invite the patient’s concern rather than brush it aside. Another important consideration for clinicians is that they need to be prepared to address the patient’s transference reactions in therapy toward the therapist’s illness. As with other transference reactions, therapists are advised to help patients put their reactions into words and bring awareness to patients’ unconscious feelings, wishes, desires, defenses, or instincts.
Mental health professionals should be aware that an experience of an illness, injury, or disability can be jarring, and can cause intense negative emotional reactions, such as terror, fear, anger, and sadness, among others. In addition, certain reactions that may appear helpful to them, particularly initially, e.g., denial, have the potential to be harmful and even traumatizing for patients. It is not in patients’ interests to be treated by therapists whose illness has rendered them incompetent, or to first learn of a therapist’s illness upon the therapist’s death. Negative impacts of their illness experience may also be directly related to the therapist’s work with patients, e.g., feeling that working with patients has become burdensome, becoming less tolerant and more reactive towards patients, thus providing another potential avenue of harm for patients.

A therapist may have to consider retirement despite a desire to continue working in the case of continued impairment. Even when retirement is not indicated, significant financial repercussions may occur as a result of illness, e.g., loss of income during the period of incapacitation, reduced income when resuming their practice due to patients not returning and fewer referrals.

Another cause for concern relates to a lack of adequate preparation for a potential crisis such as an illness. Whether this is due to a failure to address the issue in training, or a lack of awareness of ethical guidelines, a mishandled illness experience can result in harm to both the patient’s emotional wellbeing and the therapist’s reputation. Participants in the current study recommended that therapists take certain actions to counter the potential negative effects, as discussed above, such as having supports in place to help them cope with the experience of being ill, e.g., supervision, personal therapy, and a social network, and to make provisions for their patients in the event of their incapacitation, e.g., executing a professional will.
Despite the above negative considerations, hope exists for mental health professionals experiencing a serious medical condition. As the participants in the current study demonstrated, along with many others identified in the literature, an illness, injury, or disability does not signal the end of one’s professional competency or career. Therapists often have been able to work and work effectively while experiencing an illness, even if some adjustments have to be made.

Some participants were able to identify positive effects of their illness experience in both the personal and professional realms. While it allowed some to approach life with a sense of hope, gratitude, and optimism, participants also reported an enhanced capacity to work with patients, e.g., feeling more empathic, authentic, and capable of dealing with the patient’s suffering. In addition, some reported becoming more able to engage in difficult conversations with patients who had not been able to have these discussions with others in their lives. An illness experience may inspire a therapist’s reordering of priorities through the realization of human fragility and vulnerability, and thus view relationships with others and/or living in the moment as truly important—not only in their own lives but as goals for patients as well.

Implications for training programs and professional organizations. Many participants in the current study reported that their training programs, e.g., graduate schools, psychoanalytic institutes, had left them unprepared to deal with their illness. The issue of whether training programs in the field are preparing mental health professionals adequately to deal with personal crises has not been addressed in the literature. Some participants suggested that a training program’s curriculum incorporate a course on this issue, while others recommended that discussions be held with professionals in the field who have experienced an illness in a seminar, class, or workshop.
Current guidelines offered by professional organizations governing the practice of psychotherapy were perceived by many participants to be inadequate at best in advising therapists how to handle an illness situation, especially with regard to patient treatment. A couple of participants expressed the view that such organizations should issue clear ethical guidelines. Another consideration for professional organizations is the suggestion that they establish a national referral center that would not only help therapists who may need to refer patients to other practitioners, but may also expand patients’ access to mental health care through easing the process of obtaining referrals.

**Conclusion**

This study explored how an experience of illness, injury, or disability impacted mental health professionals’ work with patients and as individuals. The findings confirmed prior studies, contradicted others, and also broke new ground with unique results. Most participants viewed disclosure as helpful for treatment and thus supported it. While some scholars in the field perceive disclosure as helpful and advocate for therapists to be authentic about their experiences with patients (Brody, 2013; Brothers, 2012; Davoine, 1990; Engels, 2001; Frommer, 2009, 2013, 2016; Grunbaum, 1993; Henry, 2009; Monaco & Palombo, 2012; Morrison, 1990; 1997; A. Pizer, 2016; B. Pizer, 1997; S. Pizer, 2009a; Rosner, 1986; Schwaber, 1998; Searles, 1975; Silver, 1982, 2001; Singer, 1971; Strean, 2002; Woods, 2013), others consider disclosure to be unwarranted and not helpful for patients (Abend, 1982; Cooper, 2017; Clark, 1995; Dewald, 1982; Friedman, 1991; Gervais, 1994; Lasky, 1990; Lindner, 1984; Madonna, 2014; Meissner, 1996, 2002; Schwaber, 1998; Schwartz, 1987; Van Dam, 1987; Wong, 1990).

One area in which there is considerable agreement relates to patients’ potential reactions to a therapist’s illness. The current study is consistent with the literature in

One of the most powerful findings of this study, confirming multiple accounts in the literature (Brody, 2013; Brothers, 2012; Cole, 2001; Fischer, 2001; Grefenson, 2012; Pizer, 2009a; Shernoff, 1991, 1996), is that an illness experience can enhance therapeutic competency through increasing the therapist’s empathy for patients, and eliciting greater authenticity and vulnerability toward patients. The treatment can be deepened if the therapist has become more comfortable with having conversations about painful themes, e.g., physical suffering and dying. A patients’ unconscious awareness of the therapist’s illness in the absence of disclosure was reported by several participants and would be an interesting subject for clinicians and researchers to explore. Patients’ expressions of concern present a unique therapeutic opportunity and should be accorded attention in the future.

The current study also highlighted some significant concerns, such as a therapist’s denial of the illness. Had the participants not been able to transcend what many characterized as their initial reaction of denial, they would not have responded to the invitation to participate in the study, let alone been willing and able to recount in detail how their illness affected them. Mental health professionals who have not been able to
come to terms with their illness would not be likely to disclose the situation to patients, and thus not be in a position to help prepare patients, when necessary, for what might become a poor outcome.

The negative effects on the therapist’s subjectivity can lead to issues of therapist competency. Given the need to hold patients’ problems and concerns, while trying not to be distracted by their illness, can place a significant burden on work with patients, a situation discussed by participants in the current study as well as the literature (Durban, Lazar, & Ofer, 1993; Linna, 2002; Rytöhonka, 2015; Torrigiani & Marzi, 2005; Ulman, 2001). An additional concern expressed by participants, and consistent with the literature (Grefenson, 2012), is that ill therapists may experience changed attitudes towards patients, e.g., becoming less tolerant, more aloof, or acting out in some way in response to the illness. Manifestations of these attitudes may leave patients feeling invalidated, misunderstood, and/or hurt.

Another issue is the challenge posed by an ill therapist’s financial needs. When serious medical issues compromise therapists’ mental faculties and ego functions, they may continue to work despite a lack of competence because they need to earn a living. Is there a way to prepare therapists to meet their financial obligations when they are no longer able to work? In addition, some therapists derive so much meaning from work that the prospect of retirement is unthinkable. Is there anything the profession can do to support them to accept retirement when it is in their patients’ interest?

An illness experience for a therapist does not have to be unrelievedly negative. A factor that delays, if not prevents, the onset of a more positive outlook is how unprepared therapists may be for a crisis, such as illness. Given the wide array of intense negative emotions participants reported in response to their illness, in accordance with the
literature (Brothers, 2012; Counselman & Alonso, 1993; Elliott, 1996; Engels, 2001; Fajardo, 2001; Frommer, 2009, 2013; Kahn, 2003; Linna, 2002; Monaco & Palombo, 2012; Morrison, 2008; Schwaber, 1998), it is particularly problematic that participants felt so unprepared. Participants advised that clearer guidelines be issued by professional organizations and that training be revised to incorporate education on this topic. Creating a professional will can help therapists feel more prepared as well.

Overall, much ambiguity exists regarding how to deal with the issue of the therapist becoming ill, injured, or disabled. Many therapists have offered divergent views on issues such as (a) how to deal with disclosure, (b) the patient’s transference responses and concern towards the therapist and (c) how the therapist’s subjectivity can be impacted by an illness experience. While all of these experiences and opinions have value, what is most important is that the situation is addressed in an ethical manner with no harm to the patient to the extent possible.

How can we, as a field, support mental health professionals, and their patients, through this difficult process? Avoiding the worst case scenario—therapists working until the day that they die without having disclosed their situation to their patients—may be facilitated through education, preparation, and support. Discussing the issue, fostering awareness, and coming to terms with the reality that mental health professionals, as all humans, may become sick and will eventually die, is an important first step. It is this author’s hope that therapists may be helped to inform their patients about their illness and thus allow patients to process the potential loss of their therapist, and help therapists to process and come to terms with their own mortality, and share their experiences with others. If this can occur, a therapist’s illness can be dealt with in a humane, ethical, and dignified manner that will benefit therapists and patients alike.
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Appendix A

Advertisement for Listservs

My name is Joshua Romero and I am a doctoral student at the Graduate School for Applied and Professional Psychology at Rutgers University. I am looking to interview psychoanalysts or therapists (trainees, doctoral students, social workers, and other mental health professionals included) who practice from a psychoanalytic or psychodynamic perspective, who have gone through or are currently going through a medical condition, which can include a sudden or gradual; acute or chronic illness; injury, or a temporary or permanent disability for my dissertation study.

The study will look at how a therapist’s experience with a serious medical condition can affect the self-of-the therapist, patients’ emotional reactions towards the therapist, and the therapist’s therapeutic relationships with patients. The study will also address important questions regarding ethics and an analyst’s preparedness to cope with personal crises such as a serious medical condition. This research is trying to foster awareness of the seriousness, inevitability, and ubiquity of this issue while also attempting to uncover what therapists’ can expect to happen when working with patients while dealing with a serious medical condition. It is important to research this topic further because a serious medical condition is an anxiety-provoking and trying experience, especially for analysts who have to take care of patients, in addition to taking care of one’s self. More research and awareness of this issue is needed so that, mental health professionals can be better prepared to deal with personal crises such as a serious medical condition when these situations arise.

Due to the unique nature of the study, I am asking three questions to determine if you [the reader] would potentially qualify to participate in this study. If you can answer yes to the following three questions, then you would be a good fit to participate in this study.

1. Have you experienced a medical condition for any period of time AND did the medical condition occur or begin occurring while working with patients?
   - Yes
   - No

2. Did the medical condition cause you to be absent from work for any length of time OR do you feel that the medical condition impacted your ability to work with patients?
   - Yes
   - No

3. Do you adhere to a psychoanalytic or psychodynamic theoretical orientation with regard to working with patients?
   - Yes
   - No
If you have answered yes to the above three questions and you are interested in participating, then you have a choice to participate through the following options:

1. In-person interview
2. Phone interview

Interviews are expected to take up to 90-120 minutes. If the interview is not completed within the allotted time of 120 minutes, you may have the opportunity to complete a written interview consisting of the remaining questions. Participating in a written interview is completely optional and will not result in any penalty to you. If you decide to agree to participate in a written interview, the remaining questions will be sent to you via a Microsoft word document to the email address you provide. You may complete the written interview at your leisure as there is no time limit.

If you have answered yes to the three prescreening questions and you are interested in participating in this study, then please contact me, Joshua Romero at: joshuaromero2@gmail.com and inform me of whether you have answered yes to the three prescreening questions, your intent to participate in this study and the interview option that is best for you. Furthermore, if you have any questions about this study, please do not hesitate to ask. Thank you for your attention and interest and please have a most pleasant day.

Sincerely,

Joshua Romero, M.A., Psy.M.
Fourth year doctoral student, Clinical Psychology
The Graduate School of Applied and Professional Psychology
Rutgers, The State University of New Jersey
(646) 623-7834
Joshuaromero2@gmail.com
Appendix B

Informed Consent Agreement

Interview Consent Form

with Audio Recording

I am an advanced doctoral student in the Clinical Psychology (Psy.D.) department at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University, and I am conducting interviews for the completion of a dissertation study. I am studying how a therapist’s experience with a serious medical condition (e.g., illness, injury or disability) can affect the self-of-the-therapist and various aspects of the therapeutic relationship. The purpose of the interview is to gather therapists’ opinions on whether therapists with a serious medical condition should disclose their illness to patients, how patients’ transference reactions are affected by a therapist’s medical condition, and how a therapist’s countertransference and sense of self are affected by his or her medical condition. Interviews are also designed to obtain information on the ethical dilemmas and professional difficulties therapists face when trying to work with patients while dealing with a serious medical condition. The literature written on these topics have offered some insights and discussion of how a serious medical condition may affect therapists, patients and the treatment process; however, there is a lack of systematic research, concrete hypotheses, and a unifying theory on how therapists can and should manage their work with patients while convalescing from a serious medical condition. The successful navigation of an illness experience by the therapist can mean the difference between a therapist’s medical condition serving to enhance the patient’s therapeutic progress or a therapist’s medical condition serving to re-traumatize the patient. Therefore, it is necessary to begin investigating the issue more systematically, so that future research can provide revisions in theory and practical guidelines that will help therapists manage their respective medical condition in ways that will be beneficial to patients but also to the therapist him or herself.

During this study, you will be asked to answer some questions requesting your opinion on whether therapists should disclose their illness to patients, how your experience with a serious medical condition may have influenced your patients’ transference reactions and how the experience may have impacted yourself and your countertransference responses with patients. This interview was designed to range from approximately one and a half hour to two hours. However, please feel free to expand on the topic or talk about related ideas. Also, if there are any questions you would rather not answer or that you do not feel comfortable answering, please say so and we will stop the interview or move on to the next question, whichever you prefer.

This research is confidential. Confidential means that the research records will include some information about you and this information will be stored in such a manner that some linkage between your identity and the response in the research exists. Some of the information collected about you includes age, ethnicity, education history, and personal
experiences with illness and its impact on you as a mental health professional. Also, you will be asked to talk about patients as part of this interview. You will not be asked to disclose any confidential information about patients. Any information that you provide which may be used to identify a patient will be removed from the transcript. Names of people and places will be replaced with pseudonyms. Please note that we will keep this information confidential by limiting individual’s access to the research data and keeping it in a secure location. Hard copies of interview data will be stored in a locked filing cabinet while audio recording files and transcriptions will be stored in a password-protected folder within my personal password-protected and firewall-protected laptop. No one other than myself will have access to this information. In addition, you will be given an identification code, in which only myself will have access to the code key. The data gathered in this study are confidential with respect to your personal identity unless you specify otherwise.

The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law. If a report of this study is published, or the results are presented at a professional conference, only group results will be stated. All study data will be kept for at least three years after the date of completion of the research. After the three years have expired, all documents with identifying information will be shredded, audio and video tapes will be erased, and any computer files will be erased by me.

You are aware that your participation in this interview is voluntary. You understand the intent and purpose of this research. If, for any reason, at any time, you wish to stop the interview, you may do so without having to give an explanation.

The risks of participation include feelings of emotional discomfort arising from talking about your personal experiences with a serious medical condition. However, it is expected that this discomfort will be similar to the level experienced when discussing such experiences with supervisors, personal therapists, colleagues, family members, and patients. If at any time you feel overwhelmed or highly uncomfortable during the interview process it is advised that you discontinue your participation.

You may receive no direct benefits from participation in this study. However, the present research will contribute to the literature on therapists’ experiences with a serious medical condition. Participants will play a major role in helping other researchers, graduate programs in mental health, social workers, psychologists, and others understand the experiences that therapists go through while working with a serious medical condition.

The audio recording(s) of the interview will be used for analysis by the research team. The recording(s) will include any demographic information and responses that you provide verbally during the interview. No other identifiers will be recorded. If you say anything that you believe at a later point may be hurtful and/or damage your reputation, then you can ask the interviewer to rewind the recording and record over such information OR you can ask that certain text be removed from the dataset/transcripts. The recording(s) will be stored electronically and password protected in a folder within my personal password-protected and firewall-protected laptop device. The audio recording
files will be named with a code to your identity. The recordings will be kept for three years after the date of completion of this research study. After the expiration date, all files will be erased by me from my personal laptop device.

If you have any questions about the study or study procedures, you may contact myself at:
Joshua Romero
70 Ross Street, Apt. 6F
Brooklyn, NY 11249
United States of America
Email: joshuromero2@gmail.com
Phone: (646) 623-7834

You may also contact my faculty advisor:
Dr. Nancy Boyd-Franklin
Graduate School of Applied and Professional Psychology, Rutgers University
152 Frelinghuysen Road
Piscataway, NJ 08854
Email: boydfrank@aol.com
Phone: (848) 445-3924

If you have any questions about your rights as a research participant, you can contact the Institutional Review Board at Rutgers (which is a committee that reviews research studies in order to protect research participants).

Institutional Review Board
Rutgers University, the State University of New Jersey
Liberty Plaza / Suite 3200
335 George Street, 3rd Floor
New Brunswick, NJ 08901
Phone: 732-235-9806
Email: humansubjects@orsp.rutgers.edu

You will be offered a copy of this consent form that you may keep for your own reference.

Once you have read the above form and, with the understanding that you can withdraw at any time and for whatever reason, you need to let me know your decision to participate in today’s interview.

Your signature on this form grants the investigator named above permission to you as described above during participation in the above-referenced study. The investigator will not use the recording(s) for any other reason than that/those stated in the consent form without your written permission.

Subject (Print)__________________________
Appendix C

Background Information Questionnaire

What is your age?
____________

What is your gender? (Please circle one)
- Male
- Female
- Other ________________________

What is your ethnic background? (Please circle all that apply)
- Caucasian / White
- African-American / Black
- Latino / Hispanic
- Middle Eastern
- Asian / Pacific Islander
- Native American
- Multi-racial
- Other ________________________

What is your job title?
Examples:
- Clinical psychologist
- Psychiatrist
- Psychoanalyst
- Social Worker

How many years have you been in practice (including training)?
____________

Where did you receive your analytic training / training as a mental health professional? [List as many sites that apply]
Examples can include:
- Graduate school: Ph.D. program at Adelphi University
- Psychoanalytic institute: William Alanson White Institute
- Post-doctoral program: NYU Postdoctoral program in psychotherapy and psychoanalysis
In what years did you complete your training?
Examples:
- 1990-1995
- 1940s
- Graduated in 2008

What is [are] the theoretical orientation(s) that you adhere to in your clinical practice?
[List as many that apply]
Examples can include:
- Classical psychoanalysis
- Object-relations theory
- Self-psychology
- Relational psychoanalysis
- Integrative – CBT & Psychoanalytic or Existential & Psychoanalytic, etc.
Appendix D

Semi-Structured Interview

Opening Prompt for Interview
This interview is attempting to address questions related to therapists’ experiences with an illness, physical injury, or disability. I am interested in how such experiences with illness can impact the person of the therapist and his or her ability to function as a therapist, but also to examine the effects an illness experience can have on patients and the therapeutic process. Talking about one’s experiences with illness can be a sensitive topic; therefore, it is warranted that I have your permission to continue with this interview. Shall we continue?

Please remember that you can take a break at any point during the interview. You may also stop at any point throughout the interview without explanation and you can request to have any data collected to be withdrawn from the study.

Please look over this consent form that I am handing to you now. It contains a description of this study and an overview of how the data will be analyzed and who will have access to the data. Before the completion of this interview, I will request that you sign the consent form. Are there any questions before we begin?

Describe the Experience

1. Can you describe in a way that is comfortable for you, what occurred when you became ill, injured, or disabled?

2. Describe the range of feelings you experienced during the experience?

3. How long did this experience last?
   - And is it still currently ongoing?

4. Did you have to take time off from working with patients?
   - How long did you take off?
   - If you took time off, how were patients informed about the absence?

Self-Disclosure

5. Did you decide to tell patients about your illness?

6. Were there some patients that you told about the illness and other patients that you did not tell about the illness?
   - What influenced your decision to tell some patients and not others?
7. If you chose not to disclose your illness to any of your patients, do you think that your patients became consciously aware or intuitively (i.e., unconsciously) aware of your illness even without telling them?

8. Do you have any thoughts about how a therapist’s disclosure of his or her illness might affect the well-being of different patients who have different character dynamics, different levels of functioning and/or different symptoms?
   o Can you provide an example(s)?

9. Do you feel that disclosing the illness impacted the treatment process?
   o How so?

Patient’s Concern for the Therapist

10. Did you get the sense that patients (regardless of whether or not they knew about your illness) wanted to help you or show concern (e.g., by giving medical advice or sending a get-well card) while you were ill?

11. Did you feel that allowing the patient to show or demonstrate concern for you would be helpful towards the patient’s progress in therapy or would be helpful in your work together?

Transference

12. Do you feel that the illness, injury, or disability affected your patients’ transference reactions towards you?
   o Can you provide examples

13. How did you help the patient(s) to work through that particular transference reaction?
   o Can you provide examples

Countertransference

14. How do you think your illness, injury, or disability affected your own countertransference towards patients?
   o If so, how?
   o Were these feelings different from before you found out about the illness?

15. What were some challenges you encountered when working with patients during the course of dealing with and convalescing from the illness, injury, or disability?
   o What are some of the things that therapists might struggle with?

Therapist’s Subjectivity

16. Do you think that the illness, injury, or disability affected your capacity to work with patients?
   o How so?
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o Have there been any effects on your ability to be “present” for patients?

17. Do you think that the illness experience altered your self-states while providing
therapy, or your identity as a therapist, or your “analytic self,” or your self-as-a-
therapist, in any way?
   o Do you feel that any of the changes that you experienced in yourself as a
therapist, has endured over time (even after recovery)?

18. How did you cope with the illness; especially when you were working with patients?
   o Do you think that the illness experience caused you to utilize defense
mechanisms to help you cope while working with patients?

19. Do you think that your experience changed how you conceptualize your work with
patients; pre to post-illness?

20. How did your experience affect your livelihood?

Ethics & Preparedness

21. Is it difficult to make ethically sound decisions regarding work with patients while
dealing with an illness, injury, or disability?

22. What do you feel are the major ethical problems that can arise when a therapist has to
deal with a serious illness while working with patients?

23. Do you feel that the current ethical guidelines are clear in how to make ethical
decisions about working with patients while dealing with an illness?

24. Do you have a professional will indicating what should happen with patients in the
event you were to have a crisis or illness?

25. In retrospect, do you think that the training you received provided sufficient
preparation to deal with the illness and/or other crises that have occurred in your life?

26. What would have been useful to help you deal with the illness, disability, or injury
more effectively?

27. What advice would you give to future clinicians about dealing with personal crises
such as an illness?

28. What advice would you give training programs about dealing with personal crises
such as an illness?

Conclusion

29. Is there anything that has not been discussed that you would like to share with me?
Closing Prompt for Interview
Thank you for participating in my study and sharing your story and experiences with me!