



Smith ScholarWorks

Theses, Dissertations, and Projects

2009

"There is something you should know" : the reasons therapists disclose their chronic physical illness to clients and the therapeutic implications of self disclosure

Caitlin Mara Cotter

Follow this and additional works at: <https://scholarworks.smith.edu/theses>



Part of the [Social and Behavioral Sciences Commons](#)

Recommended Citation

Cotter, Caitlin Mara, ""There is something you should know" : the reasons therapists disclose their chronic physical illness to clients and the therapeutic implications of self disclosure" (2009). Masters Thesis, Smith College, Northampton, MA.

<https://scholarworks.smith.edu/theses/1184>

This Masters Thesis has been accepted for inclusion in Theses, Dissertations, and Projects by an authorized administrator of Smith ScholarWorks. For more information, please contact scholarworks@smith.edu.

Caitlin Mara Cotter
“There is something you
should know”: The reasons
therapists disclose their
chronic, physical illness to
clients and the therapeutic
implications of self
disclosure

ABSTRACT

This study sought to ascertain reasons why therapists with a chronic physical illness chose to self disclose information about their illness to their clients, and their perception of the effects those disclosures had on the therapeutic relationship. This qualitative, exploratory study aimed to expand the body of knowledge on self disclosures of this nature, which is limited and written largely from a psychoanalytical perspective.

Licensed psychotherapists diagnosed with a chronic physical illness in adulthood, who had self disclosed their illness to at least one client, were recruited from the Boston metropolitan area to participate in a single, in-person interview. Ten therapists participated in the study.

The major findings of this study were that the therapists were more likely to self disclose to clients who also had a physical illness. They utilized their disclosures to clients with an illness to model certain behaviors, join/identify with their client's experience and decrease the client's anxiety. The most frequent reasons why participants disclosed to clients without a physical illness were: the illness was visible; they had to take time away from their practice; and to maintain authenticity in the relationship. Common effects on the relationship include increased anxiety/worry and caretaking behaviors in the client; relationship building or termination by the client.

"THERE IS SOMETHING YOU SHOULD KNOW": THE REASONS THERAPISTS
DISCLOSE THEIR CHRONIC, PHYSICAL ILLNESS TO CLIENTS AND THE
THERAPEUTIC IMPLICATIONS OF SELF DISCLOSURE

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Caitlin Mara Cotter

Smith College School of Social Work
Northampton, Massachusetts 01063

2009

ACKNOWLEDGEMENTS

I wish to thank the therapists who participated in this research for their generosity and willingness to support this study and utilize their own experiences to assist others in the future. I am also grateful for what they all taught me about the love that exists between therapists and clients and the power that love can have in healing them both.

To all my friends who sat across from me at endless coffee shops and kitchen tables or offered encouragement in a multitude of ways; I could not have completed this without you.

To Carla Naumburg, my thesis advisor, for guiding me through this journey; I have appreciated your clarity and compassion.

Finally, to my parents and family for believing I could accomplish this in the first place and for all of the love and continual encouragement they have provided me.

transferring eddie's hours

I'd listened for years:
Dad had drowned on an August beach,
Mom then threatened their fractured home.
Eddie's booze, cocaine, the black dog.
Sobriety, defree, job, woman, child.

Tests, lapses, moving on.
Hour beyond hour I'd held
A steady mirror to his boyish cheeks
And budding heart, those eyes
That desired tomorrow-

Till Today, and my disclosure:
"Unfortunately, my diagnosis
Is serious and uncertain.
And so we must find you another
Therapist with more hourse."

After quiet, he replied,
"Will you have more hours, later?"

Truth ruptured.
My jaw spasmed, my eyes spit.
I'm sorry, I didn't mean this
to happen, the quiver of lips,
the tissues.

I never meant this,
To have holes in my
spine, my hold,
my hours.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	ii
TABLE OF CONTENTS.....	iv
CHAPTER	
I INTRODUCTION.....	1
II LITERATURE REVIEW.....	3
III METHODOLOGY.....	24
IV FINDINGS.....	29
V DISCUSSION.....	43
REFERENCES.....	53
APPENDICES	
Appendix A: HSR Approval Letter.....	59
Appendix B: Recruitment Letter.....	60
Appendix C: Informed Consent.....	61
Appendix D: Demographics Questionnaire.....	63
Appendix E: Interview Guide.....	64

CHAPTER I

INTRODUCTION

Being diagnosed with a chronic illness is a life changing experience. There are many implications for individuals as they grapple with their diagnosis. But what happens when the individual diagnosed with a chronic illness is a psychotherapist? The "entire foundation of therapy is inevitably shaken" (Farber, 2006, p.174) and the psychotherapist may feel vulnerable and fragile. A practicing psychotherapist suddenly diagnosed with a chronic illness in adulthood may struggle to let go of the common myth that the therapist and client can often hold to, that the clinician is invincible or indestructible (Pope, 2006). Alternatively, the concept of the "wounded healer" suggests that the therapist's vulnerabilities and pain may sometimes be an advantage when working with sick patients, by increasing empathy and ability to model coping in difficult times (Durban, Lazar & Ofer, 1993). The diagnosis of a chronic physical illness inevitably affects the therapist but what place does the illness have in the therapeutic relationship? Is the illness already present, an elephant in the room that has the potential to hinder the therapeutic relationship if it is not acknowledged? Or should tarnishing the myth of the indestructible therapist be avoided in service of the client's needs?

Self disclosure is inevitable. Clinicians expose pieces of themselves in everything that they do, from the clothes they wear to the content of their interpretations. Self disclosure is also considered a fundamental aspect of relationship construction and maintenance (International Encyclopedia of the Social Sciences [IESS], 2008). There are many kinds of self disclosure and the decision to self disclose usually depends on the clinician's theoretical orientation and the content of the self disclosure (Edwards &

Murdock, 1994). The amount the therapist decides to disclose verbally remains a perpetual dilemma because disclosures of content of the life of the clinician are considered the most controversial regardless of his or her theoretical orientation (Wachtel, 1993). However, events will occur in the life of a therapist that may impact therapy whether the clinician chooses to verbally disclose these to their client or not.

A number of papers have been written about psychotherapists' self disclosure of an illness (Dewald, 1982; Abend 1982; Durban et al 1993; Pizer 1997; Simon 1990; Morrison, 1997; Cristy 2001). However, there are no empirical studies designed to clarify why psychotherapists might disclose information about their diagnosis and the implications of these disclosures on the therapeutic relationship (Hott, 2001). With life expectancy rates for both men and women rising steadily since the 1900's (Lederburg, J, 2000) and deaths due to cancer continuing to drop since 1993 (McCarthy M, 2007), it seems that more people are surviving with their illness, if not recovering wholly. Since clinicians are just as likely to become ill as the rest of the population (Bram, 1995), it is important to understand the therapeutic implications of this phenomenon.

This study will explore how psychotherapists diagnosed with a chronic physical illness choose to self-disclose their illness to their clients and the therapeutic implications of this choice.

CHAPTER II

REVIEW OF THE LITERATURE

Self Identity and Illness

Emotional effect and sense of self

"There is a fear that goes through you when you are told you have cancer. It's so hard in the beginning, to think about anything but your diagnosis" (American Cancer Society, 2008). All chronic diseases and terminal illnesses generate emotional responses (Marshallfield Clinic, n.d.). Individuals often report feeling anxious, angry, hopeless or sad, particularly if they see their illness as a roadblock to their happiness (American Cancer Society, 2008). The rate of depression is two to three times higher in adults diagnosed with cancer as compared to the average rate of depression in physically healthy adults (Marshallfield Clinic, n.d.). However, each individual's reaction manifests itself in different ways depending on several factors including the individual's attitude, family structure, support system, spirituality and cultural beliefs (Charmaz, 1984).

The type of illness and its specific set of symptoms can also effect one's response (Charmaz, 1993). A chronic illness is defined by the U.S. National Center for Health Statistics as an illness that last longer than three months (Mednet.com, 2009). The ambiguity of this criteria can create confusion for individuals (Charmaz, 1993) For example, a case of cancer can vary from acute to chronic to terminal depending on the course of the illness, which isn't always known at the time of diagnosis. Any illness can be experienced in three ways; as interruption, an intrusion and an immersion. Chronic illness as an interruption consists of periods of acute symptoms that come and go. An

intrusive chronic illness feels ever present and can be a consistent interruption of daily life while immersion into chronic illness is when life becomes founded upon one's illness; one's illness stays in the forefront of their life. Each illness trajectory may hold one or more of these experiences and each experience comes with a different set of emotional states (Charmaz, 1993).

In a study by Schiaffino, Shawaryn, & Blum (1998), patients who saw their illness as incurable or felt responsible for their illness consequently experienced higher symptom variability and significant increases in depression over time. Depression rates are also higher when the individual is suffering many symptoms that are debilitating (Marshallfield Clinic, n.d.). The stage of the illness that the individual is in also affects their emotional state. For example, women newly diagnosed with breast cancer experience more difficulties in select areas of well-being compared to women in a later, more stable stage in their illness (Frost et al., 2000).

Being diagnosed with a physical illness also undermines one's sense of identity, requiring a reorganization of the self on a physical, emotion, and cognitive level (Durban, Lazar & Ofer, 1993). One may feel vulnerable and out of control as he or she questions his or her ability to work and be functional (Ulman, 2001) struggling with the question: "who am I now that I am sick?" (Holzman, 2006). Many diagnosed with a chronic illness experience social isolation, restriction in life activities, and increased dependability on others. In addition, western society's ideologies are predicated on independence, hard work and individual responsibility. This conflict between one's abilities and society's expectations can cause low self esteem and lead to a greater loss of self in the individual diagnosed with a chronic physical illness (Carmaz, 1984). As one sheds old ideas of him

or herself self and begins to develop ways to cope with new, unwanted changes in life, grief can be a common response. Loss associated with illness also comes in many forms. A person with a seizure disorder may lose the ability to drive, while someone with severe fibromyalgia may lose the ability to live without physical pain (Marshallfield Clinic, n.d).

Chronic illness may diminish an individual's physical capacities or change an individual's identity by introducing a new element that may conflict with their present identity. Faced with many changes, an individual is forced to make a choice whether to fight the illness or to "coexist" with their illness by accepting it into their state of being (Holtzman, 2006). Scambler and Hopkins (1986) suggest that the amount an individual's diagnosis impacts him or her is linked to the person's relationship to their illness. An individual's ability to integrate their illness into their identity has the largest impact on one's wellbeing. Much greater, in fact, than negative messages about their illness they may receive from society. To incorporate one's illness is defined by Charmaz (2002) as building a self concept to include having an illness but not limiting a self concept to being ill. This requires acknowledging the illness, taking it into account and living with it but not living for it. Also, failure to achieve resolution in this transition of self results in an unsatisfactory or "diminished" sense of self (Adams, Pill, & Jones, 1997).

A study on male identity and illness (Charmaz, 1993) shows that men may have an even more difficult time accepting the fact that their abilities have been altered due, in part, to society's emphasis on males being powerful, independent, and brave. This may cause them to feel like they can't grieve or express sadness about their illness, which may lead to depression. This shows interplay between society's stigma against illness and an

individual's own beliefs about illness, in the resulting impact of a diagnosis on an individual's sense of self.

Visible and invisible illnesses and social stigma of physical illness

It has been found that the experience of someone with a visible illness is inherently different than the experience of someone whose illness is considered "invisible" (Acorn & Joachim, 2001; Dudley, 1983; Goffman, 1963; Holtzman, 2006). Those lacking visible signs of an illness may have more options if they choose to keep their illness secret and their original identities intact. Individuals with a visible illness are more exposed by having their new identities forced upon them, limiting the control they have over the information that they disclose to others (Holtzman, 2006). Individuals with a visible illness also face more stigmatization by others; they may feel "discredited" (Goffman, 1963) or like "damaged goods" (Phillips 1990). However, the level of rejection can depend on the type of illness one has (Acorn & Joachim, 2001). Crandall et al (2006) found that the amount of rejection was dependent on the severity of the illness, and whether the illness was behaviorally caused or not. Rejection was much more likely in cases where the illness was both severe and behaviorally caused, such as AIDS, compared with an illness like asthma that is considered less severe and non-behaviorally contracted (Crandall et al, 2006).

It is common for individuals diagnosed with an illness to contemplate trying to "pass" as healthy and avoid self disclosure to avoid potential rejection or discrimination. Kyngas & Hentinen (1995) found that young diabetics would eat and drink things they knew they shouldn't in order to avoid appearing different from their peers, despite lacking outwardly visible signs of their illness. Other strategies for passing include eliminating

any signs of the condition, attributing any signs of the condition to a less stigmatizing condition, and compartmentalizing the world into those who know and those who don't (Acorn & Joachim, 2001). Those who are aware of the individual's illness are often told in confidence and provide support and confidentiality (Goffman, 1963).

Passing can create stress as one worries about being discovered. Should one be caught lying, he or she will likely feel embarrassed, in addition to having to face the stigmatization they have been avoiding (Thorne 1993). However, to disclose risks being rejected and stigmatized in addition to facing personal fears of losing control (Charmaz, 1993).

Individuals with visible signs of an illness do not have the option to pass in the same way that those with invisible illnesses can, although they often try "covering" their symptoms in an attempt to minimize the stigmatizing effect of their illness (Goffman 1963). Covering is an attempt to make others feel more comfortable by minimizing the effects of the illness. For example, one might joke about a symptom. A consequence of covering can be feeling caught between wanting to fit in with healthy others but also wanting to identify with those who also feel stigmatized due to their illness (Acorn & Joachim, 2001).

Effect of Illness on the Clinician

Western society tends to view "healers" idealistically. When a therapist is diagnosed with an illness she can view herself, and be perceived by others, as impaired in her healing ability (Durban, Lazar and Ofer, 1993). Feelings of loss, powerlessness, fear, disbelief, and panic at having to face the possibility of their own death can all cloud the way clinicians relate to others, the world and themselves (Ulman, 2000). After suffering

his own chronic illness, Freud theorized that a person who is tormented by organic pain gives up his interest in things that do not concern his illness (Halpert, 1982). "[A] sick man withdraws his libidinal cathexes back upon his own ego, and sends them out again when he recovers" (Freud, 1914, p. 32).

A therapist's preoccupation with his or her vulnerabilities may preclude his or her ability to act in the best interest of the client (Bram, 1995). For example, Dewald (1982), a psychoanalyst, diagnosed with an acute and life threatening illness, speaks of a period of regression and self absorption where his initial sense of responsibility and concern for his clients greatly decreased. Subsequently, he felt a restless drive to return to work sooner than recommended by his physicians, in order to reassure himself of his professional skills and intactness. The chronically ill therapists must cope with a life that no longer reflects back to them their beliefs about themselves (Holtzman, 2006).

Abend (1984), also a psychoanalyst who experienced an illness, expressed a desire to return to work because he longed to feel missed, needed and appreciated by his patients in order to boost his dwindling self esteem. Maintaining a "normal" life or returning to the life one is familiar with becomes the symbol of a valued self; in other words, "living is the best revenge" (Morrison, 1997, p. 254).

In addition to struggling with the transformation of their professional identity, clinicians also grapple with personal fears of regression, helplessness, lack of control, falling apart and death (Durban, Lazar & Ofer, 1993). This can leave the psychotherapist feeling more vulnerable and fragile (Farber, 2006). For example, Cristy (2001), a licensed clinical social worker diagnosed with Multiple Sclerosis not long after becoming licensed, reports using denial to cope with her powerful emotions around her illness. This

split causes her to vacillate between feelings of helplessness, ineffectiveness, and sadness to feelings of entitlement, strength, and power.

I always feel as if I am swimming in the ocean, fighting against an unusually strong undertow. If I am not vigilant, if I get too tired, if I allow myself to slow down, if I stop swimming, I will drown – into my rage, into my despair, into total dependency, into death. Keeping my illness out of awareness...is what holds me together and enables me to live a relatively normal life under abnormal circumstances (p. 35).

Wounded healers

The belief that the therapist's vulnerabilities and pain can be an advantage when working with patients was born out of Greek mythology and Eastern philosophies (Farber, 2006). Termed the "wounded healer," this concept suggests that it is an individual's experience in healing her own wounds that endows her with the wisdom to teach another to heal herself as well (Durban, Lazar & Ofer, 1993). Therefore, a psychotherapist wounded healer is one who is able to cope with her illness by using the skills that she in turn used to help her clients cope (Hott, 2001).

It is believed that both therapist and client benefit from acknowledgement of their ability to be both wounded and healed (Miller & Baldwin, 1999). "To be wounded also means to have the healer power activated within us" (Adler, 1956, p. 35). A true healer cannot just be an observer of the healing process but must be ready to examine her own wounds. The better the therapist is at reflecting on his or her own wounds, the better able the therapist is at passing these skills onto clients. Therefore, the therapist with a chronic

illness who is able to look internally at her wounds may be more empathetic to her clients who are also trying to examine their own vulnerabilities (Miller & Baldwin, 1999).

An example of this can be seen in Barbra Pizer's (1997) statement reflecting on her experience as a working psychotherapist diagnosed with breast cancer, "Cancer was at the center of our interaction, at the same time, issues of life and death, change, loss, and grief lie at the center of experience and growth" (p. 456). In other words, her ability to cope with the grief and loss associated with her diagnosis was valuable in helping her clients work through their own grief and loss issues.

Laura Maggio (2007), a therapist with lupus, wrote about a conversation she had with her rheumatologist, who recently experienced a serious injury himself. He reflected on his experience with her, reporting that he was grateful to have had the experience of pain that so many of his patients experience, feeling it increased his ability as a physician and his ability to empathize with his clients.

Pain and trauma are normal parts of the human condition and therapists who avoid their own feelings about being ill can deprive their patients of important opportunities to work through its meaning (Alonso and Counselman, 1993). Also, if the therapist is in denial about her illness, the client may still become aware of the therapist's "wounds", and become a care taker of the therapist's split off feelings (Miller & Baldwin, 1999). Therefore, to ignore or deny their own pain, therapists may be denying both the client and themselves the possibility of growing from their experience of illness (Elliot, 1996).

In conclusion, being diagnosed with a chronic physical illness inevitably affects an individual's view of him or herself (Durban, et al, 193) but it can also affect how

others view the individual as well. The extent to which one's illness is visible can greatly influence how the illness affects individuals and their relationships. A diagnosis of a chronic illness can also present very real complications in the therapeutic relationship as well. Perhaps the therapist's ability to cope with her own vulnerabilities enhances her clinical skills in the process. However, an ill therapist contradicts the myth that both clinician and client can cling to of the "impervious clinician" (Pope, 2006). Self disclosure plays a key role in the destruction of that myth but the impact on the therapeutic relationship when the myth is tarnished by the reality of self disclosures about the psychotherapist's illness is unknown.

Self Disclosure

Definition

Self-disclosure is defined by the International Encyclopedia of the Social Sciences as "revealing personal information about one's self" (IESS, 2008, p. 467). Self disclosure is considered vital for relationship construction and maintenance by increasing feelings of intimacy, acceptance, trust, and self-worth within the relationship. In any relationship, deciding when and what to self disclose involves negotiating between the fear and danger of exposing too much of ourselves and the helpfulness and intimacy gained from revealing parts of ourselves to others (Farber, 2006).

In a clinical relationship, self-disclosure by the therapist may improve both the quality of the therapeutic relationship and the outcome of treatment (Beret & Berman, 2001). Clients report having new insights, endorsing a new perspective or making a change in their life as a consequence of self disclosures made by their therapists. Also, clients reported that their therapist's self disclosures helped to normalize their feelings,

and restore their confidence in addition to increasing feelings of authenticity and equality in the relationship (Knox, Hess, Petersen & Hill, 1997).

The impact of self disclosures depends on both the context and the way in which information is delivered by the clinician (Audet & Everall, 2003). Self disclosures related to an ongoing conversation or a client's own disclosure has been found to be more beneficial than a disclosure made out of context (Norcross, 2002). Clients who received more of these "reciprocal" self disclosures reported liking their therapist more and having a greater decrease in distressing symptoms (Berret & Berman, 2001).

While research shows that disclosures are helpful in the immediate process of therapy, the effects of self disclosures on the outcome of treatment have mixed results (Norcross, 2002). In six studies (Beutler & Mitchell, 1981; Braswell, Kendall, Braith, Carey & Vye, 1985; Coady, 1991; Hill et al 1988; Kushner, Bordin & Ryan, 1979; William & Chambless, 1990) using a correlation method, there was no relationship found between the frequency of therapists' self disclosures and clients' or therapists' judgment of treatment outcomes. These results are unclear, in part, because of "poor and inconsistent" definitions of self disclosure (Hill & Knox, 2001, p.5). Many different definitions have been used in these empirical studies, making it difficult to compare results across studies (Norcross, 2002).

A lack of consistency in defining self disclosure can also be found in theoretical literature (Farber, 2006). For example, Wachtel (1993) simply divides clinical self disclosures into two categories: those reflecting the clinician's thoughts and feelings about what is transpiring in the present session, and those relating to the clinician's personal life outside of the session. Zur (2008) has divided clinical self disclosures into

five types: deliberate, unavoidable, accidental, inappropriate, and client initiated. Deliberate disclosures range from the photos clinicians chooses to display in their office to their intentional expressions of thought or emotion in the session. Unavoidable disclosures include gender, age, style, or that which is intrinsic to the clinician's presence and cannot be concealed. Accidental disclosures include the clinician accidentally seeing a client outside of the session, to an unintentional display of emotion or verbal reaction in the session. Inappropriate disclosure are disclosures that are based on the clinician's needs and do not take into account the effect on the client. Finally, client initiated self disclosures apply to information that is found out about the clinician by the client through an on-line search.

For the purpose of this study, I will be excluding non-verbal, unavoidable or unintentional disclosures (including body language) from the definition of "self disclosure". Instead the focus will be on occasions when the therapist deliberately reveals information about their illness verbally. However, the impact of accidental and inappropriate disclosures will also be explored.

Self disclosure from a classical psychoanalytic perspective:

From the classic psychoanalytic perspective the subjective states and personal lives of the therapist are not considered relevant to the therapeutic relationship. In fact, therapists attempt to leave as much of themselves out of the room in order to function as a "blank screen" for clients to project their unconscious fantasies and transference feelings upon (Cohen & Shermer, 2001). "The analyst should be impenetrable to the patient, and, like a mirror, reflect nothing but what is shown to him" (Freud, 1959, p. 330-331). This allows the clinician to access the client's unconscious conflicts and self

object world, which guides the analyst in helping the client work through their past trauma by making these unconscious fantasies and emotions, conscious for the client (Berzoff, Flanagan, Hertz, 1998). The more information therapist self disclose about themselves, the more the client's transference distortions will be contaminated, interfering with the therapist's ability to access the client's unconscious world, hindering treatment (Dewald, 1982). In other words, if the therapist reveals too much of what she thinks about the clinician's fantasy than the client may edit his fantasy to more closely align to what he thinks the therapist will approve of. If the clinician is able to remain neutral, it is believed the transferences will be more purely connected to the client's unconscious. From this perspective, transference is something that is created from within a client and "bubbles up" from within (Wachtel, 1998). The client is simply reenacting past relational patterns and is not necessarily affected by who the analyst is (Berzoff, Flanagan, Hertz, 1998). Therefore, the transference would be the same regardless of who the treating analyst is, if both analysts were able to keep comparable levels of neutrality (Wachtel, 1998).

Within psychoanalysis there is a range in how strictly the analysts adhere to these "blank slate" standards. For example, Greenburg (1995) spoke about his tendency to remain silent in the face of a client's questions in order to unveil valuable unconscious content from them. Other contemporary psychoanalysts such as Renik (1995) believe that every action a clinician chooses to take or not to take with a client is significant and discloses an aspect of him or herself. Therefore, when clinicians censor their thoughts and feelings, they are merely modifying the way in which the client is experiencing them, not eliminating the client's sense of them.

Kempler (1987) and other psychoanalysts (Ehrenburg, 1995; Renik, 1995), are not exclusively opposed to self disclosures but focus on the importance of clinician's responsibly to act and think critically about "what, to whom, and for what purpose" (Kempler, 1987, p. 109) is a self disclosure being made in order to limit potential harmful effects of the self disclosure on the client. This is a contrast to the strict opacity described by Freud (1959), Dewald (1982), and Greenburg (1995).

Self disclosure from self psychology and intersubjective perspectives:

Relational psychologies mark the evolution from a "one-person psychology" to a "two person psychology". The focus is no longer just on the client's internal structure and experience but the relational field shared by both therapist and client (Berzoff, Flanagan, Hertz, 1998). The therapist is no longer a neutral observer but an active participant in the therapeutic process (Stolorow, 1992). Self psychology and Intersubjective theory are both considered relational psychologies.

Central to self psychology is the belief that a healthy self is developed in relationship to others, known as self objects, who meet specific needs. While not all selfobject needs can be met, continual and traumatic empathetic failures can lead to a weakened sense of self (Goldstein, 1997). "Flaws in the self are due to disturbances of self object relationships in childhood" (Kohut, 1984, p. 53). Therefore, self psychology views treatment as the resolution of a client's frustrated early selfobject needs within the context of a more empathetically attuned relationship (Berzoff, Flanagan & Hertz, 1998). The therapist must use self object transferences to identify these early self object needs that were not met and use the therapeutic relationship to rebuild the client's sense of self. The three main self object transferences identified in self psychology are twinship,

idealization and mirroring. Twinship self object transference refers to a client's need for the therapist to possess similarities to herself. Idealization is the client's need to view the therapist with high regard and mirroring is the client's need to have the therapist listen and reflect the client back to herself (Berzoff, Flanagan & Hertz, 1998). Thoughtful self disclosures by the clinician can be a form of empathetic attunement that fulfills a self object need for the client (Goldstein, 1997).

This concept originated with Ferenczi (1933) who worked with clients with a history of incest or molestation in a home environment filled with shame and secrecy. By making some self disclosures, he believed he was helping to heal these client's past wounds by offering them a different, more authentic, relational experience (Cohen & Shermer, 2001). By thoughtfully revealing her own humanness, a clinician can help a client accept the clinician as a whole person. If clients can accept the clinician as having flaws, they will, in turn, learn to accept their own flaws (Wachtel, 1993).

Other examples of past missattunements may include clients who felt shut out of their parents' lives or had their perceptions of a traumatic experience invalidated. If clinicians are not attuned to these needs they may replicate this experience with their client, missing a valuable reparative opportunity (Goldstein, 1997). For example, Goldstein (1997) worked with a client whose prior clinician had to stop treatment abruptly due to his illness. The client reported witnessing her therapist looking sick and tried to talk to him about it but her questions went unanswered. Goldstein (1997) believes that if the clinician had self disclosed his illness, instead of ignoring her questions; the client would have been able to process her emotions around the loss.

Twinship and idealization transferences may also call for some self disclosures as well. For example, clinicians may disclose something about themselves to increase their three-dimensionality and reduce these transferences (Wachtel, 1993). However, not all self object needs benefit from a clinician's self disclosure. When a client presents as very self absorbed his primary self object need is usually mirroring. In this case the client is not always able to see the clinician's humanness and a self disclosure may not be helpful or may even feel threatening to the client (Cohen & Shermer, 2001).

Within inersubjectivity, it is understood that there is not just one reality but separate realities for both the client and therapist, in addition to a shared reality. The therapeutic process is no longer about uncovering the truth through insight but about the client's discovery of him or herself by restoring the core subjective truths by encountering the subjectivity of the therapist (Benjamin, 1990). The therapist's reactions can also help reshape the client's experience and understanding of him/herself (Stolorow & Atwood, 1992). The client and clinician mutually impact each other and the acknowledgement of that is a significant piece of the work (Stolorow, 2002). In other words, the curative factor lies in the relationship itself.

It is believed that the client may be able to sense differences in the clinician and a self disclosure may help to validate the client's feelings. For example, while mourning the loss of a close colleague, Goldstein (1998) reports that a client sensed her sadness and asked her directly about it. Goldstein decided to disclose that she had in fact lost someone close to her. This allowed the client to then talk about how she was never able to talk to her mother about her mother's depression. Goldstein believed this to be reparative because it validated the client's experience of the relationship where in the past she had

been denied that opportunity. She argues that withholding certain information can affect patient's feelings of safety, ability to trust, or possibly recreating past traumas.

Relational theories perceive the client and clinician as mutual contributors to the therapeutic relationship. However, there is also acknowledgement within the theory of the inherent power difference that comes from any professional relationship (Cohen & Shermer, 2001). The clinician's self disclosures are thought of as a tool and hold a different meaning than the disclosures made by the client (Berzoff, et al., 1998). Therefore, within these theories it is most important that clinicians develop a positive working bond with the client so their disclosures can be empathetically attuned to what the client is unconsciously experiencing and trying to express (Cohen & Shermer, 2001). Understanding the meaning and needs of the client will better inform the use of self disclosure (Stolorow & Atwood, 1992).

Therapists' Self Disclosure of Illness: Reasons for Doing So

In the literature on clinician self disclosures there are marked differences between the uses of self disclosures by therapists who are aligned to different schools of thought (Edwards & Murdock, 1994). In a review of psychotherapy literature, relational/humanistic therapists have been found to use self disclosure more frequently than psychoanalytic therapists (Hill & Knox, 2001). However, the use of therapist self disclosures over all occurred infrequently and was used cautiously. Therapists aligned to a variety of clinical theories were found to consistently support the use of self disclosure for modeling behaviors and to increase feelings of similarity (Edwards & Murdock, 1994) The three most commonly reported reasons why a therapist would self disclose included strengthening the therapeutic alliance, normalizing the patient experience, and

providing the patient with alternative ways of thinking (Louis, 2001). In addition, most practicing social workers surveyed said they would not self disclose if they thought their disclosure would shift the focus from the client's own work, decrease the client's ability to disclosure, interfere with the transference, create role confusion, or deviate from the client's expectations of professional behavior (Anderson and Mandel,1989).

As therapists with a physical illness try to balance the maintenance of their practice along with their changing physical health needs, they are often faced with the question of whether or not to tell clients about their illness. In a review of the clinical literature written by therapists with an illness, some of the more frequently reported reasons for disclosing their illness to their clients included: the client's struggle with loss and death issues (Abend, 1982; Morrison, 1997), the clinician's illness becoming visible to others (Abend, 1982; Cristy, 2001), in response to client's question regarding the therapist's health (Cristy, 2001; Dewald, 1982; Morrison, 1997), and a desire to be transparent with their clients about the situation in case the illness worsens (Pizer, 1997; Engles, 2001).

However, Abend (1982) regretted disclosing his illness to his clients because he felt that it interfered with their transference feelings. He concludes that as much as therapists try to be objective, their countertransference feelings will always influence their choice to disclose. He believed his self disclosure came out of his own unconscious needs, instead of the client's (Bram, 1995). Perhaps the clinician maybe unable to be objective enough in this situation to trust his choice to self disclose and should refrain from self disclosing to avoid indulging his own narcissist needs to be seen and taken care of (Abend, 1990; Arlow, 1990; Dewald, 1982).

However, Alonso & Counselman (1993) argue that the therapist's reluctance to self-disclose may be a product of the therapist's denial towards her illness and her desire to maintain a sense of control. Therefore, the decision to not disclose has the potential to harm the therapeutic relationship because it's rooted in a desire to avoid the reality of the illness and protect their vulnerability of the therapist and not the client's needs. Thus, therapists should find ways to disclose to their clients that don't leave them feeling too exposed or damage the treatment relationship (Lasky, 1990).

Engles (2001) believes that some clients are not able to use the self-disclosure in a productive way. Therefore, a therapist should tailor the disclosure to the client's own needs, which may mean disclosing to some clients but not all. Morrison (1997) chose to postpone disclosure of her cancer diagnosis to a specific client who was recently diagnosed with a different acute illness because she felt that her self-disclosure would dilute her client's work around his own diagnosis.

It is apparent in the literature that self-disclosure by clinicians about their illness is complicated and that there are many reasons why clinicians have chosen to disclose or not disclose their illness. A significant factor that has impacted clinicians' reasons to self-disclose has been the perceived effects of their disclosures on clients and each reason also has the potential to produce varied effects in the different therapeutic relationships.

Effects of Therapists' Self-Disclosures of Illness

A therapist's self-disclosure about her illness has the potential to be both beneficial and damaging to the therapeutic relationship. Possible positive effects of disclosing include a decrease in the client's anxiety by making the situation clear and available for discussion (Renik, 1995). Disclosing provides the client the right to assess

the seriousness of the situation and decide whether to continue treatment (Bram, 1995). Knowledge about the situation can also give the client an opportunity to genuinely express his or her emotions regarding the therapist's illness (Bram, 1995). These reactions at times may be angry or full of despair but the ability to process them can lead to a deepening of the work and increased acceptance of the clinician's illness (Morrison, 1997). The client's ability to express his or her emotions around the therapist's illness may also build a level of trust that allows the client to access other material that had been previously out of reach (Elliot, 1996; Munn, 1996). With some clients, self disclosure can also bring honesty and authenticity into the therapeutic relationship, intensifying the therapy (Munn 199; Pizer, 1997). A disclosure may also allow the therapist to be more connected and attuned to the client's needs (Cristy, 2001; Elliot, 1996; Farber, 2006; Morrison, 1997; Munn, 1996).

While I consequently lived with the nagging unease that I was clinically unbalanced, my work in fact was often at its most sensitive and intuitively inspired during the times I was bared to myself emotionally during episodes of illness...I was empathetically closer than ever to my patient's affects. (Munn, 1996, p. 5)

Alternatively, a therapist's self disclosure about her illness may burden the client with anxiety and worry for the therapist's wellbeing (Friedman, 1991). Some clients may also express fear that they can no longer depend on the therapist or worry that their issues may now be too taxing for the therapist (Durban, Lazar & Ofer, 1993; Munn, 1996). If there is a loss of trust in the relationship, then the effectiveness of the therapy may also dwindle. Knowledge about the therapist's personal life may also impede the treatment by tarnishing the client's transference fantasies (Abend, 1990; Arlow, 1990; Dewald,1982).

It is clear that the effects of disclosure are varying and exhibit both constructive and destructive consequences for the therapeutic relationship. This range reflects the complexity of the issue and, often times, conflicting theoretical beliefs in the value of self disclosure.

In conclusion, the current literature on the use of self disclosure by a clinician with a chronic physical illness is limited and scarce (Weinburg, 1988; Lasky, 1990). The bulk of the literature was written at least 10 years ago, and consists mostly of theoretical papers by psychotherapists based largely on their own experience being diagnosed with an illness (Abend, 1982; Christy, 1993; Dewald, 1982; Lasky, 1990; Morrison, 1997; Pizer, 1997; Rosner, 1986; Weinberg, 1988). While these perspectives are useful, they do not provide an empirical examination on the topic. In fact, there are no empirical studies on clinicians with a chronic physical illness and their use of self disclosure. Also, the vast majority of these papers are written by psychoanalysts, which limits the theoretical perspective the issue has been examined under. Considering the frequency that a clinician suffers from a chronic physical illness, there is a dearth of literature on the topic of self disclosure by a clinician with a chronic illness (Halpert, 1982; Lasky, 1990; Weinberg, 1988). The lack of information in such an important and significant area requires further exploration (Abend, 1982).

The intent of this study is to start filling the gap that currently exists in the literature today. This study will examine this issue under a broader theoretical lens, looking not merely from a traditional psychoanalytic perspective but from contemporary relational theories as well. It will also examine reports from several clinicians in order to

identify patterns and begin to clarify the reasons and implications for self disclosure when a clinician has an illness.

The purpose of this study is to explore how therapists who have been diagnosed with a chronic physical illness use self disclosure in the therapeutic relationship. Specifically, it will 1) identify reasons why therapists with a chronic physical illness chooses to self disclose information about their illness, 2) consider the factors that effect the therapist's use of self disclosure, 3) present the therapist's perception of the effects of these disclosures on the therapeutic relationship, and 4) provide a conceptual framework and rationale from which to examine this issue.

CHAPTER III

METHODOLOGY

Research Design

This qualitative research study was designed to explore the reasons why therapists with a chronic physical illness choose to self disclose information about their illness to their clients. This study also sought to better understand, from the clinician's perspective, the effects of these disclosures on the treatment process. Due to the limited amount of research in this area, the researcher conducted an exploratory study using grounded theory methods.

The researcher created semi-structured interview questions and a short demographics questionnaire, written out in advance, with some flexibility by the researcher to probe further on pertinent issues during the interview. This flexible method of research was chosen to allow the therapists to express their personal views and provide space for unanticipated data to be examined as well.

This method also reflects the researcher's understanding of the complexity of this issue and circumstances that the clinicians may have experienced. An interview allows the researcher to be flexible in their questioning to better capture the participant's experience. A self administered survey would lack this flexibility to tailor the questions to the participants possibly leaving the researcher with incomplete answers.

A limitation of this method is the interviewer effect bias, where the information gathered is affected by the style of the particular interviewer (Rubin & Babbie, 2007). The researcher made attempts to decrease this by conducting all the interviews and

standardizing the list of questions asked and their order as much as possible. However, the interviewer's particular style may still have affected the participant's answers. This method is also limited by the use of self reporting to gather information because participants are only able to provide you with their naturally biased perspective.

The researcher did not use an existing scale because this is the first study of its type and the researcher was seeking qualitative data due to the dearth of information in this area of study. To increase the internal validity of the interview questions, the questions were pilot tested by a psychotherapist with a chronic illness. However, due to the small sample size, the results will not be considered externally valid.

Sampling

A nonprobability sample was amassed through a combination of convenience and snowball sampling in the greater Boston, Massachusetts region. Participants had to be licensed psychotherapists, diagnosed with a chronic physical illness in adulthood or by age 21. This criteria reflects the researcher's attempt to broaden the existing information on this data by including participants with a variety of clinical training. Also, interviewing individuals diagnosed as adults assumes that there is a difference in the impact on the therapeutic relationship when the clinician is coping with a more recent diagnosis as compared to a diagnosis they have incorporated into their identity since childhood.

For the purpose of this study, the researcher used the U.S. National Health Statistics definition of chronic illness as an illness that last longer than three months (U.S. National Center for Health Statistics, 2000). This definition reflects the researcher's acknowledgement of flexibility and fluidity of symptoms within and between various

illnesses, placing greater importance on the participant's perception of their physical illness. This study is restricted to examining therapists with a physical illness and does not include mental illness as a qualifier to participate in the study.

Participants must have self disclosed information about their illness to at least one client since their diagnosis. They were either currently experiencing symptoms or experienced symptoms within the last ten years. The self disclosure will also need to have been during the time of their illness. In addition, participants were required to conduct individual psychotherapy as part of their practice.

This researcher did not exclude participants based on gender, race, ethnicity and sexual orientation. The diagnosis of a chronic physical illness does not depend on these factors and a diverse pool of participant would only enrich the data found by reflecting the complexity of each situation. However, non-English speaking individuals were excluded because this researcher doesn't have the resources to provide adequate translations to non-English speakers.

After the study was approved by the Smith College School for Social Work Human Subjects Review Board, recruitment largely consisted of referrals from other students and colleagues. The researcher sent Smith College School for Social Work alums a request for participation, as well as a request to forward it to additional colleagues. The researcher also contacted the Boston chapter of the NASW and received referrals from Carol Curtain, chair of an NASW committee for social workers concerned with disability/chronic illness. This researcher also received referrals from other participants as well.

Initial contact with participants was made via e-mail or phone. This researcher screened each participant over the phone by reviewing the inclusion and exclusion criteria. This researcher also reviewed the purpose of the study to ensure that the participants understand their role. If a participant met the criteria and was still interested, this researcher mailed two copies of the informed consent, one for them to read and one for them to sign and return. Addressed and stamped envelopes were included with the consents for them to use in returning the signed copy of the consent. If the participant preferred, the researcher e-mailed the informed consent instead. The participant either brought the signed copy of the consent to the interview or signed an extra copy that was made available at the interview.

Comment [CC1]: I mention above that non English speakers will be excluded but is that not enough to note exclusion criteria here?

Data Collection

Pre-established, semi-structured interview questions and a brief demographics questionnaire were the method of data collection. The interview questions were designed by the researcher to guide the interview process and encourage the respondents' perceptions of the events to unfold in a narrative format.

There were 10 participants who took part in this study. Each participant took part in a single, in-person interview that took approximately 30-60 min to complete. A few of the interviews took closer to 90 minutes to complete only with the participant's approval for additional time to complete the interview. All of the interviews were recorded with a digital audiorecorder with the permission of the participants. All interviews took place in a location of the participant's choice that offered them an assured level of privacy. Six of the interviews took place in the participant's office, two took place in the participant's homes, another interview took place in a library meeting room and another in a meeting

room on a college campus. The interviews were conducted over an eight week period. The audiotapes were then transcribed verbatim by the researcher.

Data Analysis

The method of data analysis was content theme analysis which consisted of examining the narrative data for common themes from subject to subject. Each theme was coded and then the codes were consolidated into consistent and relevant themes.

Ethics and Safeguards

To keep the identity of the participants concealed, all of the informed consents will be kept locked and separate from the rest of the data. Any vignettes or quotes will be carefully disguised. This researcher asked the participants to refrain from using identifying information during the interviews. Any identifying information that appeared on the tapes was deleted and did not appear in the transcripts. Subject numbers replaced the names of the participants on both the tapes and the transcripts. Audiotapes will be kept secure and transcripts will be stored on an external hard drive, in a file secured with a password. All data for this study will be stored for three years and then destroyed as required by federal policy. If this researcher has need for the data beyond the three years it will be kept secure until no longer needed.

CHAPTER IV

FINDINGS

The major findings from this study were that all participants reported by and large feeling pleased with their decisions to self disclose. Over half of the participants disclosed information about their illness to 100% of their clients. The majority of respondents believed they were more likely to disclose to clients also diagnosed with a chronic illness and 7 participants reported that the visibility of their illness played a part in 'forcing' their disclosure.

The reasons for self disclosing fell into two categories: self disclosures made to clients with a chronic illness and self disclosures made to clients without a chronic illness. Some of the main reasons given for self disclosing to clients with a chronic illness include using self disclosure to "model" talking about illness, to advocate for clients and other clinicians with an illness, to "relate" to their clients, and to decrease the client's anxiety. The main reasons given for disclosing to clients without an illness diagnosis include the visibility of the clinician's illness, to explain time taken off by the therapist due to her illness, and to maintain "authenticity" in the therapeutic relationship particularly with long term clients. Some of the most frequently reported effects on the treatment relationship include initial increased anxiety and worry in the clients and increased caretaking behaviors towards the therapist by the client. All participants reported experiencing a "deepening" or "strengthening" in at least some of the therapeutic relationships with clients after disclosing, although the majority of participants also reported having at least one termination related, in part, to their disclosure.

Demographics

All ten participants identified as Caucasian females, between the ages of 52 and 67 years of age with the average age being 58 years old. Three out of the ten participants identified their ethnicity as Jewish, while 4 participants did not identify ethnicity. Within the remaining three participants, one identified her ethnicity as Portuguese/Scottish, another identified German/Swedish, and the third reported Irish.

Seven respondents had a master's in social work as their professional degree. Two of these respondents reported also having a PhD in addition to their MSW. Two participants had a doctorate in psychology and one had a master's in counseling psychology. The subjects' years in clinical practice ranged from 22 to 38 years, with the average years in practice being 29.

Seven of the interviewees reported working in private practice, one of which worked in private practice but currently works at a clinic for women with breast cancer. Another participant works on an oncology unit in a hospital; one subject works at a college counseling center and another at a community mental health clinic.

All participants identified adults as the majority of their client population with one participant also working with young children. All participants conduct individual therapy and half of the participants also conduct couples and/or family therapy. All participants stated a preference for tailoring the length of treatment to the client's needs and seeing at least some clients on a longer term basis. All participants report working with at least one client with a physical illness while seven of the subjects report working specifically with individuals diagnosed with a chronic illness at some point; most have run therapeutic or support groups for individuals diagnosed with a chronic illness.

The theoretical training described by six of the participants was psychodynamic theory, while three respondents identified with an eclectic theoretical training and one identified having insight oriented training. The current theoretical perspectives identified by the subjects were split down the middle with five participants reporting relational theory and five reporting psychodynamic theory. Three participants reported using additional theories including family systems, narrative therapy and cognitive behavioral therapy.

The types of chronic physical illnesses that the participants were diagnosed with are as follows: five of the participants had breast cancer, two of which were diagnosed twice with different types of breast cancer, one subject had tonsil cancer, two were diagnosed with multiple sclerosis, another was diagnosed with fibromyalgia, chronic fatigue and chronic daily migraines, and one participant was diagnosed with Lupus.

The years of diagnosis ranged from 1977-2008 with the average time of diagnosis being 14 years ago.

Self Disclosure to Clients with Chronic Illness

Six of the participants report disclosing their illness to all of their clients at some point during their illness. However, only two of these participants still disclose to all of their clients. They attribute this decision to the fact that they work exclusively with individuals afflicted with cancer. One of these participants did not disclose to any of her clients when she was first diagnosed with cancer and working in a private practice without clients diagnosed with chronic illnesses.

Eight of the interviewees believed they were more likely to disclose to individuals with an illness, 5 of whom disclosed to 100% of their clients with an illness or disability.

The three additional participants stated that they disclosed more to some clients with a family history of chronic illness, but most of these participants specified that they were careful about this and typically disclosed less to those with very recent family history. Just under half of the participants cited examples of not disclosing to a client with a family history for fear it would make them too anxious, and “didn’t feel necessary” to the treatment. One participant gave an example of how her own illness has influenced her work with a client with a family history of illness, although she has decided that a verbal disclosure would be unnecessary to her treatment:

I have another client whose father just died of M.S. He got sick when she was a little girl. And I really understand from the child’s point of view what it means to worry about a parent. I haven’t shared this with her, but I know that where I am going to within myself having worked with my own children with what it was like for them to have to worry about me. Now with this kid there would be no reason for me to divulge. I don’t believe that there is any utility for her.

Seven of the participants reported currently self disclosing information about their illness, to at least some of their clients. Those same participants described intentionally working with individuals with a chronic illness in some capacity; individually, support groups. The remaining interviewees all stated having clients diagnosed with an illness in their practice at some point but have not intentionally sought to work with this population. Nine of the respondents reported working with individuals with a physical illness currently.

Three of the subjects recounted having their illness while going to graduate school and always working with an illness population, in various capacities, since starting their clinical practice. The remaining participants are split with four stating they did not work

with clients diagnosed with an illness prior to their own illness diagnosis and three stating that they did.

Several themes were identified in the reasons given by the participants for disclosing their illness to clients who also have a physical illness. These themes include modeling, advocacy, identification/ joining and anxiety reduction.

Modeling

By disclosing their illness to their clients, some of the participants were able to become models for their patients also coping with having an illness. How and what they modeled varied between participants.

Just over half the participants reported self disclosing their illness to clients with an illness to use themselves as a model for health and survival. One participant spoke about how her use of modeling has increased due to an improvement and stabilization of her illness:

My improved health has changed my self disclosure. I don't think I would be able to offer myself as an example of a bright future. Now I am excited to work with and be a witness for others with a chronic illness.

Another aspect of modeling includes modeling ways to normalize talking about illness. For the majority of the subjects, disclosing was also done to model talking about illness. One respondent describes her disclosure as a way to contradict secrecy around illness rooted in shame:

I think I am modeling a contradiction of shame. People feel a lot of shame about having an illness and don't feel that they can talk about it. I find that just being natural about it contradicts any shame and contradicts any stigma, so that's a big piece of it.

Advocacy

Over half of the respondents recalled using their disclosure to gain legitimacy with their clients with a chronic illness. An example of this can be seen in this respondent's description of her experience working with cancer patients after her own diagnosis of cancer: "I have fabulous credibility. Don't you think that for any important life experience there is a little experience that you can't quite get if you haven't had it. So I get it. And everybody knows that."

These same participants believed this legitimacy helped them advocate for their clients who were also coping with an illness diagnosis. This participant explained how advocacy has become an important part of treatment of clients with an illness:

I think that in quite a large number of situations clients have become more active, better advocates for themselves. I think it helps to know somebody who has got stuff going on and has been able to build a life despite. Often I have direct interventions with healthcare providers I probably do a lot more of that than most therapists in private practice. I have been able to develop an understanding of what these people's fears are, there is so much fear around medical treatment...and I can intervene medically.

An additional form of advocacy came in the form of writing papers or speaking publicly about the experience of having a chronic illness. Seven of these subjects reported taking part in some mode of public discourse about their illness. Although this was typically directed more towards helping other mental health professionals, six of the subjects reported having at least one client learn of their diagnosis this way.

Identification and joining

Self disclosure was frequently used to connect to clients with a chronic illness. Every interviewee who disclosed her illness to a client with an illness expressed a desire to use the disclosure as a way to relate to their client's experience. One interviewee

described the value of being able to relate to her clients in this way which can be seen in a frequent reaction she receives from clients when they learn about her illness:

Clients will say, 'I don't want you to have a chronic illness but I am glad that you do. You get it' and that's really important to people. They feel so misunderstood in the world...having an illness and disclosing it does build a bridge and I think that there is a lot to be said for that.

For the three participants who had already been doing work with clients with a chronic illness before being diagnosed with their own illness, this experience helped them to relate to their client's experience on a more personal level. This interviewee illustrates how her own experience with cancer enlightened her work:

I had been doing this [social work oncology] for more than a decade by the time that I was diagnosed and I really thought that I knew if not everything about what it was like [to have cancer], I knew a great deal about what it was like. And then I realized I knew nothing about what it was like. And now I do.

Anxiety reduction

All the participants reported that clients who have an illness diagnosis showed, on average, more anxiety towards their therapist's diagnosis. This participant explains her use of self disclosure in decreasing her client's anxiety:

And the minute that they realized I had cancer they became very anxious. And so I gave them a little bit more information about what the diagnosis was and what the prognosis was and my expectations of not having it interfere which was more than I told most people.

Seven of interviewees explained that they disclosed more information about their illness to clients showing increased anxiety in an attempt to decrease the client's anxiety. As one participant clarified, "I don't want to withhold things if that is going to make them more anxious."

Self Disclosure to Clients without a Chronic Illness

Over half of the respondents declared that, at some point, their self disclosures to clients without an illness felt “forced” or “circumstantial” due to the visibility of their illness or having to take time away from their practice. Of the 6 participants who disclosed to 100% of their clients, half of these participants reported no longer disclosing to all of their clients. Two cited the discontinued visibility of their illness as the reason and the third cited not needing to take time off for her illness since her surgery.

Visibility

Six of the participants reported that their illness was visible at some point and all but one of these participants explained that the visibility of their illness contributed to their self disclosure. This respondent described her experience of having her cancer become visible only after going through chemotherapy:

It was forced. There was no hiding it. Before that I went to surgery and I was back in three days and nobody knew and it was only until the hair-loss that anybody knew. So yeah it was forced, like a pregnancy. Sooner or later it’s there.

The participants reported varied degrees of visibility dependent on their different diagnoses. A progressive illness such as Multiple Sclerosis can become more visible with time. One respondent with M.S. acknowledged only starting to disclose to all of her clients within the last five years due to the increased visibility of her illness. Prior to that, her disclosures were limited to those clients also diagnosed with an illness or disability. Cancer tends to be more visible during treatment, particularly if the individual receive chemotherapy treatments, but is not visible at other times. Two participants talked about their choice to wear a wig while on chemotherapy to mask their illness, explaining that they could alter the amount their illness was visible. However, one of those participants

clarified that the wig only lessened the visibility of her illness and did not make it feel invisible:

What I very quickly figured out was that everyone was going to know that I was being treated for cancer anyway. I mean when you are bald you are bald, it's pretty obvious.

One participant described that her illness was not considered visible, despite having several surgeries related to her illness, because she was able to pass them off as other temporary conditions, keeping her clients unaware of her diagnosis.

Time off

Eight of the participants reported having to take time off from their practice, at some point, due to their illness. Two subjects did not have to take any time off due to their illness, although one chose to retire in part because of her illness. The most time off taken was approximately three months, by two participants, but the majority of participants who took time off only took one to two weeks off at a time. Five participants report having to take time off at least twice related to their illness. Three participants reported that having to take time off contributed to their self disclosure. A participant described her experience of feeling that she had to disclose because of needing to take time off from her practice:

There were certainly clients that had to know at some point that I had been knocked out of the game, and that was hard to negotiate, because then you are not choosing to disclose but it's just that your life discloses it for you. And then you have to work that through with them.

Two of these participants disclosed to all of their clients because of a sudden break from treatment for surgery while the third was able to take a smaller amount of time off, limiting her disclosure to those she sees very regularly. One of the participants

who needed to take a longer amount of time off described her reasoning into why her break justified a self disclosure:

I am very committed to the people that I work with and it is very unlike me to take time off like this. I felt as though I needed to have a legitimate enough explanation, I mean three months is a long time for some of these people.... I felt like I needed to give legitimacy to such a break.

Four of the participants reported that their illness affected their ability to work by limiting the amount of hours that they worked in a week and the amount of clients they see, but over half reported that their illness has not significantly impacted their ability to work.

Authenticity in the relationship

Most of the participants described self disclosing their illness to their clients in order to maintain “authenticity” in the relationship. As one participant stated:

I never thought that the therapeutic relationship should be a hierarchy and I think that something like this can be: ‘you’re human and have foibles’, it kind of makes the therapy authentic and on a personal level.

All of the subjects explained that they would be more likely to self disclose personal information to clients they have a long term relationship with and over half of the participants reported that they felt more inclined to self disclosed information about their illness to clients they had a long term relationship with.

Because it was cancer and there was a need to start treatment as soon as possible, many of these people I had been working with long term and very consistently for many, many years and to suddenly say I had to take a break for medical reasons just wasn’t adequate.

Effects of Self Disclosure

Increase in client's anxiety/worry

All of the participants commented on witnessing increased anxiety and worry in at least some of their clients after disclosing their illness to them. One participant stated, "The minute that they realized I had cancer they became very anxious." The majority of participants also reported that for some clients this anxiety and worry continues to come up in treatment currently. An example of how her client's anxiety manifest in treatment was described by one participant:

Some of my patients who I still have who know that I had cancer still worry if I am late or have to cancel an appointment. They worry that I am sick again or something so I am very direct with them about it. I don't want them to worry unnecessarily.

Another participant provided a similar account, stating:

My clients are still scared. It hasn't gone away. It's there. When I get a cold, people get scared. 'What's wrong with you? Are you alright?' So yeah it's palpable. And I imagine that it will be for some period of time.

Caretaking

The majority of respondents also reported an increase in caretaking behaviors by their clients after learning of the therapist's illness. These behaviors ranged from buying a card or sending flowers to simply asking questions more frequently about the therapist's health. One participant provided several examples of caretaking behaviors from her clients that she felt were positive:

They were very sweet. They were alarmed, concerned. A couple of them e-mailed me during my treatment to express concern...One of them wrote this beautiful page on her blog, and she wrote about how much I meant to her and that it wasn't fair. It was very lovely, very sweet and she gave it to me. A woman brought me a bear, which was a huge surprise because this is a woman who needs a huge amount from me.

Another respondent described additional caretaking behaviors she observed in her clients, stating “Most people sent flowers and cards and would say, ‘I know this is a little awkward but if I can do anything, tell me?’”

For as many participants who cited examples of times when these increased caretaking behaviors were welcomed by the therapists and even considered it to be beneficial to the deepening of the treatment process, even more respondents expressed concern that the client’s caretaking could impinge upon the treatment process as well. The clients withholding information vital to their own treatment to “protect” the therapist was a worry described by all of the participants. As one participant explained, “Your clients can start to feel somehow responsible for you. They can feel like, ‘I am not going to burden her with my problems, the poor thing has enough going on herself’”.

Relationship building

All of the respondents report experiencing a “deepening” or “strengthening” of the relationship, with at least some of their clients, after disclosing information about their illness. As one participant described, “I think the kind of realness in the relationship can be a very positive thing. You know seeing me deal with life difficulties.” Another participant echoed this sentiment stating, “I think it [self disclosure] does broaden and deepen the therapy relationship. Now people tell me stuff that was hard for them to get out.” A third respondent stated, “It’s a statement of trust on the part of the therapist. That you are willing to share something of your own life with them.”

Termination

The majority of participants reported having one or more clients terminate due, in part, to their disclosure. A participant described her experience with having a client terminate shortly after learning of the therapist's illness:

One person that also got diagnosed shortly after I completed treatment...actually terminated because she didn't feel like she could talk about it freely without it being a problem for me. And I don't think I generated that. And if I did that was an unconscious piece there

Eight of these participants who claimed to have had a client terminate could not recall more than one case where termination occurred. This implies that the incidence of this occurring may be limited.

Summary

This exploratory study examined therapists' reasons for self disclosing information about their illness to clients and the perceived effects on the therapeutic relationship of this disclosure. The themes presented were not exhaustive; however they did address prominent themes in the data. For these participants it is evident that the reasons they disclosed varied depending upon who the client was, particularly if the client had a chronic illness or not. For clients with a chronic illness, self disclosure was offered by the therapist to model health and survival, to advocate for the client, to relate to the client and to decrease anxiety related to the self disclosure. Self disclosures directed towards clients without a chronic illness were commonly the result of extenuating circumstances, such as the visibility of the illness or the therapist's need to take time off due to their illness. A desire to maintain authenticity in the relationship was also a common reason provided. These self disclosures resulted in increased anxiety and worry,

caretaking behaviors, and even termination by some of the respondents' clients, all of which have the potential to impinge on the treatment process. The results of this study also reflect the possibility that a self disclosure of this nature could deepen the therapeutic relationship and become a useful aspect of the client's treatment. The next section compares and contrasts these results with the literature review that was presented in Chapter II.

CHAPTER V

DISCUSSION

The purpose of this study was to answer the following question: Why do therapists with a chronic illness choose to self disclose information about their illness to their clients and what are the implications of this disclosure on the treatment relationship? The participants provided a variety of reasons for why they chose to self disclose to their client and many of these reasons can be tied together by common threads of theoretical thinking about the use of self disclosure.

The most common reason given for self disclosing was “based on the client’s needs”. Although there were slight variations in what the therapist thought that the client might ‘need’ depending on the individual client and the therapist’s training, at some point, all of these participants believed that a self disclosure about their illness was something that their client needed. The majority of the participants had training in psychodynamic theory but gave reasons for disclosing rooted in relational theories, supporting the concept that self disclosures may be a tool to be used within the therapeutic relationship. However, the participants also provided evidence for a self disclosure of this nature impeding the client’s work, offering support for traditional psychoanalytic beliefs about avoiding self disclosure. The following sections will review these theoretical perspectives as well as present the limitations of this study and the possible implications for the field of social work based on this research.

Relational Uses of Self Disclosure

The findings in this research study reflect an overwhelming majority of the participants were more likely to self disclose to clients who also have a chronic illness to

better relate to the client's own experience or model certain behaviors for the client. This finding implies that these therapists hold a belief that a client's knowledge of certain information about the therapist may be beneficial to the client, particularly if the information is related to the client. In other words, who the therapist is matters and their individual life experiences affect the treatment relationship. Acknowledgement of this is the cornerstone to therapeutic treatment from an intersubjective perspective (Stolorow, 2002). Here is an example of a participant explaining that disclosing her illness was rooted in a desire to deepen her connection with her chronically ill client and decrease his feelings of isolation.

So he is constantly dealing with people who know nothing about his experience. So me, sitting there, I think at a certain point I thought, maybe I can straddle something here with this disclosure.

These findings support the intersubjective standing that the disclosure of the therapist's own subjective experience with illness may enhance the client's ability to explore his or her own subjective experience with illness. Reports from participants that the therapeutic relationship was also deepened following their self disclosure provides further support for this standing.

The choice to self disclose to clients based on their personal history with illness also implies that a disclosure depends on the client's individual self object needs that are shaped by their relational history. These thoughtful self disclosures can be a form of empathetic attunement that fulfills a self object need for the client (Goldstein, 1997). If the therapist is empathetically attuned to the client's self object needs, they could use the transference to determine whether a personal disclosure could benefit the client.

Further support for this self psychology perspective is supported by the finding that many of the participants showed discretion in their disclosures if there are not obvious signs of their illness. This implies that a decision to make a self disclosure of this nature does depend on the client's individual transference needs. For example, a participant explained that a client with a family history of secrecy around his mother's illness benefitted from the open authenticity found in the therapist's self disclosure about her own illness. This therapist used herself in the relationship with the client to facilitate reparation of the client's past relational wounds. Instead of colluding with the secrecy and denial that the client is familiar, the clinician offered a place to process the client's feelings around the clinician's illness. The self disclosure becomes a vehicle to process the client's past feelings of loss or being left out of a family member's illness experience and has the potential to build a fuller sense of self and self objects.

The theory of the 'wounded healer', stating that both the therapist and client benefit from acknowledgement of their ability to be both wounded and healed (Miller & Baldwin, 1999), is akin to the relational theories' perspective that the client's acceptance of the therapist's wholeness contributes to the recognition of their own wholeness as well (Wachtel, 1993). Wounded healers not only acknowledge their illness but also model an ability to cope with their illness. Support for the existence of wounded healers can be seen in the findings stating that the seven participants reported using a consultant or peer support group and two others reported using family or friends as a support in making their decision to disclose. The majority of participants also talked about going to their own therapy to help them cope with the stressors brought upon them due to their illness. Eight of the participants also reported feeling that they were "better" therapists after their

diagnosis because they had a greater understanding of the pain and loss associated with the emotional and physical experience of being diagnosed with an illness and the daily struggles associated with a chronic illness. By processing their pain and struggles in therapy, these participants gained a greater set of skills for coping with their pain. It is these skills that helped them become better therapist, because they can not only relate to the pain that their clients feel but also model ways of coping with pain in order to survive day to day.

An additional reason to self disclose rooted in relational theories was the use of self disclosure to help “ground” clients in reality, particularly those with a trauma history or with a borderline character structure. In psychodynamic theories, it is believed that while self disclosure should be limited, it should be particularly limited with those clients who have a less defined characterological structure because their transference feelings are thought to be much more intense and a self disclosure would alter their transference fantasies (Dewald, 1982). These intense transference fantasies were the exact reason why several participants found self disclosure more helpful with this population. They agreed that their self disclosure did impact the client’s transference fantasies, by replacing those fantasies with reality based information that helped to decrease the client’s anxiety and improved the therapeutic connection. As one participant stated, “People can have fantasies about their therapists and who knows where they can go. I didn’t want them to have fantasies about me.”

This population is considered particularly sensitive to changes in the therapist. Several participants described occasions when a client reported sensing changes in the

therapist, even if the changes were not always visible. Here is an example of one of the respondent's describing her decision to disclose based on her client's sensitivity to her:

I wasn't going to be myself and they would know I am not myself particularly people who are very sensitive to me and have been with me a long time and know me very well would know very, very quickly know that something was very wrong. So I needed to tell them so that they had a reality base and they knew it wasn't them.

Therefore, participants were more likely to self disclose to these clients, particularly when questioned by the client, in order to maintain authenticity in the relationship and validate the client's experience of change as well. These participants believed their honesty helped traumatized clients feel a sense of trust and safety in the relationship and furthered reparation of past emotional wounds.

When asked what the most surprising result of their self disclosure was, the majority of the participants report that they were surprised that their self disclosure of their illness did not interrupt treatment more. Given their psychodynamic training, these participants were concerned that a self disclosure would draw attention away from the client's transference needs and focus would land on the therapist. However, participants reported that the majority of clients were respectful of their privacy and the limits they set on their disclosure. They felt the experience of disclosing their illness to their clients was handled better than expected. This finding challenges the psychoanalytic school of thought on disclosure and gives room for a more relational perspective; the client may benefit from experiencing the therapist as a whole person instead of a blank slate.

There are times when a therapist's ability to conceal their illness under the veil of the "blank screen" is hindered, despite their best attempts. When their illness became

visible, all participants disclosed. As one participant stated, “I didn’t think I had to be a blank screen because I wasn’t.”

Some participants discussed incidents when clients did not say anything about their visible illness and they would encourage clients to talk about it, believing that if they ignored the visibility of their illness they would be colluding with the client’s denial and possibly hinder treatment. This participant explained how her disclosures freed up the treatment process:

I think our patients pick up really quickly what they can talk about and what they are supposed to talk about. So they really knew they were not supposed to talk about how I was looking and how I was being. I hope that they felt more freedom after I disclosed.

This point argues against the psychoanalytic theory’s warning against contaminating a client’s work with a disclosure about the clinician, by stating that a visible illness non-verbally discloses for the therapist, destroying aspects of their privacy and to avoid discussing their illness may be harmful to the client’s treatment.

Limitations of Self Disclosure

While the majority of participants found several benefits of self disclosing information about their illness, most also reported having at least one client terminate treatment following their disclosure. This finding implies that, for some clients, a disclosure of this nature may actually impede treatment. This supports the psychoanalytic perspective that a self disclosure interrupts the client’s ability to process treatment issues in the relationship because they are burdened by the therapist’s life stressors. Participants felt that their disclosure disrupted the client’s feeling of safety in the treatment relationship, and that they couldn’t talk about their own experience with illness now that

they knew about the therapist's illness. The therapist can no longer use the therapeutic relationship as a tool when the client lacks trust in the relationship or feels burdened by the therapist's own life stressors.

Also, all of the participants reported placing a boundary on what they were willing to disclose to their clients, implying that not all self disclosures were perceived to be helpful. As one participant stated:

I certainly didn't share details... just 'yes, it would be radiation and chemotherapy'. I would answer in a limited way. The reality is that I was very anxious about the feeding tube. I was very anxious about the pain but I would never tell them that. They need to know that I can withstand it, I will come back, I will be here in the future, I expect to.

Despite the fact that these participants utilized relational theory to find useful ways to self disclose, it seems that they were also mindful of psychoanalytic theory's warning of impeding the client's work with information about the clinician as well. This respondent explained:

I have to be very careful about what I am doing because I can't just spill all over the place it's got to be within the confines of what is useful to him, and that gets very complicated. But I still think it's worthwhile.

To make a sweeping positive claim for a self disclosure of this nature would inadequately reflect the intricacy involved in making this decision. These results reflect a self disclosure's ability to both help and hinder a client's treatment. Psychodynamic and relational theories overlap in their belief that each client should be treated as an individual and their individual histories and transference feelings should always be taken into account. As all the participants stated, the client's needs should come first. What this study has shown is that the client may also benefit from learning about the clinician's illness as well, particularly if the client also has an illness or if there are visible signs of

the clinician's illness. A case by case decision for self disclosure may be most beneficial given these mixed results. However, these results also show that that may not always be possible if the illness becomes visible, or the clinician needs to take a sudden break from work. Otherwise, a self disclosure should come as an empathetic attunement to the client's transference, self object needs. If the therapist senses that this self disclosure could benefit the client, based on these findings, there is room to believe that they are right.

Implications for Social Work

This research has opened up the possibility for therapists faced with a chronic illness to consider using self disclosure as a tool for treatment. This study also starts to identify ways in which a therapist with a chronic illness may use their experience to inform their practice and benefit their clients. All of the participants encouraged any therapist diagnosed with an illness to connect with a supervisor or peer support group who have experience with chronic illness. Those who sought knowledgeable support found this to be a helpful way to process their experience and gain the insight into their own struggle that gave them the tools to help their own clients. Without properly examining our own situation how can we use ourselves in treatment? Hopefully this research will encourage therapists with an illness to get connected to others, to start peer lead groups or become more public about their experience.

Limitations

The limitations of this study include the time limited nature of the study, the small sample size, and the sample consisting of all Caucasian and female participants. This researcher also only interviewed therapists who reported self disclosing. This population

may reflect a positively skewed view of self disclosure when compared with therapists who choose not to self disclose information about their illness.

Using in-person interviews to collect the data can create an interviewer effect bias, where the information gathered is effected by the style of the particular interviewer. Although this was limited by the fact that all the interviews were conducted by this researcher, the interviewing style of this researcher still may have affected the participant's answers. This method is also limited by the use of self reporting to gather information because the participants are only able to provide their naturally biased perspective. This researcher also only interviewed therapists, thus limiting the researcher's ability to understand the clinical implications of the psychotherapist's self disclosure from the therapist's perspective and not the client's.

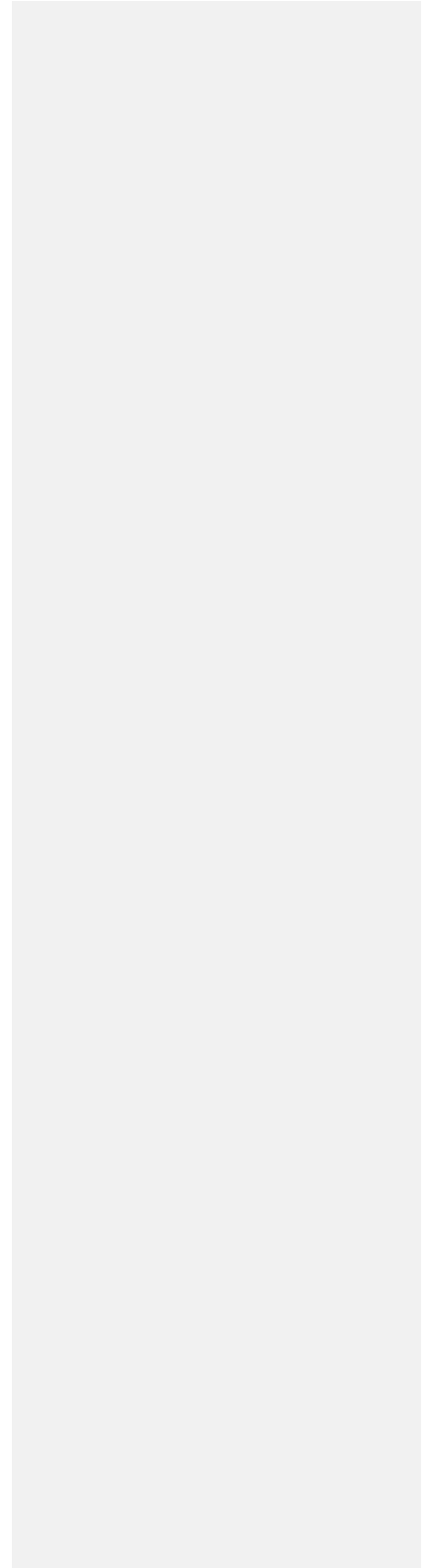
Also, due to the use of snowball sampling, some of the participants were professional acquaintances or friends. These relationships may have narrowed the results by providing a sample with greater similarities compared to individuals unknown to each other.

Recommendations for Future Research

Further research on this topic is needed to increase the field of social work's understanding of the impact of this situation on both therapists and clients. Given the complexity of the issue future areas of research should include a large, more racially diverse sample, including both male and female participants.

Future areas of interest that arose through this research include a client's perspective of the therapist's disclosure of their illness; therapists with a chronic illness who choose to not disclose their illness; the benefits of peer support groups for therapists

with a chronic illness; how therapy with chronically physically ill clients differs between providers also diagnosed with an illness when compared to therapists who are not diagnosed with an illness. More specific research on the effects and differences in self disclosures by clinicians between specific types of illnesses, particularly ambiguous or invisible illnesses, is needed.



REFERENCES

- Abend, S.M. (1982). Serious illness in the analyst: Countertransference considerations. *Journal of the American Psychoanalytic Association, 30*, 365-379.
- Acorn, S., & Joachim, G. (2001). Stigma of visible and invisible chronic conditions. *Journal of Advanced Nursing, 32*(1), 243 – 248.
- Adams, S., Pill R., & Jones, A. (1997). Medication, chronic illness and identity: the perspective of people with asthma. *Social Science and Medicine, 45*(2), 189-201.
- Alonso, A., & Counselman, E. F. (1993). The ill therapist: Therapists' reactions to personal illness and its impact on psychotherapy. *American Journal of Psychotherapy, 47*(4), 591-602.
- American Cancer Society. (2008). *The Emotional Impact of a Cancer Diagnosis*. Retrieved January 3, 2009 from: http://www.cancer.org/docroot/MBC/content/MBC_4_1X_The_Emotional_Impact_of_A_Cancer_Diagnosis.asp.
- Anderson, S., & Mandell, D. (1989). The use of self-disclosure by professional social workers. *Social Casework, 70*, 259-267.
- Arlow, J. A. (1990). "The Analytic attitude in service of denial". In H. Swchartz and A.L. Silver (Eds). *Illness in the Analyst*. New York: International Universities Press, p. 9-25.
- Audet, C., & Everall, R. (2003). Counselor self-disclosure: Client-informed implications for practice. *Counseling and Psychotherapy Research, 3*(3), 223 – 231.
- Barrett, M. S., & Berman, J. S. (2001). Is psychotherapy more effective when therapists disclose information about themselves? *Journal of Consulting and Clinical Psychology, 69*(4), 597-603.
- Benjamin, J. (1990). An outline of intersubjectivity: The development of recognition. *Psychoanalytic Psychology, 7*, 33-46.
- Berzoff, J., Flanagan, L. M., Hertz, P. (1998). *Inside Out and Outside In: Psychodynamic Clinical Theory and Practice in Contemporary Multicultural Contexts*. Northvale, NJ: Jason Aronson.
- Beutler L. E. & Mitchell, R. (1981). Differential psychotherapy outcome among depressed and impulsive patients as a function of analytic and experiential treatment procedures. *Psychiatry, 44*(4), 297-306.
- Bram, A. (1995). The physically ill or dying psychotherapist: a review of ethical and clinical considerations. *Journal of Psychotherapy, 32*(4), 568-580.

- Braswell, L., Kendall, P. C., Braith, J., Carey, M. P., & Vye, C. S. (1985). Involvement in cognitive behavioral therapy with children: process and it's relationship to outcome. *Cognitive Therapy Research*, 9, 611-630.
- Carveth, D. L. (1994). Selfobject and intersubjective theory: A dialectical critique part 1. *Canadian Journal of Psychoanalysis*, 2, 151-168.
- Charmaz, K. (1984). Identity dilemmas of chronically ill men. *Sociological Quarterly*, 35(2), 269-288.
- Charmaz, K. (1993). *Good Days, Bad Days: Self in Chronic Illness and Time*. New Jersey: Rutgers University Press.
- Carmaz, K. (2002) Self as habit: The reconstruction of self in chronic illness. *Occupational Therapy Journal of Research*, 22(1), supplemental.
- Coady, N. F. (1991). The association between complex types of therapist interventions and outcomes in psychodynamic psychotherapy. *Research on Social Work Practice*, 1(3) 257-277.
- Crandall, C.S. (2006). Multiple stigma and AIDS: Illness stigma and attitudes toward homosexuals and IV drug users in AIDS-related stigmatization. *Journal of Community & Applied Social Psychology*, 1(2), 165 – 172.
- Cristy, B.L. (2001). Wounded healer: The impact of a therapist's illness on the therapeutic situation. *Journal of American Academy of Psychoanalysis*, 29, 33-42.
- Darity, W. A., Jr. (Ed.). (2008). *International encyclopedia of the social sciences*. (2nd ed., Vols. 1-10). Detroit: Macmillan Reference.
- Dewald, P.A. (1982). Serious illness in the analyst: Transference, countertransference, and reality responses. *Journal of the Psychoanalytic Association*, 30, 347-363.
- Durban, J., Lazar, R., & Ofer, G. (1993). The cracked container, the containing crack: Chronic illness – it's effect on the therapist and the therapeutic process. *International Journal of Psychoanalysis*, 74, 705-713.
- Dudly, J. R. (1983). *Living with Stigma: The Plight of People Who We Label Mentally Retarded*. Illinois: Charles C. Thomas.
- Edwards, C. E. & Murdock, N.L. (1994). Characteristics of therapist self-disclosure in the counseling process. *Journal of Counseling & Development*, 72, 384-89.
- Elliot, C. M., (1996). Through the glass darkly: Chronic illness in the therapist. *Clinical Social Work Journal*, 24(1), 21-34.

- Engles, R., (2001). The therapeutic value of self-disclosure in group treatment when the clinician has a catastrophic illness. *Psychoanalytic Social Work*, 8, 11-22.
- Farber, B. A., (2006). *Self Disclosure in Psychotherapy*. New York: Guilford Press.
- Ferenczi, S., (1933). Confusion of the tongues between the adults and the child. *International Journal of Psychoanalysis*, 30, 225-30.
- Friedman, G. (1991). Impact of a therapist's life threatening illness on the therapeutic situation. *Contemporary Psychoanalysis*, 27, 405-421.
- Freud, S. (1953). *On Narcissism: An Introduction. The Standard Edition of the Complete Psychological Works of Sigmund Freud*. London: Hogarth Press.
- Frost, M.H., Suman, V. J., Rummans, T. A., Dose, A. M., Taylor, M., Novotny, P., Johnson, R., & Evans, R. (2000). Physical, psychological and social well-being of women with breast cancer: The influence of disease phase. *Psycho-Oncology*, 9(3), 221-231.
- Goldberg, A. (1993). *The Widening Scope of Self Psychology Progress in Self Psychology*. New Jersey: The Analytic Press.
- Goldberg, A. (1993). *The World of Self Psychology*. New Jersey: The Analytic Press.
- Goldstein, E. (1997). Self-disclosure in treatment: What therapists do and don't talk about. *Clinical Social Work Journal*, 22(4), 412-418.
- Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. New Jersey: Prentice-Hall.
- Greenberg, J. (1995). Self disclosure: Is it psychoanalytic? *Contemporary Psychoanalytic*, 31, 193-211.
- Halpert, E. (1982). When the analyst is chronically ill or dying. *Psychoanalytic Quarterly*, 52, 372-389.
- Hill, C. E. (1989). *Therapist Techniques and Client Outcomes: Eight Cases of Brief Psychotherapy*. California: Sage.
- Hill, C. E., & Knox, S. (2001). Self disclosure. *Psychotherapy: Theory, Research, Practice, & Training*, 38(4), 413-417.
- Holtzman, E. (2006). *Living with Chronic Illness*. Retrieved January 10, 2009 from <http://www.umass.edu/fsap/articles/ill.html>

- Hott, R.B. (2001). Healing the wounded healer: How women psychotherapists deal with their breast cancer. *Dissertation Abstracts International*, 61, 11B. (UMI 0419-4217).
- Kempler, B. (1987). The shadow side of self disclosure. *Journal of Humanistic Psychology*, 27(1), 109-117.
- Knox, S., Hess, S. A., Petersen, D. A., & Hill, C. E. (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. *Journal of Counseling Psychology*, 44(3), 274-283.
- Kohut, H. (1984). *How Does Analysis Cure?* Chicago: Psychoanalytic Press.
- Kushner, K., Bordin, E. S. & Ryan, E. (1979). Comparison of Strupp's and Jenkins's audiovisual psychotherapy analogues and real psychotherapy interviews. *Journal of Consulting and Clinical Psychology*, 47(4), 765-767.
- Kyngas, H. & Hentinen, M. (1995). Meaning attached to compliance with self-care, and conditions for compliance among young diabetics. *Journal of Advanced Nursing*, 21(4), 729-726.
- Lasky, R. (1990). Catastrophic illness in the analyst and the analyst's emotional reactions to it. *International Journal of Psychoanalysis*, 71, 455-473.
- Lederberg, J. (2000). Infectious history. *Science*, 288(5464), 287-293.
- Maggio, L. (2007). Externalizing lupus: A therapist/patient's challenge. *Professional Psychology: Research and Practice*, 38(6), 576-581.
- Marshfield clinic. (n.d.). *Emotional rollercoaster can accompany physical illness*. Retrieved January 4, 2009 from http://www.marshfieldclinic.org/patients/?page=cattails_2006_janfeb_emotional.
- Mednet.com, (2009). *Definition of Chronic Illness*. Retrieved August 7th, 2008 from: <http://www.medterms.com/script/main/art.asp?articlekey=2731>.
- Mcarthy M. (2007). *Measuring Quality in Cancer Services*. Retrieved February 8, 2009, from London Department of Health Web site: <http://www.sdo.nihr.ac.uk/files/project/65-final-report.pdf>.
- Meissner, W.W. (1996). *The Therapeutic Alliance*. Michigan: Bookcrafters.
- Miller, G. & Baldwin, D. (1999). Implications of the wounded healer for the use of self in therapy. In M. Baldwin (Ed.), *The Use of Self in Therapy*, (pp 243-251). New York: Haworth Press.

- Morrison, A.L. (1997). Ten years of doing psychotherapy while living with a life threatening illness. *Psychoanalytic Dialogues*, 7, 225-241.
- Norcross, J. (2002). *Psychotherapy Relationships That Work*. New York: Oxford University Press.
- Pizer, B. (1997). When the analyst is ill: Dimensions of self-disclosure. *Psychoanalytic Quarterly*, 66, 450-469.
- Philip, C.E. (1993). Dilemmas in self disclosure to patients and colleagues when a therapist faces life threatening illness. *Health and Social Work Journal*, 18, 72-83.
- Pope, K. S. (2006). *What Therapists Don't Talk About and Why*. Washington, DC: American Psychological Association.
- Renik, O. (1995). The ideal of the anonymous analyst and the problem of self disclosure. *Psychoanalytic Quarterly*, 64, 466-495.
- Rosner, S. (1986). The seriously ill or dying analyst and the limits of neutrality. *Psychoanalytic Psychology*, 3, 357-371.
- Rubin, A. & Babbie, E.R. (2007). *Research Methods for Social Work*. California: The Thomas Corporation.
- Schiaffino, K. M., Shawaryn, M.A., & Blum, D. (1998). Examining the impact of illness representations on psychological adjustment to chronic illnesses. *Health Psychology*, 17(3):262-268.
- Scambler, G., & Hopkin, A. (1986). Being epileptic: Coming to terms with stigma. *Sociology of Health & Illness*, 8(1), 26-43.
- Simon, J.C. (1990). A patient-therapist's reaction to her therapist's serious illness. *American Journal of Psychotherapy*, 44(4), 590-597.
- Stolorow, R. D. (1993). *Thoughts on the Nature and Therapeutic Action of Psychoanalytic Interpretation*. New Jersey: The Analytic Press.
- Stolorow, R. D., & Atwood, G. E. (1992). *The Context of Being*. New Jersey: The Analytic Press.
- Thorne, S., & Paterson, B. (1993). Shifting images of chronic illness. *Journal of Nursing Scholarship*, 30(2), 173-178.
- Ulman, K.H. (2001). Unwitting exposure of the therapist: Transferential and countertransference dilemmas. *Journal of Psychotherapy Practice*, 10(1), 14-22.
- Wachtel P. L. (1993) *Therapeutic Communications: Knowing What to Say When*. New

York: Guilford Press.

Weinberg, H. (1988). Illness and the working analyst. *Contemporary Psychoanalysis*, 24, 452-461.

Williams, K. E., & Chambless, D. L. (1990). The relationship between therapist characteristics and outcome of in vivo exposure treatment for agoraphobia. *Behavior Therapy*, 21, 111-116.

Zur, O. (2008). The Google factor: Therapists' self-disclosure in the age of the internet. *Independent Practitioner*, 28(2), 83-85.

Appendix A

Smith College Human Subjects Review Approval Letter

February 11, 2009

Caitlin Cotter

Dear Caitlin,

Your revised materials have been reviewed. All seems to be in order, although at times I got a little confused as to the significance and the source of the various colored comments on the side. We are glad to give final approval to your study. Please send a clean copy to Laurie Wyman for the permanent record.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project. It is an important area and one that seems to need study.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: CARLA NAUMBURG, RESEARCH ADVISOR

Appendix B
Recruitment Letter

Hello,

My name is Caitlin Cotter and I am a Second Year student at Smith College School for Social Work. I am currently collecting data for my master's thesis which examines the use of self disclosure by clinicians who have been diagnosed with a chronic physical illness. I am writing to see if you or someone you know may be interested in participating in this study. I am looking to interview mental health professionals (LCSWs, MFTs Psychologists, Psychiatrist, or Psychoanalysts) who have been diagnosed with a chronic physical illness in adulthood, about their use of self disclosure with their clients about their illness.

To participate, you will also need to conduct individual psychotherapy, speak English fluently and preferably live in the New England area, as I will be conduct the 30-60 min interviews in person.

If you feel that you qualify and are interested in participating in this study, please contact me by e-mail at ccotter@smith.edu or phone at (801) 597-3179. I have also attached the informed consent form which expands on the study in further detail. I am more than happy to address any questions or concerns you make have.

Please forward this e-mail to anyone you know who may qualify or is in a mental health profession. Thank you for your time.

Best,

Caitlin Cotter

Appendix C

Informed Consent

Dear Participant,

My name is Caitlin Cotter and I am a Masters student at Smith College School for Social Work. I am conducting a research study to learn about your experiences with clinical self disclosures as a licensed psychotherapist. To participate in this study you must have been diagnosed with a chronic physical illness in adulthood or by age 21. For the sake of this study, a chronic illness is defined as an illness lasting at least three months. You must either be currently experiencing symptoms or have experienced symptoms within the last ten years. Also, you must have self disclosed information about your diagnosis to at least one client during the time of your illness. Having a chronic mental illness does not qualify you to participate as this study. You must also speak English fluently and conduct individual psychotherapy. My hope in conducting this research is to bring attention to the decision making process to self disclose when a therapist has a chronic physical illness. There is currently limited research in this area. Participation in this study has the potential to benefit the field and other clinicians diagnosed with an illness who are grappling with the choice to self disclose. This study is for my Smith College thesis and possible presentation and publication.

I invite you to participate in this study. As a participant in this research, you will be asked to take part in a single, in-person interview consisting of some demographic questions and several semi-structured interview questions regarding your decision to make clinical self disclosure(s) about your diagnosis. This process should take approximately 30-60 min to complete. Interviews will be audio-taped and I may take a few notes. Your completion of this interview is voluntary and you may therefore decline to answer any questions in the interview and stop the interview at any time and any of your data will not be used. You may also withdraw from the study up until 4/16/09. If you choose to withdraw, all materials relating to you will be immediately destroyed.

Minimal risk from participating is expected. Great care has gone into wording the questions sensitively however you may experience distressing and painful feelings due to the intense and personal nature of the subject matter. Since this study will be exploring your professional action, possibly in a time of personal crisis, you may have feelings of embarrassment, guilt, or inadequacy while sharing these events. I am hopeful that you will benefit from sharing your experiences and contributing to a research project that will provide important information to the field of social work, particularly existing and future members of the community of mental health providers who have also been diagnosed with a chronic physical illness. Participation will also offer you the opportunity to reflect on your experience, hopefully providing increased clarity.

Strict standards of confidentiality will be maintained throughout the study process. To keep the identity of participants concealed, all of the informed consents will

be kept locked and separate from the rest of the data. Also, after the data is written up, I will present the material in aggregate and any vignettes or quotes will be carefully disguised. I will also ask participants not to identify any client information they may talk about. Any identifying information that appears on the tapes will be deleted and will not appear in the transcripts. Subject numbers will replace the names of the participants on both the tapes and the transcripts. My thesis advisor will have access to this data, but only after any identifying information has been removed. Audiotapes will be kept secure to be erased and destroyed after three years, in accordance with federal policy. Transcripts will be stored on an external hard drive, in a file secured with a password. Once the thesis is complete, this data will be kept on the external hard-drive in a locked file cabinet for three years as required by federal policy. After three years the information will be destroyed by compromising the physical integrity of said external hard drive prior to throwing it away. If I still have need for the data beyond the three years I will keep it secure until no longer needed.

Participation in this study is voluntary. You may withdraw without penalty at anytime before April 16th, 2009. Should you choose to withdraw, all materials associated with your participation will be immediately destroyed. You will need to notify me of your intent to withdraw by using the contact information listed below. Should you have any concerns about your rights or about any aspect of the study, please contact me using the contact information listed below or contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Caitlin Cotter
ccotter@email.smith.edu
(801) 597-3179

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY. PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS. THANK YOU FOR PARTICIPATING.

AUTHORIZATION FOR THE INITIAL INTERVIEW:

Signature of participant: _____

Signature of researcher: _____

Date: _____

Appendix D
Demographics Questionnaire

Age:

Gender:

Race:

Ethnicity:

Degree(s):

Theoretical training:

Current theoretical perspective:

Years in practice:

Type of therapy (short term, long term etc):

Client Population:

Diagnosis:

Year of diagnosis:

Appendix E

Interview Guide

- 1) According to the theoretical orientation under which you practice, how do you typically determine whether a self-disclosure is appropriate or necessary in treatment?
- 2) What factor(s) most often guide(s) your overall decision to self-disclose?
- 3) Please describe how you came to your decision to self disclose information about your diagnosis? Planned/Unplanned?
- 4) What was your intended purpose for disclosing information about your diagnosis?
- 5) What impact did your countertransference feelings have in your decision to self disclose? Explain.
- 6) What type of supervision, if any, did you have during this process?
- 7) Had you discussed your decision to self disclose with anyone?
- 8) Do you consider your illness to be visible to others? Explain.
Was the onset sudden or gradual?
- 9) How has the visibility or non visibility of your illness impacted your choice to self disclose?
- 10) Have you had to take time away from your practice due to your illness? If so, duration/frequency? Role in self disclosing?
- 11) Did any of your clients report sensing that something was different about you before you told them about your illness? Dream content?
- 12) Do any of your clients have a physical illness or have close family members with a physical illness? If so how did this play into your decision to disclose or not?
- 13) What information did you disclose to your clients?
- 14) Did you disclose to all your clients? If not why? If so why?
- 15) Did the information you provide to your clients about your illness vary between clients? Explain.
- 16) What were the reaction(s) of your client(s) after your disclosure?

- 17) Did any of your clients terminate after your self disclosure? Explain.
- 18) How have your self-disclosures about your diagnosis affected the treatment process?
- 19) How do you feel your self disclosure has impacted your clients? Positive impacts?
Negative impacts?
- 20) What would you say was the biggest unforeseen effect of your disclosure?
- 21) Based on your experience self-disclosing this information to your clients would you make any changes in how you use this type of self disclosure with future clients?
- 22) How has your use of self disclosure about your illness changed since you were first diagnosed if at all?
- 23) Reflecting on your situation, what advice would you give to other therapists faced with a similar situation?