PSYCHOTHERAPY 2 (201) 2022
PAGES: 61–69
DOI: 10.12740/PT/150573

Milena Kansy[1, 2], Katarzyna Gdowska[1]

AILING HEALER – DILEMMAS OF A PSYCHOTHERAPIST WHEN FACING HER/HIS OWN ILLNESS

[1] University Hospital in Kraków, Clinic of Adult, Child and Adolescent Psychiatry, Family Therapy Outpatient Unit

[2] Jagiellonian University, Collegium Medicum, Chair of Psychiatry, Department of Family Psychotherapy and Psychosomatics

psychotherapist's ailing
psychotherapist's self-disclosure
dilemmas in the course of psychotherapy

Summary

The paper presents dilemmas and difficulties that a psychotherapist may encounter when faced with his or her own illness, which makes it more difficult or even impossible for him or her to carry on psychotherapeutic processes in the way they were carried up to that moment. It pertains to situations which often require modification in usual practices and arrangements made with patients. Sometimes it requires innovation and breaching of some conventions. Ailing of a psychotherapist makes itself present not only in the therapist's mind but reveals itself in the therapeutic relation with a patient and affects patient's experiencing of psychotherapy and of him/herself in relation with therapist. Psychotherapist's illness and its possible consequences for the treatment are related to the question of therapist's self-disclosure. The psychotherapist is responsible for deciding when, how, and to what extent disclose these circumstances and its potential impact on the course of psychotherapy to the patient. Drawing on our own experiences and literature of the subject, we are aiming in this work to delineate and underscore some conditions that may take place during psychotherapy, including the external reality domain, subjective world of experience and the intersubjective relational domain. We suggest to conceive of these moments as possibly critical ones, that embrace some risks and chances for facilitating a change altogether. Therefore, our ultimate aim in this paper is to put in motion thoughts and second thoughts based on these conditions. The work contains some literature review and ideas from our own psychotherapeutic and supervisory work.

„Separation from own helplessness means also separation from the helplessness of others. Separation from own fragility means separation from the other's fragility.
It means separation from our and their vulnerability,
Our mortality and theirs. […]
If we want to escape helplessness at all costs,
If we do not accept any limitations,
We cannot let others be helpless nor limited".
T. Stawiszyński, Ucieczka od bezradności, s. 312 [1]

Introduction

The issue of a psychotherapist's illness is rarely analysed in the psychotherapeutic literature. It is also rarely or even never presented during trainings for psychotherapists and supervisors. One of the authors of this article had a personal experience of an illness and the other used to supervise an ill psychotherapist, which made them aware of a significant lack of material in this area and made them review the literature of the subject. The possibility to use the literature and experience of other therapists would be very helpful, as the situation of an illness often leaves no time for deeper consideration, as a sudden diagnosis may force the therapist to terminate therapeutic processes or change their form to an online (phone) version.

In this paper, we would like to present dilemmas and difficulties in psychotherapy, that are related to, and result from a psychotherapist's physical indisposition. We are aware that we are unable to touch on every aspect of this issue, nor to provide clear answers to every question. We hope to evoke inner discussions and interpersonal conversations, that will help everyone engaged in similar situations, mainly patients, psychotherapists and supervisors, choose the best path available in this ethically difficult and existentially complicated situation. We focused our attention on therapists working individually, as we recognise that the intensity of dependence and intimacy of this situation requires specific care and attention. Therapeutic work with families and couples present slightly different phenomena and dilemmas that would require a separate presentation.

An ailing psychotherapist — a rarity?

An inner contradiction of this term – an ailing psychotherapist – clearly illustrates the complex nature of this phenomenon that leads to the neglect of the issue. An illness of a person who is there to cure is not obvious in his/her role and can be experienced as an obstacle against the therapeutic function. It is possible that another source of this situation is that an ill psychotherapist requires more attention, whereas traditionally it is only the patient who needs attention. The fact that therapists/ researchers write articles about therapy may further strengthen this attitude. It is also possible that a little number of publications in this area results from the fact that therapists need to invest extra energy into the elaboration of this difficult issue, both in their consultation rooms and clinically, which leaves little space for operationalisation of this experience in the form of a theoretical elaboration [2].

Moreover, the nature of a therapeutic relationship requires therapists to be engaged, stable and predictable, as well as their physical and emotional presence. When participants of a therapeutic relationship consider to terminate it, they usually assume that it will be the result of intentional activity. Therefore it may be difficult to imagine, that a third party – an illness – may play its role in it. Experiences of reality suggest that it is necessary to assume that (1) when the health or life of a therapist is threatened, the basis of the therapy is shaken, and (2) therapists sometimes get ill and this experience penetrates their therapeutic relationship even if they and their patients would prefer to experience them as unbreakable.

Self-disclosure

A psychotherapist's illness may manifest itself in the therapeutic space in numerous ways. Sometimes it may be observed in the body and behaviour of the therapist, or it may be the reason why she/he is absent or unavailable or available in an irregular way, generating a feeling of uncertainty. It may be present silently in the therapist's mind when he/she struggles with pain, anxiety or discomfort. It raises a question of what can be seen by the patient, what is perceived in a conscious and unconscious way, as well as the question of how can a therapist talk about such an intimate issue as his/her health condition. Therapeutic conversations are meant to be about patients and their intimate experiences. On the other hand psychotherapist's health may become the key issue. Therefore it poses the question of what should become the centre of a therapeutic dialog in such an unusual situation. Can a psychotherapist's self–disclosure be at all, or to some degree, appropriate? Can it have a healing value?

Psychotherapist's self-disclosure in the history of psychotherapy

The culture of psychotherapy in the last three decades has been changing towards a more relation-oriented practice, changing its tones. We do not focus here on the broader reasons of these changes. Various modalities underline the role of universal healing factors such as the quality of the relation (alliance), the coherence of the patient's and therapist's objectives, etc. [3]. It leads to more attention being focused on the relation itself and an analysis of the therapist's engagement in it. Being authentic and presenting this authenticity in the presence of the patient is defined as *self-disclosure.* In the field of psychotherapy, there is a continuous, almost paradigmatic debate between two historical extremes: a total withdrawal of all issues related to the therapist, professional neutrality/withdrawal [4], and an idea of "mutual therapy", exchange of –therapist-patient roles, as well as keeping social relations between a patient and therapist with unlimited self-disclosures of the latter [5]. The assumption that a therapist and a patient create a system, that can be best described by means of two-person psychology, where words, meanings, behaviours and emotions are co-evoked and co-constructed, allowed to keep the golden mean. The course and outcome of therapy are influenced in this understanding by the quality of the bond and participation of both subjectivities – therapist's and patient's in a co-creation of the therapeutic couple and therapeutic work [6]. From this perspective, a therapist's self-disclosure of his/her emotions or inner states, that until recently, apart from humanistic approaches, used to be perceived as rather intrusive and distorting, is contemporarily more often recognised as a way of strengthening interpersonal relation and serving a better recognition of the patient in the therapist's mind, which supports its healing function. It is still good to see both perspectives, where an act of self-disclosure can be healing or damaging or can be done spontaneously or purposefully when the therapist wants to be perceived by a patient in a specific way (honest, non-sadistic, responsive, etc.). The consensus here would be to make a decision considering withdrawal or disclosure on the basis of a thorough analysis or a post-factum reflection on the developmental needs of the patient, the moment of the process and the characteristics of the therapeutic relationship [7, 8]. Similarly to all others

therapist's activities presented in the course of psychotherapy, this should be motivated by the patient's welfare and be reflected in order to avoid possible acting outs of therapist's own emotional difficulties.

In the consultation room

In various therapeutic schools, the permanence of the place and time of sessions is an element of the treatment process. The therapist's summer holidays and other breaks in the therapeutic process are planned and discussed similarly to the breaks caused by therapist's pregnancy. A serious illness, that may require a break in psychotherapy (unexpected or planned) or a change of therapeutic conditions (online psychotherapy), faces therapists with some dilemmas. One of them is how does the fact of being ill influence the therapist (both consciously and unconsciously)? How does the participant of therapy experience this influence, and how it is then translated into the common experience of this dyad? It will greatly depend on whether this change is due to a planned treatment and recovery, or results from an accident or an unexpected diagnosis, giving limited time for reflection for both interested parties [9]. We would like to formulate below some dilemmas that psychotherapists may encounter in these cases.

An ailing therapist and his/her patients

What is the experience of an ill psychotherapist? What feelings, sensations, defences are evoked in the therapist's **inner world by an illness**? Getting ill, especially in the period of middle adulthood, when psychotherapist's work in the most intensive way [10], touches the issue of mortality, the unpredictability of life, as well as helplessness. Basing on our work experience, we know how often this leads to denial, avoidance or disavowal of meaning. A more or less conscious anxiety is present in each disease. In our everyday work with people and their inner worlds, we can see how a disease, its discovery, a diagnosis or a lack of it leads to fantasies of injustice, being punished, feelings of abandonment and bad fate, etc. It changes the perception and experience of an inner or external world that may become more dangerous. It may increase the need to create a relational system and focus on own bodily and inner states. It may also lead to denial and delegation of an ill part onto others, e.g. patients. A therapist may start to become anxious about his/her ability to continue their work or be jealous of others' (patients') health and energy [11]. The question of whether these states and defence mechanisms interfere with therapist's ability to work with patients should be discussed and analysed during supervisions and intervisions. It seems that in the face of such grave issues, often handled in an unconscious way, an individual decision might be distorted or shaped by narrowed, conscious or unconscious emotions. A physical illness of a psychotherapist may change his/her self-image not only in the context of general identity but also in the context of professional identity – to what extent a therapist who needs help, might still offer it to others? To what extent his/her visible somatic issues might be troubling to some of their patients?

A psychotherapist may be unwilling to share information considering his/her health issues with supervisors and colleagues being worried that it may cause emotional or professional consequences or as an attempt to protect him/herself and others, who are dependent on them. One of the potential consequences might be shame or fear that the therapist may be perceived as emotionally weaker and less reliable professionally [11]. A decision not to share this information in supervision, nor in the therapeutic team leaves the therapist alone, unable to receive professional support and discuss his/her feelings and opinions. Non-disclosure of psychotherapist's health condition to patients may sometimes result from the lack of preparation for such discussions and difficulties in containing patient's difficult emotions related to the quality of the therapeutic role of a sick therapist – his/her instability and uncertainty, that a psychotherapist with unstable health condition might want to avoid. It might also be understood as a way of protecting patients. The idea of protection by avoiding to inform is often quickly verified by careful observation of patients, who observe psychotherapists on whom they depend, recognizing subtle changes in their mood, appearance and behaviour, not to mention such bold changes as a loss of weight, loss of hair, a plaster cast or a bandage, a change of position in the armchair or repeating cancellation of sessions. Patients not only "feel" their therapists, but they can also find other sources of information about them, which cannot be prevented, although psychotherapists should be aware of it [12]. Those, who support the view that psychotherapists should not disclose their health issues or should do it in the most limited "informative" way predict that such disclosure may carry the risk that a psychotherapist might unconsciously enact the wish to receive support and consolation from the patient, occupying the space that should belong to patients. Between the arguments supporting disclosure for the benefits of the process and those against it (for the same reasons), there will always be the third perspective, where the therapist's disease will be considered to be his/her own and intimate issue, and the level of conscious reflection and conscious experiencing ofit differs between people. It does not support any of these options. Discussions about self-disclosure of therapist's health issues should be seen as an existential dilemma, and its elaboration always depends on the therapist's moment of life as well as inner and external conversations.

The dilemma of **how detailed information about the disease should be revealed** to the patient is related to the manifestations of the disease itself. Is it visible? Can the patient observe changes in the body, appearances, and the way the psychotherapist moves? It is hard to avoid something that is clearly visible, yet there still remains the question of **who should speak first**. Does the therapist introduce the topic? Does she/he wait for the patient's reactions, fantasies and thoughts related to the situation? The general rule that the psychotherapist does not interfere with the imaginative field of the patient with own issues and respects the patient's rhythm of acknowledging (difficult) external reality says that the psychotherapist should wait for the patient's fantasies and associations [11]. Lack of a patient's reaction to visible changes in the psychotherapist is a reaction itself and should become a topic of discussion in the right moment. When the psychotherapist gives time and observes a patient (his/her reactions or a lack of them) in order to talk about their reasons, it gives a therapeutic opportunity to experience and discuss the ways in which the patient's perception of reality is acknowledged, denied or distorted and its developmental sources. Yet, this is possible when the psychotherapist's health problem is not sudden or

dramatic. Relational way of thinking in various therapeutic modalities acknowledges the fact, that a psychotherapist is unable **not to** interfere with the patient's world. Psychotherapist's presence, participation and influence is a fact in itself. They introduce into the session plenty of sensations and references, both silently, verbally and kinesthetically. Therefore some opinions (coming from various psychotherapeutic modalities) suggest that the psychotherapist should introduce the issue of his/her illness [13] or can be even made responsible for that. Confrontation with an illness, pain, suffering and mortality often changes a psychotherapist's existential point of view and his/her perspective. There are some examples of changes in the work of a psychotherapist diagnosed with cancer (and a perspective of death) with patients, with whom he talked early enough **about his disease**, its **nature**, and its **consequences** for them [14, 15].

It seems that **the therapist** needs to initiate self-disclosure of his/her health condition and some details of it, when it is sudden, and it is clear that it will change the rhythm of psychotherapy and may require to prepare a patient for separation from the psychotherapist. In such cases, psychotherapists should provide enough time (whenever possible) to talk about the patient's feelings, impressions and fantasies. Waiting for the patient's initiative may leave little or no space for emotional work related to separation, and if the psychotherapist waits for the patient to see and guess what is going on, it may lead to the repetition of a parental attitude of avoiding and neglecting key issues, that may further lead to a conscious or unconscious psychic injury [16].

A patient and his/her ailing psychotherapist

A patient whose psychotherapist becomes ill may experience various emotions, depending on what information he/she receives, the stage of psychotherapy, the quality of therapeutic relation, as well as own experiences and fantasies that may be evoked by this situation. Patients' reactions are, to a great extent, a result of their history and contemporary transference relationship [2]. Psychotherapist's disease and pauses in psychotherapy may evoke **patient's anxiety and uncertainty**, whether an ill therapist is able to work and contain the patient's emotions. Depending on the stage of psychotherapy and therapeutic issues discussed when the psychotherapist discloses his/her illness, patient may feel guilty, that **his/ her behaviour might** be **the source of the psychotherapist's weakness or illness**. An ailing psychotherapist may be experienced as weak, too absorbed with him/herself to take care of the analysis of patient's inner world [17]. A patient may also struggle with **anger or helplessness with the abandoning therapist**, who is absorbed with their own health. The feelings of the patient may be further transformed. Helplessness may be changed into the wish to take care of the therapist, and anger may turn into excessive compassion or pity. Even in the presence of these secondary emotions, which are a reaction to primary processes (anger, helplessness), the therapist in his/her mind should not forget that compassion and empathy are still possible reactions to this existential situation in the whole repertoire of patient's emotions. Patients may feel **disappointed with sudden changes** of settled rhythms and try to protect him/herself against further unpredictability by expecting that therapists will give them some promises about the future. A break in psychotherapy or remote psychotherapy may evoke **feelings of longing and remind patients of earlier**

losses and worries about the continuity of relation. Other patients may present distance and declare that they "have no needs". A switch to remote sessions, when we inform patients about its health-related reasons, evokes numerous ideas and fantasies of what might be going on with the therapist who is invisible (phone sessions) or partly visible (audio-visual sessions). It may evoke the feeling of being excluded from some information about the psychotherapist's indisposition (not seen on the screen). Another source of painful, loss-related emotions, is a loss of shared physical space, looking together in one point in space, rituals related to approaching the consultation office and leaving it, which for many patients form an important, integrative part of therapy.

A patient whose psychotherapist is ill must cope with him/her by discovering new aspects of self or by modifying present ones [17].

An attempt at a summary

Rachman [18] writes that psychotherapist's self-disclosures in the course of psychotherapeutic process are unavoidable, however, they should always serve facilitate of the process itself and not the therapist's enactments nor fulfilling his/her needs. It is important to consider empathetically what kind of information will support the development and treatment of an individual patient [17].

Dilemmas of psychotherapists who are about to share health-related information with their patients or have just begun to do so, are divided by Farber [19] into three competing areas – questions: 1) how to remain authentic, 2) how to retain professional boundaries of therapy, 3) how to respond to the patient's needs related to the phase of psychotherapy [2] and his/her diagnosis, when something real and concrete (not symbolic) is taking place in the consultation office.

There are no categorical answers. Just a few clues: not to take decisions individually, to remember that a psychotherapist has unconscious aspects of his/her psyche that are unconscious to him/herself. When the psychotherapist has a strong feeling that some action is best for the patient, one might speculate if it is not caused by a need of distance, protection of therapist's omnipotence, or an inability to acknowledge an own vulnerability and weakness, or some other avoidance and denial.

Apart from individual discussions of psychotherapists who are touched by an illness at a certain moment of their life/work, it would be important to open a broader discussion in the professional environment. If this issue brings about so many uncertainties, maybe the situation of disease and death of a therapist should be introduced into the program of therapeutic courses, or should it still remain a topic that may be discussed only in supervisions? Should therapeutic associations prepare guidelines of what to do in the cases of a therapist's illness? Should his/her patients be supported by a supervisor or by another therapist selected earlier individually? Who should inform patients in case of sudden illness or death of a psychotherapist? This dilemma would have a number of solutions. It is different when someone works in private practice or in an institution, where patients are in contact with other specialists and the institution's secretary/registration. This dilemma has been discussed by various authors, who posed the question, of whether every therapist

should consider, from the very beginning of working with his/her patients, how to take care of them in the case of (always possible) death [20,21] and should these precautions be taken individually, or should their patients be informed about that.

These and other dilemmas may be worth considering in broader therapeutic environments, professional associations of various modalities, and definitely in the minds of individual therapists in various moments of their professional development and physical conditions.

Literature

1. Stawiszyński T. Ucieczka od bezradności. Kraków: Wydawnictwo Znak Literanova; 2021.
2. Schwartz HJ. Illness in the doctor: implications for the psychoanalytic process. J. Am. Psychoanal. Ass. 1987; 35(3): 657–692.
3. Czabała Cz. Czynniki leczące w psychoterapii. Warszawa: Wydawnictwo Naukowe PWN; 1997.
4. Freud S. Recommendations to physicians practicing psychoanalysis. Standard Edition, 12. London: Hogarth Press; 1958.
5. Ferenczi S. Confusion of tongues between adults and the child (1933). W: Balint M. red, Final contributions to the problems of methods of psychoanalysis. New York: Basic Books; 1955.
6. Wallin JD. Przywiązanie w psychoterapii. Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego; 2011.
7. Greenberg J, Cheselka O. Relational approaches to psychoanalytic psychotherapy. W: Gurman AS, Messer SB, red. Essential psychotherapies: Theory and practice. Guilford Press; 1995, s. 55–84.
8. Orange DM, Stolorow RD. Self-disclosure from the perspective of intersubjectivity theory. Psychoanal. Inq. 1998; (18): 530–537.
9. Bram AD. The physically ill or dying psychotherapist: a review of ethical and clinical considerations. Psychother. 1995; 32(4): 568–580.
10. Guy JD. The personal life of the psychotherapist. New York: Wiley and Sons; 1987.
11. Counselman EF. The ill therapist: therapist's reactions to personal illness and its impact on psychotherapy. Am. J. Psychother. 1993; (47): 4
12. Silver ALS. Resuming the work with a life-threatening illness. Contemp. Psychoanal. 1982; 18(3): 314–326.
13. Weinberg H. Illness and the working analyst. Contemp. Psychoanal. 1988; 24: 452–461.
14. Friedman G. Impact of a therapist's life-threatening illness on the therapeutic situation. Contemp. Psychoanal. 1991; 27: 405–421.
15. Halpert E. When the analyst is chronically ill or dying. Psychoanal. Quar. 1982; (51): 372–389.
16. Morrison AL. Doing psychotherapy while living with a life-threatening illness. W: Schwarz HJ, Silver AL, red. Illness in the analyst: Implications for the therapeutic relationship. New York: International University Press; 1990.
17. Parkinson J. The ill psychotherapist: a wounded healer. W: Burke J. The topic of cancer. New perspectives on the emotional experience of cancer. London: Karnac; 2013.
18. Rachman A. Judicious self-disclosure by the psychoanalyst. Int. Forum Psychoanal. 1998; (7): 263–269.

19. Farber BA. Self-disclosure in psychotherapy. New York: The Guilford Press, 2006.
20. Cohen J. Psychotherapists preparing for death: denial and action. Am. J. Psychother. 1983; 37(2): 222–226.
21. Tallmer M. The death of an analyst. Psychoanal. Rev. 1989; 76(4): 529–542.

Address: milenakansy@gmail.com