The Ill Therapist: Therapists' Reactions to Personal Illness and Its Impact on Psychotherapy

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When a therapist becomes ill, the therapeutic relationship is affected as much by the therapist's manner of handling the illness as by the illness itself. Countertransference may cause mishandling. Illness challenges a therapist's defenses against neediness and helplessness; feeling vulnerable is uncomfortable; and the seriousness of a threat may be denied. Therapists who avoid their own feelings about being ill deprive their patients of important opportunities to work through its meaning. An ill therapist must permit all expressions of patient affect. Therapists need to plan ways to manage their practices in the event of illness. Psychotherapy training programs should address therapist-illness issues for therapists and their supervisors.

Sooner or later most people get sick. If they are fortunate, the illness is brief, and they recover. In other instances, the illness is long term, recurrent, chronic, or even terminal. Although they might wish otherwise, therapists are no less vulnerable to these exigencies than other human beings. However, the nature of psychotherapy creates unique and potentially serious problems when a therapist does become ill.

The purpose of this paper is to explore some of the problems therapists confront when they become ill. While it is always tempting to focus on the fears and the well-being of the patient, in this paper we will discuss the conscious and unconscious dilemmas for the therapist and the impact they may have on patient care. We will also offer some suggestions for managing countertransference and professional concerns as well as the needs of the patients in one's practice.

Our focus is on the internal, interpersonal, and practical management of serious physical illness. We will not examine the meanings of healthy medical

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interruptions, such as the birth of a child nor the multitudinous meanings of the therapist illness for the patient.

THE SIGNIFICANCE OF INTERRUPTIONS

One way in which therapy is different from virtually any other profession is in the lack of available substitutes. When a teacher calls in sick, a principal can call a substitute teacher. Even a physician can refer patients to a covering physician or emergency room. While a psychotherapist can arrange temporary coverage for a practice (and frequently does during planned absences), there is no way to truly substitute for the therapeutic relationship that has been forged between the therapist and patient. This alliance is mutually created and forms a unique holding environment for the work of therapy. It cannot be easily replaced.

The circumstances of the interruption no doubt dictate the extent of the shock to the relationship. A planned surgery, announced well ahead of time, is a very different experience for a patient from a sudden phone call saying that one's therapist has been taken ill and will be unavailable for an undetermined time. These scenarios no doubt are very different experiences for the therapist as well. It is important to remember, however, that a long warning time is not necessarily helpful if the time is not used optimally by both parties. Similarly, an emergency, while always shocking, may pass well and be processed by both therapist and patient as part of the universal human problem of life's unpredictability.

The foundation on which psychotherapy rests is interpersonal trust, and any deviation in the therapeutic relationship can undermine this foundation temporarily or permanently. A therapist's illness *per se* does not automatically damage the basic trust between therapist and patient. However, the ways in which a therapist chooses to manage the many issues created by sudden or planned illness or hospitalization are of paramount importance for maintenance of the trust between patient and therapist and can have an enduring effect on the psychotherapy. The management of these issues is complicated by the fact that relatively little has been written to guide the ill therapist in clinical decisions and perhaps even more by the enormous potential for countertransference created by personal illness.

In this paper we will discuss various countertransference ramifications related to illness in the therapist. We will also examine common dilemmas for the ill therapist and suggest ways of thinking about them.

COUNTERTRANSFERENCE ISSUES IN THERAPIST ILLNESS

The subject of therapist illness and its implications for treatment was relatively uninvestigated until the past decade. Friedman[1] counted only nine

articles written about therapists' personal experiences with illness. Halpert[2] noted that even such a prolific writer as Freud, though chronically ill with cancer of the jaw for the last 17 years of his life, never wrote about the effects of his illness on his work.

Abend[3] speculated that countertransference problems are behind the lack of papers on therapist illness. He suggested that people are reluctant to write about this topic for a variety of reasons. His discussions with colleagues indicated that most used a "common sense" approach to handling their illness but were reluctant to write about their experiences. He surmised that they feared an unconscious gratification of their needs by retelling the facts, as well as discomfort about personal exposure. Furthermore, as Friedman[1] has observed, illness is hard enough to live through, much less write about.

Illness, or even thinking about illness, can stimulate a variety of potential reactions for a therapist, including a challenge to one's defenses, shame and envy, and realistic worries about one's clinical decisions and overall therapeutic practice. These various reactions will be discussed with respect to their implications for the therapist's management of personal illness.

Therapist Defenses

Professional helpers have typically organized their personalities around being useful, competent, giving, and not demanding. They prefer to cope with anxiety by being givers, not receivers. When illness deprives clinicians of these customary buffers against anxiety, they may regress to a more primitive level of defense. The voluntary and appropriate suppression of the clinician's agenda in the therapy hour readily can disintegrate into a denial of mortality and helplessness on a much grander scale. The stage is then set for an unconscious collusion in the transference/countertransference. Patients like to see their therapists as invincible and try hard to deny their vulnerability to mortal circumstances. It is very tempting for therapists to agree with this flattering view, and to deny their own vulnerability to illness, aging, and inevitable death.

Fieldsteel[4] wrote of her surprise at the pervasive denial of aging and possible illness among analysts. Younger analysts treated these concerns as "hypothetical questions," while among the older analysts "It seemed as though there was the unspoken assumption—one goes on forever." (p. 428). Many authors[1,3,5] have suggested that this denial of mortality is yet another reason for the relative paucity of literature on therapist illness and its effects on treatment.

Another variant of this denial has to do with fantasies about who gets sick. Although many people consider illness to be a topic for "older" therapists, therapists at all ages may need to face this issue. One of the

authors became ill with pneumonia at age 37 and experienced many of the countertransference issues discussed in this paper. Supervisors may need to advise students on how to handle their illness (including miscarriage or infertility investigation) with their patients. One of us was called by a supervisee who said she was about to go to the hospital because she was having a miscarriage. She asked for immediate advice about what to tell her patients.

Similarly, there exists a fantasy that any illness has come on gradually, and so one can be prepared (i.e., remain in control). One of us supervised a 34-year-old therapist who developed a life-threatening condition requiring emergency surgery and a prolonged recovery period. She needed help working through with her patients the meaning of her sudden unavailability and communication to them through a colleague. One of the authors found herself facing serious surgery several times in one year, having had little warning, and faced a period of sharp anxiety and confusion around coping and recovering while arranging for the care of herself and her patients.

Challenging one's denial about illness leads to examination of other aspects of one's role as a therapist. How omnipotent must one be? When does being responsible slip into neurotic behavior such as seeing patients when one is ill? Therapists who are ill lose an occupationally familiar sense of omnipotence and a feeling of being above what happens to regular people, and that can be a painful loss. Kriechman[6] discussed the omnipotent defense of "personal specialness" that many analysts erect against their fear of death. He noted that "[I]n recognizing the limits of a belief in personal specialness, a therapist enables the patient to work through fear of death and dying as well as experiences of early loss. Both patient and therapist eventually must lose each other. This cannot occur when both cling to the magic of the therapist's omnipotence as a screen against death—and life" (p. 385).

During a bout with pneumonia Chernin[7] confronted his previously unconscious use of omnipotence as a defense mechanism; "illness affects patients, not therapists" (p. 1328). He initially denied his worsening condition until a patient expressed concern about his cough. He then noted the following stages in his emotional state: depression (after his diagnosis), anger, isolation, counterdependency struggles, and a final acceptance and working through, assisted by writing an article about his experience.

Finally, ill therapists may project their own feelings about their illness onto their patients and completely lose empathic contact with the patient's experience. Halpert[2] wrote movingly about a patient who came to him after her analyst had died. The analyst never confirmed her suspicion that he was mortally ill, even though she had brought up her concerns during treatment.

Treatment ended when the analyst's wife called the patient to say that her husband was too sick to continue seeing patients. One month later she read his obituary. Hopefully, such extreme mistreatment of patients in service of one's own narcissistic denial is very rare.

Shame and Fear

The shame and fear that the ill therapist may experience when confronting colleagues as well as patients can be a serious factor in the aftermath of a serious illness, especially a life-threatening one. The therapist may feel that he or she is now a pariah in the eyes of colleagues who (the therapist suspects) would rather not have their own denial and omnipotent fantasies challenged. The physical and psychological exposure that accompanies illness may threaten a therapist's self-esteem and be projected onto friends and colleagues. It is crucial that the therapist address these powerful feelings rather than act them out defensively.

Realistic Concerns and Clinical Judgment

Ill therapists' anxieties may not only be a projection, however. Most of us would hesitate before referring a patient to an ill colleague, unless we can be pretty certain of a speedy recovery. The ill therapist may realistically fear a diminishment of professional and financial options, at a time when these are most needed. Anxiety about a declining practice may further cloud the ill therapist's clinical decisions about such matters as accepting new patients and managing terminations, or may push a recovering therapist to return to practice prematurely. Salaried psychotherapists who do not have to worry about continuing to receive referrals may be less vulnerable to feeling excluded from their professional community. Silver[8] wrote that she returned to her salaried job much sooner after her illness than to her private practice. The job provided a much-needed sense of community, while she felt too impaired to charge her private patients her usual fee.

Abend[3] noted the danger of conflict between the "legitimized gratifications of illness and convalescence" (p. 370) and a reaction formation against these gratifications that drives the therapist back to work too soon. However, he warned that the biggest danger was in the area of clinical judgment; therapists experiencing their own illness must assess the needs of each patient very carefully at a time when they are likely to be less objective and reliable than usual.

Evidently the therapist's illness and its impact on psychotherapy have powerful conscious and unconscious meanings for the therapist. In addition, the realities of the illness create many treatment decisions that must be made. Many of these choices may have dramatic and/or long-lasting reper-

cussions in the therapy. It is crucial for the therapist to make these decisions in a manner as free from countertransference encumbrance as is humanly possible and to be aware of the ramifications of any decision. We recommend that therapists not carry the burden of these decisions alone but should turn to trusted colleagues, supervisors, or personal therapists for help.

DILEMMAS FOR THE THERAPIST

Depending on the nature of the illness, a variety of theoretical and clinical dilemmas are created. Concerns for the therapist fall into two major categories: (1) how much (if any) information about the therapist's illness to give to a patient, and (2) how to work therapeutically with the patient's reactions. We will discuss the following aspects of these concerns: the ambiguity of theory about giving factual information, the therapeutic work with patients around the illness, and the ethical demands for the appropriate management of patients.

Giving Information about the Illness

The literature on therapist illness raises many questions about what ill therapists should tell their patients.[1,3,8,9,10] The debate revolves around the question of therapist opacity or transparency, of responsiveness versus abstinence toward the patient, and on the need to not intrude on the patient's field of associations with the clinician's own agenda. A serious illness in the therapist wreaks havoc in all these dimensions. The lack of clear guidelines about the theoretical implications leaves the clinician ill prepared to plan carefully or move confidently when decisions must be made. For example, if the interruption is planned, as in the case of elective surgery, when does one tell patients? How does one decide that timing? If sudden, the questions of who should tell patients and how much information a third party should convey must be addressed. Should a therapist ever tell patients anything about the nature of his or her illness? If so, when?

Abend[3] addressed the question of giving factual information about a therapist's illness to patients. He recommended that any decision include consideration of the following: the need to dilute patients' anger, the invitation to offer sympathy, the avoidance of patients' death fantasies. In the case of his own illness, he had originally planned to tell none of his analytic patients and only two psychotherapy patients with whom he deliberately had limited the transference. However, he found that some patients with medical background observed his signs of illness and so he decided to give specific information on a case-by-case basis. This approach, although not originally planned, seems to reflect an appropriate flexibility based on his patients' needs rather than his own.

Kriechman[6] wrote that "the most important technical issues are how much factual information to transmit and how much the patient should be encouraged to deal with the conscious and unconscious reactions to the therapist's illness" (p. 383). While some analysts have found danger in gratifying their needs to be missed and needed, he found the hardest part for him was to recognize and analyze his patients' defenses against their individual reactions to his illness. His conclusion was that dealing with such feelings ended up facilitating their treatment, and he recommended this approach.

Exploring Patients' Reactions

Once the decision has been made about how much information to give one's patients, the challenge for the ill therapist is to remain truly neutral and to hear all expressions of affect with equal respect and interest. Silver[8] recommended that analysts struggling with their own illness be alert to their patients' ambivalent feelings about their illness. She particularly noted "the patient's simultaneous wishes to nurture and terrors of destroying his or her parents in the transference" (p. 167). One of us also noted that in the wake of her illness, patients tended to express concern, to "worry" about her, to wish her well, etc. It was necessary both to think about reaction formation in these expressions of concern, since these same patients were also at times very angry, and to recognize the very real capacity for concern they were demonstrating toward the therapist.

Halpert[2] wrote that patients who fear their own aggressive wishes can have a particularly difficult time with a therapist's illness and may thus benefit from exploration of their ambivalent feelings about the illness. In other words, at a time in their lives when they may feel very vulnerable and anxious, therapists need to be able to explore and accept their patients' aggressive as well as loving wishes.

Finally, an additional complication is sorting out ways in which the statements, while seemingly about the therapist, are in the long run always about the patient. Morrison[9] wrote poignantly of this dilemma in her account of a therapy hour during which she was exhausted from chemotherapy for her breast cancer. The patient was not aware of her illness and treatment and was very concerned about her exhaustion. After considerable internal debate, Morrison decided against revealing her illness, and the patient eventually concluded that she must be pregnant; "A wonderful reminder, I thought, that it's what is on the patient's mind that matters" (p. 232).

In summary, if a patient has been told about the therapist's illness, then it is the job of the therapist to work through with each patient what the illness

has meant. This process benefits the therapist as well as the patient, as it is a form of healing and produces a sense that work is returning to normal. Our own experiences have suggested that there is no set time over which this working through occurs, and it may return around other absences, such as vacations, or anniversaries of the therapist's illness.

Ethical Responsibility

Every therapist with regular psychotherapy patients needs to be prepared ahead of time for illness or unavoidable absence. It is our ethical responsibility to see that our patients are provided for in case of our emergency. Additionally, all therapists should consider the possibility of their dying with a caseload of patients who need to be notified and cared for. A list of one's current patients, phone numbers, addresses, and a brief summary of their situation should be available to a designated colleague in case of emergency. Each of us has a trusted peer supervision group who know the location of her patient files and who have agreed to assume emergency responsibility for her caseload.

The possible loss of a therapist is a particularly poignant matter for those patients in group psychotherapy, who may lose the whole group if they lose the therapist. Several patients in a group with one of the authors were deeply worried that they might never see one another again after having spent many months developing intimacy and trust . . . a loss that made the therapist's illness a far greater threat. Group therapists should be aware of this potential loss of group as well as of therapist and should consider providing a substitute group therapist or encouraging healthier therapy groups to meet leaderless for a while.

The question of the ill therapist continuing to see patients has been addressed by several authors. Halpert[2] pointed out that the whole situation is different for therapists who know they are going to recover than for those who are not. He felt that chronically ill therapists should not continue to see patients because of their inevitable narcissistic withdrawal, which inexorably saps their capacity for empathy, neutrality, awareness of their own feelings and reactions, and especially for tolerating aggression. Furthermore, if an illness is known to be fatal, this knowledge places too great a burden on the patient. Halpert also noted the potential countertransference problem for ill therapists created by their envy of their healthy, vigorous patients.

Grunebaum[11] wrote about his experiences with seeing three patients in his hospital room, and subsequently his home, after a serious car accident. He said that each patient dealt with his injury in a "dynamically characteristic way." Grunebaum wrote that he feared that he might be overextending his

personal limits and exposing his weakness for exhibitionistic reasons rather than in service of the psychotherapy. As a therapist he had always taken the stance of a person who attempted to face and deal with his problems, not that he was above having problems. He concluded that seeing patients from his hospital bed (once he was free of pain) was therefore consistent with his stance, and he found no ill effects from this choice. In fact, he felt that his openness accelerated therapy in a few cases.

SURVEY OF THERAPISTS WHO HAD EXPERIENCED ILLNESS

The authors decided to expand the scope of this article beyond the usual first person account of a therapist's illness and asked a small number of their colleagues to complete a short anonymous questionnaire about their personal experience with illness. This was not a random sample. All were friends of one or both of the authors and were experienced psychoanalytic psychotherapists. All were known to have had a personal experience with either illness or surgery that had required a significant interruption in their work as therapists. Although 22 questionnaires were distributed, only 9 were returned. Since these were not lengthy, arduous questionnaires, we interpret this poor return as indicative of how difficult the topic can be for people to think or write about.

Information Given

The questionnaire asked how much information patients had been given when each therapist had become ill. All who responded had given some information to their patients but tended to have kept it to a minimum. One therapist who had had emergency surgery replied: "Some absolutely didn't want to know—some who were medically trained felt more reassured with details—a few of the more disturbed clients needed to know concrete details."

Another therapist wrote: "I basically told patients I was having a routine surgery. Patients who were sicker and could not tolerate any ambiguity were told the nature of the surgery." Another told one patient more facts than his other patients because the patient had a history that made explorations of his fantasies about the therapist's illness unproductive. There was no discernible difference between sudden and planned hospitalizations as far as the information-giving processes.

Countertransference

Decisions about what to tell were less troublesome than the various countertransference ramifications. This finding supports Friedman's[1] suggestion that anxiety about technical problems is often a projection of more

general anxiety about the illness and its meaning. The questionnaire asked "What were the hardest parts for you?" Several wrote about the meaning of giving up work that they liked. One expressed anxiety about returning: "I felt as if I wouldn't remember anything about how to be a therapist. It wasn't as hard as I had anticipated, although I was physically tired all the time." Another replied simply: "My mortality." Another found the fear of surgery distracting in the weeks before the operation. A related dilemma was the impulse to reassure patients who were anxious about the impending surgery.

One therapist who had experienced sudden and severe illness hinted that his denial had been operating as he kept having to tell patients that he would be "out still a bit longer." "I minimized to myself how ill I was and ended up teasing my patients about my expected return." This therapist wrote that his biggest countertransference problem after returning to work was that "I was so glad to be back at work that I didn't appreciate how ungrateful my patients were!"

Patient Reactions

We also asked "What were the hardest parts for your patients?" Several reported that their patients had been very worried about their illness and feared it was more serious than they had been told. Other therapists wrote about their patients' guilt over their angry fantasies and feelings. This observation supports Halpert's thoughts about the importance of patients' aggression.

Two therapists had needed to have colleagues do an emergency notification of their patients. One therapist wrote that as a result of the experience he recommends keeping a current list of his patients and their phone numbers. Therapists who do not have an office secretary often do not have such a compilation readily available.

CONCLUSION AND RECOMMENDATIONS

The topic of therapist illness and its implications for treatment is not an easy one to confront. While a number of authors have written about their experiences and have begun a body of literature by doing so, more is needed. Therapists do become sick, and some do not recover. Eventually, this is something we all face, on a personal if not professional level. We need to know more about how our colleagues have handled their experiences with illness in order to build a solid base of literature.

We also recommend that psychotherapy training should include attention to management of therapist crisis, such as illness, and related patient-care issues. It is important for therapists at all levels of experience to have thought ahead about these concerns so that when they are on the spot they can make

appropriate decisions and recommendations. Supervisors are frequently asked for consultation about what information to give patients and often must to do this immediately; they need to be prepared to give this type of advice. Supervisors also need to remember that their supervisees may already be functioning at a somewhat regressed level by the time they call and that they should tailor their advice accordingly.

Finally, we believe that the interruption of treatment due to therapist illness is as big an event for the therapist as it is for the patient. There are many defenses that surface around illness. While it is obviously important to process the patient's reaction to the experience, it is probably equally important for the therapist to have the opportunity to process his experience. Trusted friends, colleagues, supervisors, and personal therapists can all offer the recovering therapist a place to "work through" the experience. The biggest danger is that feelings will remain unconscious through a patient-therapist collusion to keep painful feelings buried. If this happens, the treatment will be stuck and unproductive.

The alternative, for patient and therapist to work through the feelings stimulated by the therapist's illness, enhances self-knowledge and leads to greater understanding of a powerful relationship between two human beings.

SUMMARY

This paper examines the potential countertransference problems therapists face when they become ill. Personal illness creates conscious and unconscious dilemmas for therapists, and the psychotherapy relationship may be strongly affected by the ways in which the dilemmas are managed.

Psychotherapy is a relationship based on trust. A therapist's illness does not necessarily damage the trust that has been developed; however, the handling of the illness and interruption can create a major rupture in the relationship. Alternatively, the therapist's illness can create a useful opportunity for therapeutic work. Successful management of countertransference is a crucial ingredient for the latter outcome.

Relatively little has been written until recently on countertransference aspects of therapist illness. Available literature has noted such defenses as denial, omnipotent fantasies, and reaction formation against dependency and weakness. Illness has been seen as a problem for "older" therapists, but, in fact, illness can occur at any age. Illness may cause a defensive withdrawal from one's patients and in its most serious instance lead to total empathic failure.

Clinical concerns for the ill therapist fall into two categories: how much (if any) information to give patients about the illness and how to work

therapeutically with patients' reactions. While there are no clear guidelines, we recommend a flexible, common sense approach with the central focus always on the patient's reactions to information or to changes in the therapy. The foundation for decisions about information and for subsequent processing of reactions must be the therapist's own awareness of countertransference. We recommend consultation with trusted colleagues or supervisors. In addition, we emphasize the ethical responsibility every therapist has to provide for patients in the event of an emergency *ahead of time.*

Finally, we surveyed a small number of experienced therapists who were known to have had personal experience with illness. The results indicated that decisions about giving information were not difficult. However, the countertransference reactions of anxiety, denial, sadness, and avoidance (of patient anger) were often troublesome.

We recommend that psychotherapy training include management of therapist illness. We also recommend that supervisors be familiar with the countertransference aspects as they may be called on suddenly to give consultation. Our conclusion is that therapist illness is as big an event for the therapist as it is for the patient, and we hope that a body of literature will be developed on this important topic.

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