I WAS CONFRONTED with the issue of serious illness several years ago when a lump in my breast was diagnosed as an early stage of breast cancer. I underwent several outpatient procedures during the month after the initial biopsy, which necessitated my canceling and rescheduling sessions with some patients. Treatment for the cancer included chemotherapy and radiation, administered over a course of approximately eight months. My appearance changed; I lost my hair as a result of the chemotherapy and wore a wig.

A personal crisis causes a disruption to the state of ongoing regularity and relative predictability of one's life. It is a time of acute emotional disequilibrium in which the boundaries that people set up to protect themselves are bombarded by the presence of immediate situational stress. Psychoanalysts must contend not only with the explosion of the regularity and dependability of their personal life caused by the crisis, but also with the anxiety of disruption to their patients. The crisis fires questions that need to be immediately answered. Will patients' sessions need to be canceled? How will the cancellations be explained? What, if anything, should patients be told about the reasons behind the disruption to the predictability of their scheduled appointments?

How much explanation an analyst might offer to a patient is largely influenced by the analyst's theoretical orientation. The classical position, that patients be shielded from the analyst's personal life in order to protect the natural unfolding of the transference (see the literature review that follows), has been generally accepted until recently. Gradually, since the late 1960s, there has evolved a growing body of writing from within the interpersonal-relational analytic perspective that differs from this.
strict position. Interpersonal-relational analysts have written about how analysts' disclosure of their own subjectivities, including their experience of personal crises, may be utilized to potentiate growth within the analytic work. Through an exploration of the impact on the analytic work of my own health crisis, this article continues the development of this interpersonal-relational theme.

**Serious Illness in the Analyst: Literature Review**

Within the Freudian literature, the topic of serious illness in the analyst had largely gone undisclosed until Dewald (1990) broke the ground in an article discussing his life-threatening illness and its implication for his work. Whereas Dewald considers that self-disclosure to patients in supportive therapy may have merit, he argues against its use with analytic patients. He cautions that to give such factual information would contaminate the patient's transference distortions and "interfere with [its] subsequent evolution, analysis, and working through" (p. 77). Abend (1990) questions whether the proffering of any factual information about the analyst's illness, more than "the fact of interruption and the resumption of sessions" (p. 105) is beneficial to patients. Abend contends that powerful countertransferential elements, mobilized by the analyst's experience of personal illness, corrupt the judgment and objectivity necessary to evaluate the effects of self-disclosure. Lasky (1990) advocates that the analyst weigh both the need of the patient for explanation about an extended absence and the need of the patient for a neutral analytic atmosphere before making a decision about how much to divulge.

Contrary to the classical reserve concerning the analyst's anonymity, contemporary analysts of the interpersonal-relational model view the voicing of the analyst's subjectivity as integral to the analytic dialogue. Sullivan's vision of the analyst as participant-observer laid the groundwork for elaboration of the interpersonal-relational position, placing the interaction between the analyst and the patient at the crux of analytic investigation (Levenson, 1972; Gill, 1983; Ehrenberg, 1992; Hirsch, 1992; Aron, 1996). Challenges to the belief of the existence of any measure of analytic anonymity (Renik, 1995) underlie the proposition that the analyst may further analytic work through the selective use of self-disclosure (S. Gerson, 1996), including that of serious illness. While the interpersonal-relational school has never considered self-disclosure "standard" analytic technique (Hirsch, 2001), those interactional, real events between the patient and analyst are frequently viewed as precipitants to the patient's growth.

What might prompt self-disclosure of illness? Interpersonal-relational analysts have voiced varying reasons for their choices to divulge information about their illness to patients. Searles (1975), who believed that the origins of severe psychopathology could often be found in the child's unsuccessful attempt to be useful to the parent, was the first to voice the benefits to an analysis when a patient is successful at aiding the analyst. Singer (1971), who revealed to patients his experience of his wife's illness, objected to the belief that analysis should be a "one-way street" in which only the analyst engages in the helping. Singer, in accordance with Searles (1975), proposed that a patient may benefit from the opportunity to demonstrate strengths of compassion and helpfulness toward the analyst.

Friedman (1991) and Morrison (1997) revealed their diagnoses of breast cancer to protect new patients with histories of multiple losses from a possible repeat trauma of working with a therapist whose life may be at risk. Others have revealed information due to changes in the treatment frame, for example, as a rationale for the need for a temporary move of office (Gerson, 1994) or to explain extended absence (Silver, 1990).

Not only the analyst's physical unavailability, but also psychological unavailability have prompted analysts to disclose their illness to patients. Schwaber's (1998) decision not to disclose, but to contain her own anxiety during a prolonged period of decision making about her breast cancer treatment, contributed to a feeling of remoteness in her work with patients. Only after Schwaber realized that one of her patients might be at risk due to her own "affective isolation" did she attempt to speak of her illness in order to bridge the gulf between her patient and herself.

Barbara Pizer (1998) coined the term "inescapable" self-disclosure to describe a particular category of self-disclosures: "the analyst's action resulting from the presence in the treatment situation of a circumstantial event whose disruptive properties in the mind of the analyst can be handled only by verbal acknowledgment" (p. 194). During Pizer's experience with breast cancer, she revealed her illness to her patients after having concluded that the effort to refrain from mention of it—to not speak of the "elephant in the room"—appeared more disruptive to the analytic interaction than was verbal acknowledgment of it. It is likely that most analysts who have disclosed their illness to their patients have done so out of the urgency of its felt inescapable presence.
According to the literature, each analyst's own subjective experience, idiosyncratic to the combination of the psychology of the analyst, the course of her illness, the patient, and the analytic process, determines whether or not self-disclosure becomes inescapable. But how reliable is the analyst's ability to assess whether self-disclosure is warranted at a time of such vulnerability? Given that the analyst's inescapable self-disclosure has far-reaching implications for an analysis, it may be worthwhile to further unpack the term, to look closely at its layers, and to attempt to delve more deeply into what the analyst is intending in its use. In an effort to further examine the complexities that surround the process of inescapable self-disclosure, I shall begin with my own experience.

Undependability and Anxiety Escalation

During the month following the discovery of a lump in my breast, it felt urgent to me to schedule immediate medical consultations and procedures. The regularity of my schedule with patients was disrupted by my need to consult with physicians. This appeared to me to be inescapable. I typically telephoned those patients whose appointments conflicted with my doctors' appointments with a statement such as, "I need to cancel and hopefully reschedule our appointment next Wednesday." I had to reschedule some patients' appointments two to three times over the course of a few weeks. My patients had come to depend on me for my consistency; in my mind, they were no longer able to do so.

My anxious reverie went along the following lines: "Patients must find it so unlike me to be canceling their appointments. I wonder if they are alarmed that I have broken into the comfortable regularity of our sessions? Or angry? Do they view my changing their schedule as my fault? Or their fault?" My anxiety mounted with my inability to see clearly the answers to these questions, and it interfered with my ability to focus on the work with patients.

Inescapable Self-Disclosure

It was at this point that self-disclosure appeared inescapable to me. I decided to speak about my situation to those patients whose sessions I had repeatedly canceled. My intention was to address what I was worried were my patients' perceptions that my ability to focus on my work had been compromised. I wanted to reestablish my dependability by offering an explanation for my recent behavior. I therefore told them I was dealing with some health concerns that necessitated my rearranging my schedule with little advance notice. I wasn't going to discuss the details, I said, but I made it clear that my doctors had assured me that I would be all right.

At the time, I reasoned that such a disclosure would clarify my patients' confusion about why I was behaving so unpredictably around their scheduled appointments. But was that all I was doing? Might I also have been trying to reestablish my own dependability to myself? In retrospect, I suspect that my anxiety about the loss of my normal schedule was overdetermined: a displacement of my horror over loss of the dependability of my body, and the consistency of continued life. Perhaps my patients were not as anxious about the scheduling changes as I was. Had I been more cognizant that my anxiety about dependability concerned not only my patients' reactions, but my own feelings, might I have been more prepared to deal with the range of feelings my patients may (or may not) have had as a result of canceled sessions? Might I have even avoided my "inescapable" self-disclosure?

A further question occurs to me: When I told patients that my doctors had told me I would be all right, was I merely disclosing the facts of my illness? At the time, I thought so. My doctors gave me a positive prognosis, and I believed I was doing nothing more than truthfully reporting it to my patients. But wasn't I seeking to reassure not only my patients, but myself of the dependability of my health? Did I need my patients not to worry? Would it have been too disturbing for me to hear their anxieties and fantasies about what was wrong with me? Did I want to avoid worrying them about my health because I could not face my worry? I don't doubt the authenticity of my desire to tell my patients the truth; but this desire was tinged with the unconscious agenda of maintaining my own security.

Any self-disclosure of illness may contain more layers than are immediately visible. It may contain a version of the truth of the analyst's experience, but it may also house a particular version of the truth that the analyst needs the patient to believe. Aron (1996) probes the elusiveness of the concept of self-disclosure in his playful question, "if we think in terms of multiple selves, then we immediately must question which of the analyst's selves is revealing what to which of the patient's selves—and while all of this is being revealed, what are all the other selves doing?" In the case of the disclosures of my illness, my strong, unimpaired
self, was speaking to my patients. It was attempting to enlist them in joining me to push away the impact of the illness, to join me in my assertion that I was still dependable.

Patients did respond to my disclosure with relief. Several voiced appreciation that I was providing an explanation for the changes to their schedule. Those patients who were particularly sensitive to boundary violations thanked me for not telling them more about myself—they voiced appreciation for my not usurping the focus of the session. I felt relieved. Speaking aloud to my patients about some of the circumstances behind my disruption of our routine did allow me to focus again on our sessions. For the present, my disclosure had accomplished its agenda.

Resumption of Predictability

Following the course of surgical procedures and medical consultations, my schedule became predictable again, and my work resumed its usual pace. I felt able to contain the knowledge of my breast cancer from interfering with my ability to remain attuned to my work with patients. My anxiety became manageable; it was no longer inescapable. I experienced myself again as feeling dependable to my patients, and thereby dependable to myself. I was scheduled for eight rounds of chemotherapy, spaced three weeks apart, over a course of six months. I scheduled the chemotherapy close to the weekend so that its effects would minimally interfere with my schedule with patients. I was told that I would lose my hair as a result of the chemotherapy, and I purchased a wig for that eventuality.

As forecast, a few weeks after my first chemotherapy infusion, my hair fell out. I began wearing a wig. Even though I had purchased a wig that would replicate as much as possible my hair style and color, I looked different, and most patients noticed the difference. The patients to whom I had not previously disclosed my health concerns made only passing mention of what appeared to them as a new hairstyle. Patients I had told about my health problems, however, reacted to my “new hairstyle” with alarm. I asked them about their troubled reaction, and most articulated their fear that I had cancer. On their own, these patients had come to the correct conclusion. As the expression goes, they put two and two together.

Even though I had felt that the crisis affecting my ability to function as an effective, attuned analyst had abated once my schedule became regular again, my previous disclosure had made it impossible, in my mind, not to disclose further. Those patients who suspected that I had cancer were now alarmingly anxious about my dependability. Their anxiety signaled my own anxiety, and I felt the pressure to make another inescapable self-disclosure.

I therefore asked those patients who voiced their concern that I had cancer if they wanted me to tell them whether or not it was true. I felt strongly that all of them be given permission to know, if they wanted to, or not to know, if they chose not to. Each patient said that she or he wanted to know. At this point I told them that I had an early stage of breast cancer, and that I was getting chemotherapy to treat it. I added, again, so that they would not worry about me, that my doctors had assured me that I would most probably live a long life. I revealed to these patients both the truth of my diagnosis, and, as I had previously, reassurance about the doctors’ assessment of my prognosis.

Impact Upon Treatment of the Analyst’s Self-Disclosure of Serious Illness

Throughout the interpersonal-relational literature it is noted that while the analyst’s life crisis has introduced significant challenges to the treatment, overall, the disclosure of serious illness has been fruitful for the analytic process. Those who have written of their experiences have reflected that speaking with patients about their illness has provided a relational field in which the thorniest issues of life are illuminated—those concerns of living and dying, loss and pain that underlie human existence, including that of the analytic process (Gerson, 1994; Morrison, 1997; Pizer, 1998). On the other hand, there are also reports, sometimes by the very same analysts, of analyses that have been seriously derailed by such disclosures (Gerson, 1994; Morrison, 1997). How might we understand cases in which the analyst’s self-disclosure of serious illness may have been injurious to the treatment effort?

The reason for controversy over self-disclosure is fairly clear from Freudian perspectives; there is a relative emphasis on avoiding the intrusion of the analyst’s real life, in order to allow the patient the greatest freedom to develop and work through the transference. But relational
theory posits no necessary connection between analytic anonymity and successful analysis of the transference. How might relational theory, then, explain the threat to an analysis posed by the analyst’s disclosure of her subjective presence?

In order to begin thinking about this question, let us detour from the psychoanalysis of adults to a consideration of child development and mothering.

**Divulging Breast Cancer to One’s Child**

When I first thought about how I would tell my nine-year-old daughter about my breast cancer, I was operating under the assumption that a child and mother could best contend with the specter of the mother’s breast cancer by demystifying the illness and its treatment. Dr. Susan Love (1995), whose book is often considered the “bible” for women with breast cancer, advises mothers: “If you’re being treated with radiation or chemotherapy...where your children are permitted to see the treatment areas, it’s a good idea to bring them along once or twice. The environments aren’t intimidating, and a child that doesn’t know what’s happening to you can conjure up awful images of what ‘those people’ are doing to mommy” (p. 305).

With the intention of being authentic and forthcoming, I told my daughter that I had breast cancer. Although I do not recall my husband or me speaking about cancer to her before, she was aware enough of the disease to know that I was telling her something ominous. Not surprisingly, she started to cry, protesting the news. I patiently and evenly tried to reassure her that I would be taking medicine to make me well again. I included that I would lose my hair temporarily, but that we could pick out a wig together. She was not the least interested in being included in that excursion.

After several days of rather futile attempts to talk further with my daughter about the cancer and its treatment, and, more importantly, about her fears of my dying, it started to occur to me that my daughter was neither buying my factually forthcoming approach, nor was it helpful to her, or to myself, that I include her in my process, as I navigated the illness. She was scared, which she defended against with outrage: She had lost her normal, “low-maintenance” mommy—the sometimes annoying mom who insisted that she turn off the TV and practice the piano—to a sick mother with cancer, and worse, a mother who wanted to talk about it all the time.

It was not until my hair started to grow back, once the chemotherapy was over, that our relationship assumed a more normalized, relaxed form. As I began to look and act normal, my daughter gradually became reassured of my constancy. Then I became annoying and embarrassing again, over those ordinary, far less disturbing matters.

How can we make sense of the shift in the relationship between my daughter and me? First, let us look at my daughter’s experience. It is a mainstay among childhood developmentalists (A. Freud, 1936; Erikson, 1950; Sullivan, 1953) that the youngster of middle childhood, having emerged, first, from her absolute dependence on maternal presence in infancy and, second, her diminished but still continuous dependence on her parents’ active presence in early childhood, is equipped with the emotional resources to turn to the interpersonal world beyond family bounds. The child’s attention shifts to extrafamilial environs—to school, to teachers, to friends, to friends’ parents, to adult figures in their community—to acquire experiences and role models used in further development of autonomous selfhood.

Stochower (1996) views the school-aged child as more self-involved than in earlier development, developmentally needing her parents to recede from their more active participation of earlier childhood. The parents “remain a reliable but non-intrusive background presence. The developing child needs and depends upon the parents’ consistent, yet unobtrusive presence in order to fully develop and exercise a sense of self—of separate, affectively alive, autonomous potential” (p. 62; italics added). Certainly, for any child, the specter of mother battling cancer makes it impossible for that mother to remain nonobtrusively in the background. When I tried to include my daughter in more of the details of my process, however, was I making matters worse? Was speaking openly to her about my illness making the experience of my cancer not less toxic, as intended, but more frightening?

As I look back, I see that I overestimated my daughter’s ability to metabolize a frank, factual account of my navigation of breast cancer. Although I presume that she might have been made more anxious had I said nothing (as she would have been left to intuit alone my withholding a terrible secret about my health and viability from her), I did not sufficiently foresee the press of her need not to know.
Further, I wonder if, similar to some of the motivation behind my self-disclosure to patients, I may have been seeking, in my attempts to speak to my daughter about my navigation of illness, some reassurance from her of my continued normalcy. It was as if I was bargaining with her: "If you would feel okay about my cancer (in recognizing that it is only temporary), then I could feel okay, secure in my own viability as your mother?"

Once I did allow my daughter room not to confront my cancer—not to be included, for example, in my reactions to how much I hated my wig, nor to reassurances of how relatively well I felt, nor to news of So-and-So who once had breast cancer but was now "fine"—once I attempted to keep my experience of breast cancer more out of her awareness, I let her assume the stance of the normative, self-involved girl of middle childhood who she needed to be: a girl with freedom to work and to play, to listen to her own agenda, rather than to be forced to confront mine.

After I began to titrate what I chose to share with my daughter, it worked better for me, as well. My daughter's loud protest that I was ill had shaken my robust view of myself as mother, admired by her daughter. Once I kept details about my experience of cancer from her, I was able to feel more solid and dependable in her eyes, and then, correspondingly, in my own.

Is it possible to draw relevance between the relationship with my daughter and those with my patients around the feeling of intrusion to our relationship caused by my disclosures? Certainly there are glaring conceptual disparities, including differences in the scale of need and differences in level of maturity, between my child's dependence on me and her terror of losing me, and my patients' needs for me. Despite these differences, however, evident parallels lead to the following questions: Like my daughter, were some of my patients unduly burdened by the introduction of my illness? Did I unwittingly suspend patients' license for unfettered self-involvement in their treatments, once my cancer was disclosed? And further, just as my daughter's protest about my breast cancer detailed me in my ability to feel competent as a mother, did my patients' knowledge that I was sick collapse the boundary I used to protect my conviction in myself as the doctor? Let us now turn to my patients, whose experiences with my self-disclosure may shed further light on this experience.

The Patient's Experience of Intrusion When the Analyst Discloses Serious Illness: Case Examples

Barbara, a woman in her early thirties with whom I had been working for several years, presented with pervasive feelings of bitterness, depression, and rage. She viewed me through an idealized lens as the embodiment of who she was striving to be: Where she was oppressed and constricted in movement, I was strong, free, and able to chart my course successfully through life.

Often I felt uncomfortable with Barbara's lofty appraisal of me. For one thing, it left me feeling rather unknown, and not very optimistic that a more collaborative interchange could develop between us any time soon. Further, I was well aware that on the flip side of her idealization lay split-off measures of disappointment, rage, and envy, which, unless owned and experienced with me in at least titrated force, had the potential to blow up, to devastate her ability to find any protection from me at all. My attempts to gently disabuse Barbara of her lofty opinion of me met with little success, however. For example, when she claimed that I would never lose my temper, or never handle a social situation clumsily, I would say "Never," hoping she might consider the improbability of such an exalted vision of me. I found, however, that she ignored my avowals of emotional clumsiness, and when I further questioned her vision of my near perfection, she became quiet and depressed, refusing to consider my attempts to introduce her to a more complex view of myself. I wondered if my forcing Barbara to confront the limits of my capacities might deprive her of a needed illusion of me, crucial in her effort to elaborate, in the treatment with me, her experiences of herself and others. I decided to hold on to my more complex view of myself until a time further into the treatment, when Barbara might more usefully tolerate me in imperfect form.

Barbara came from a family that led her to believe that she needed a strong figure to protect her. Her father, an alcoholic, dominated her mother through frequent outbursts of verbal as well as physical abuse, often roaring obscenities and heaving furniture. Barbara, as a terrified little girl, escaped into her bedroom, squeezed underneath her bed, and waited out her father's violent tantrums. As Barbara grew older, she remembers trying to protect her mother, a depressed, passive woman, by diverting her father's attacks, often putting herself on the front line of his
could not make use of my interpretations. Had it been possible for Barbara to speak about her feelings—her disillusionment, or anger, or fear, or sadness—I might have felt more hopeful that my self-disclosure would allow her to contact these feelings that I viewed necessary for her elaboration and growth. But instead, at this time, she increasingly withdrew from treatment. She cut down her sessions from twice per week to once per week, insisting that she enroll in a karate class that met during one of our sessions. She tolerated my interpretations about her search for means of self-defense, now that she had lost hope in me; but they did not deter her from scaling back treatment.

After several weeks of rather lifeless affect in our sessions, Barbara uncharacteristically bounced into a session, brimming with good news. She had just spent the weekend at a beach house in which she had recently rented a share. She exuberantly described the great layout of the house, the interesting new people she met, and how she hoped the summer would last “forever.” She then came screeching to a halt, as if she had exposed excessive ebullience. She cried, “How can I wish the summer to go by slowly, when you must want it to be over already!” At first I did not follow what she meant. She clarified, “You said your chemotherapy would be finished at the end of August. You must not be able to wait for the summer to be over!” (I was surprised that she had recalled the timing.) She was crying. I responded, almost without thinking, “But can’t I be happy for you? Do I need you to suffer along with me?”

Thus broke our impasse, brought on by my revelation of my physical vulnerability. Barbara’s expression of guilt at surviving my affliction, of leaving me, allowed her to access feelings about feeling “horrible” as she departed for school in the morning, leaving her mother behind, defenseless, at the mercy of her father. In our work, a door had been opened to consider how Barbara might act to curtail joy from her life.

Now, several years after that late spring session, our relationship seems to have evolved from the more stilted period of her idealization of me, and following my disclosure of breast cancer, from the months of her more extreme detachment from treatment. Barbara has seen me withstand the chemotherapy, grow my hair back, and look healthy again. I hope that my experience with affliction and struggle may provide for her a different kind of model, no longer one of perfection, but rather one that includes problems and complications. As the interpersonal-relational analysts reviewed before (Gerson, 1994; Pizer, 1997) also experienced, the crisis to the treatment of my disclosure may be viewed as
having potentiated Barbara’s encountering essential aspects of her relational life.

And yet, I continue to question the impact of surprise for Barbara when she was forced to confront my vulnerability. Was Barbara a patient whose need for illusion about my invulnerability was eclipsed by my needs, by the exigencies of my life circumstances? Did her knowledge of my battle with breast cancer provide her with the trauma of yet another caretaker-at-risk to whom she was forced to accommodate? Would a more gradual disillusionment of me have provided greater opportunity for her to create a more complex picture of me?

Slochower (1996) speaks to these questions in her synthesis of Winnicott’s “holding environment” (Winnicott, 1965) with contemporary relational theory. She counters the automatic assumption that self-disclosure will always work to deepen the analytic inquiry, and posits a tension between a patient’s need for recognition of the subjective presence of the analyst and the need for exclusion of such awareness of the analyst’s separate subjectivity. Slochower advocates that the analyst keep open the question that self-disclosure is propitious for an analysis until evaluating its meaning for any particular patient.

Similarly, Greenberg’s (1986) conception of neutrality may be used to address questions about the evolution of Barbara’s analysis after my disclosure of breast cancer. Greenberg elaborates the connection between the analyst’s neutrality and the patient’s experience of safety in the analytic relationship, and suggests that what constitutes neutrality in each individual case is determined by the qualities of the patient’s object relations. For each patient, the analyst’s neutrality is idiosyncratic to the quality of the patient’s internal objects. Although Greenberg does not write about self-disclosure of serious illness per se, he implies that for certain patients, the analyst’s revelation of illness might interfere with the neutral atmosphere necessary for the patient’s optimal growth. In a more recent article, Greenberg (2001) objects to what he views as the penchant of relational writers for self-revelation, when navigating a treatment impasse. He stresses the need for the analyst’s restraint to potentiate the patient’s ability to bear disturbing affect.

Divorced from the theoretical persuasion of the viewer, there is no correct judgment on whether Barbara’s knowledge of my breast cancer was beneficial to her analysis. Barbara and I, together, in the private space of my office, will continue to puzzle these questions, as we explore her emotions surrounding my fall from invincibility, particularly during those times in her life when she despairs and yearns for the illusion that I can protect her.

Another patient, Sharon, a woman in her mid-forties, came into treatment with a horrendous history of abuse. She was verbally denigrated and then abandoned by her father, sexually abused by her older brother, and then, once married, physically abused by her husband. Her mother, obese, with serious medical problems, had a history of psychosis for which she was repeatedly hospitalized. Sharon vacillated between adoration of her mother as “the only person who ever loved me” and rage at her mother’s insatiable needs. Sharon had been responsible, beginning at fourteen, for forcibly hospitalizing her mother in the state psychiatric facility.

Sharon came into treatment with feelings of guilt over her mother’s death (she died of a heart attack directly following another involuntary admission to the psychiatric unit). Despite chaotic personal relationships, she found satisfaction in her work as a health technician, a responsible position that allowed her considerable autonomy. She often vacillated between appreciation of the emotional independence and protection afforded by autonomy and insularity (she could manage on her own and didn’t need anybody for anything) and her desperate wish to be cared for by another person. She spoke of wanting to find a husband to fill the emptiness in her personal life, but equally she spoke of her terror at not being able to decipher whether the man she chose to marry would turn into an abuser, like her former husband.

Early in the treatment, she asked me to promise her that I would warn her if I ever thought she was getting involved with an abusive man. I understood Sharon’s request as a plea that I protect her, where her mother had failed, from the kinds of physical trauma meted out by her father, brother, and husband, and further, that I shield her from the responsibility of having to take care of me, as she did her increasingly ill, deranged mother. Sharon’s history of abuse, coupled with her request for my protection, alerted me to the likelihood that the transference would be stormy. I did not foresee the added challenge to the work, for both of us, imposed by my illness.

Sharon’s one-year treatment prior to the introduction of my breast cancer was characterized by themes of victimization: she related painful memories of abuse, then expressed rage that I did not truly care about.
her, and was terrified that I would find her crazy and would forcibly institutionalize her. I expended much effort trying to contain her wildly vacillating feelings and fantasies toward me.

Because I had never disclosed my health concerns to Sharon (I had not needed to cancel Sharon's appointments during the earliest phase of my breast cancer), I was hoping that Sharon might view my wig as a change in hairstyle, obviating the disclosure of my breast cancer. Sharon, however, a religious woman who wears a wig for reasons of ritual, spotted my hair piece immediately. She asked me why I was wearing a wig. I decided to answer her question directly, after I thought about Sharon's penchant for blurred boundaries and wild swings of feelings toward me. I reasoned that a matter-of-fact response to her question would lend itself to the most clarity for her (and me).

Following my disclosure, Sharon authoritatively told me that she concurred with my doctors about a favorable prognosis for me. She based her reassurance on her experience at her job, in an area related to oncology. I felt cautiously optimistic that Sharon's expertise in health care might somewhat even the ground between us, leveling the power discrepancy that so often left her feeling powerless and enraged toward me.

What followed was contrary to my hope for increased stability in the treatment. At first, Sharon could not do enough for me. Starting with my wig, which she found inferior, she handed me a business card of someone she knew who made fantastic wigs "indistinguishable from real hair and half the price you must have paid." I placed the card on the footstool between us, contained any of my own doubts about my wig (Was my wig that bad?), and shared with Sharon my perception that her tip about a wig-maker was her desire to give me a gift, which I appreciated, but one that I would not be using. Sharon came into session the following week with a gift of anesthetic cream to apply on my arm for days when I went for chemotherapy. Again I thanked her for her concern, but explained that given the nature of our relationship—one of talking (rather than doing) about her life (rather than mine)—I could not accept the cream. On another occasion, Sharon, after stating that she was not going to concretely give me anything this time, asked if I could tell her my biblical name so that she could recite a blessing for my healing. I was momentarily speechless. She took this to mean that I did not know the name, and then asserted that God could listen to my English name in her prayers, as well. It was not until she commenced a session relating the details of a friend-of-a-friend who died of complications from chemotherapy that I more fully heard Sharon's helplessness and rage at having a seriously ill analyst. Sharon seemed to relax once she heard from me that I got that she both worried about me and hated me—for being ill, and for my not letting her help me. Several productive sessions ensued, in which Sharon spoke about how powerless and hateful she felt in relation to her mother, and about how guilty she felt about her mother's death on the psychiatric unit, days after Sharon called to get her rehospitalized. While Sharon's attention to my cancer appeared to wane in sessions, she commenced calling me more between sessions, needing either to talk with me ("only for five minutes") about various interpersonal dealings in which she felt victimized, or to request changes in appointment times that suited her schedule better than mine. I attempted to reinforce the treatment frame by stating my need to limit phone calls, and to hold to regular appointment times. She was angrily compliant.

A month later I raised my fees, resulting in what I thought was a modest increase for her. She pleaded poverty, telling me that if she were to pay my fee, she would be deprived of necessities. I tried to work with her around her feelings of betrayal and rage at my needs, this time about my need for money. She was furious at me, and stormed out of the session early, despite my attempt to convince her to stay and talk. Two days later, I received a letter in the mail from Sharon, stating that she needed to "take a break" from therapy. I called her and spoke with her on the phone, and asked her to return for at least another session. She said she would think about it, but never called me back.

Sharon's flight from therapy left me questioning what went wrong. Was our work a case example depicting the terrain of treatment with a woman with a severe history of abuse—therapy de rigueur with a patient presenting with borderline themes? In my view, Sharon's particular history of abuse did inform her need to test me—to test whether I could be depended on to withstand her neediness and her rage without collapsing or retaliating.

On the other hand, was Sharon's already difficult treatment compounded by the introduction of my illness? The escalation of Sharon's anxiety following my disclosure of illness might suggest the following: Sharon was overwhelmed by my needs, powerless and furious in the face of my illness, frantically trying, and then failing to figure out what to do for me. The replay, with me, her ill analyst, of the helplessness and rage she experienced with her psychotically ill mother became untenable for her. Sharon may have perceived my fee raise as "the icing on the
cake” or perhaps a clarion call, loud and blaring, that our relationship was about me and my needs. Did she so angrily leave treatment because she felt it had more to do with my needs than hers?

But is not such an explanation also incomplete, leaving out the question of my personal input to the analytic dyad, of my idiosyncratic contribution to the demise of the treatment? Let us consider the effect on me (the day she asked for my biblical name), it was a day in which I felt particularly exhausted from what felt like endless cycles of chemotherapy. On that particular afternoon, I actually wondered if I was in a position to refuse anyone’s prayers. Couldn’t I use all the help I could get? This reverie alerted me to how invaded I felt by Sharon’s gifts. Were they intended as gifts at all? According to Sharon, I needed a new wig because mine was bad, I needed anesthetic cream because my chemotherapy would become more painful, and if I wanted to recover, I needed her prayers. Further, as I heard from Sharon, I could die from chemotherapy—a fact that had not occurred to me, given the workings of my denial. I began dreading our sessions. Not long after, I raised her fee. Why did I decide to raise her fee at that particular time? Didn’t I know Sharon well enough to foresee how hurt and enraged she would be by such a change? Could I have been trying unconsciously to get rid of Sharon? Or was I trying to establish who was the doctor—who was in charge? who needed whom?

It was not until after Sharon fled treatment that I found the capacity to understand further her gift-giving. I realized that Sharon’s history of abuse may have informed her sensitivity to my distress as a cancer patient, and that she may have been attempting to care for me (Singer, 1971), even to cure me (Searles, 1975). Davies and Frawley (1994) write that it may be particularly beneficial for an abused patient to be effective in curing the therapist: The therapist’s allowance and acceptance of the patient’s ministrations may “relieve the patient’s intense sense of herself as toxic” (p. 181).

Why, while I was seeing Sharon, was it so difficult for me to reflect about the meaning of her behaviors toward me? What happened to my capacity to think, to play, to access the internal space within which to contemplate the transference-countertransference enactments, the themes of attack and counterattack in which we were involved? These questions lead me to a more general inquiry into what happens to the analytic boundaries when the analyst has a life-threatening illness.

Potential Aftermath of the Analyst’s Self-Disclosure: The Patient Violates the Analyst’s Boundaries

Writers before me, within the relational literature on self-disclosure of serious illness, speak to the issue of the analyst’s weakened protection from patients’ intrusions. Gerson (1994), who wrote about letting patients see aspects of her personal life and experience while navigating a high-risk pregnancy and its subsequent loss, reflects upon her heightened “susceptibility to transfersences, distortions, and patients’ reactions [at a time when her] therapeutic armor was weaker” (p. 8). Pizer (1997) remarks on her own need for “hyperalert(i)on) to what might lie beneath or alongside” patients’ responses to her breast cancer. She cautions, “Whenever the analyst . . . chooses to reveal something about herself, she remains responsible for that revelation as she considers any subsequent interaction in the life of that particular treatment” (p. 457).

Within the analytic dyad of a seriously ill analyst and her patient, a collision often occurs at the boundaries. The patient’s need to know the analyst in her illness often collides with the analyst’s need to protect her own shaken sense of reliability and integrity. In my work with Sharon, her need to see me, to “treat” my illness, collided with my need not to be seen, not to look at my illness in the ways Sharon was perceiving it. Sharon’s close inspection of me in my cancer brought up anxieties that I could only face in a very private space of my own. When I was at work, I needed these anxieties more contained, a feat difficult to achieve when my patient was reminding me regularly about the gravity of my diagnosis.

With most of my patients, unlike with Sharon, I was able to manage my discomfort at being seen by them as sick by titrating what they would see about my illness. I informed them that my breast cancer had been caught at an early stage, about my ongoing chemotherapy, my favorable prognosis, consciously intending to avoid turning our attention from their problems to mine and thereby usurping their treatments. But unconsciously, I was setting ground rules that patients continue to view me as dependable—basically healthy, and only temporarily ill. In effect, my self-disclosures were invitations for patients to see me as ill, but also, and paradoxically, as particularly hardy and healthy. Once I set the parameters of how much I could tolerate my patients seeing, then I invited their reactions to my disclosure, to seeing me in my wig, to imagining what I must be going through, and so on.
My exposure to patients' intrusions into my protected space sometimes impaired my ability for attunement to them. My anxiety increased when patients attacked my image of myself as still dependable and relatively healthy, and it interfered with my empathy for them at those moments. Aron (1996), speaking to this issue in his reflections on self-disclosure, confirms that self-disclosure leads to increased anxiety in the analyst. He cites Wachtel (1993) and Hoffman (1994), who also propose that limiting self-disclosure increases the analyst's tolerance and understanding of the patient. In a similar vein, it is widely known that Freud, almost a century earlier, adopted the use of the couch as standard analytic technique in order to limit his exposure to patients—to remove himself from the anxiety provoked in his patients' scrutiny.

The following vignette depicts an example of how the analyst's self-disclosure may open a door for the patient to walk through, carte blanche, and surprise the analyst with jarring material. A patient was upset when she received from me a bill I had miscalculated in her favor. She reasoned that for me to be making such an error, I must be more worn by the cancer than I was admitting. My first response to her query was defensive, something like, "You've got to be kidding. It was just a miscalculation, signifying nothing more than math sloppiness" (quite a denial from someone who believes in unconscious processes!). What was going on for me? On that particular day, I was seeking to push the awareness of my vulnerableness as much as possible out of my awareness, and here was my patient walking through the door, saying something like "Hi. I'm concerned by how your breast cancer may be robbing you of what you deserve, in ways you're not even aware of." It was months later that my patient and I realized how crucial it was for her to walk through that door, to push against my boundary—to not let me silence her on the reality of my illness, as she saw it. For this patient, whose mother chronically avoided my patient's attempts to perceive her in her unhappiness, my putting up a façade of strength could have enacted a particularly unhealthy dynamic, had my patient not resisted my attempt to silence her.

The Potential of Self-Disclosure of Breast Cancer to Enrich Analytic Work: Case Examples

Despite the potential for boundary collision in the conflict between some patients' needs to see me as sick, and my need not to be seen, I found that for many of my patients, the process of working with my self-disclosure did serve to deepen and enrich the work.

Harry, a reclusive computer programmer in his late thirties, presented with a bored and disdainful attitude toward analysis in general, and me in particular. He was referred by his wife, who actually gave him the ultimatum that if he did not work on becoming less withholding and more loving toward her, she would seek a divorce. While Harry tried to give the impression that he only tolerated me, I was aware that his feelings were more complicated, even including his looking forward to our sessions. I had been working with Harry for two years before my discovery of breast cancer. After I had to cancel several of his sessions due to emergency doctors' visits, I disclosed to him that I was dealing with health concerns. I recall Harry's candor in telling me that he was glad that I was not telling him any of the details of my "problems." I understood that Harry's endorsement of my relative terseness derived from his aversion to a repetition of his history with an intrusive and hypochondriacal mother who turned to Harry for emotional sustenance once her husband left her, when Harry was five.

When Harry saw me in my wig for the first time, he registered discomfort at my appearance. All I said to him was "What?" I remember thinking that we knew each other quite well by now, and I felt rather moved in that moment. He responded, with feeling, that he noticed that I was wearing a wig, and wanted to know if I was all right. After I ascertained that he was certain that he wanted to know, I told him what I told other patients—that I had breast cancer, was undergoing chemotherapy, expected to recover, and so on. He said that he was sorry, which I thanked him for. Every few sessions he asked me how I was feeling. In my desire not to unduly intrude upon him, in ways in which his mother had, I usually answered something contained, like "Okay" or "Hanging in there" and then proceeded in the session with his life. At the beginning of one session I decided to inquire about why he was asking about how I was feeling. He said "You're looking kind of green to me." He asked me about my chemotherapy. I told him about it making me nauseated and exhausted for the first few days after each treatment. The next session he handed me a scrap of paper, on it scribbled the name of a homeopathic remedy for the side effects of chemotherapy, which he had found in a health food store. I felt moved and told him how much I appreciated his gesture to help me feel better. He said he was surprised with how I seemed to be handling my cancer—that I did not let it stop...
he from working, from getting on with my life. He said he appreciated that I had not turned the sessions into being about me. We spoke more about his experience with his mother, her turning his life into being about her needs.

Why was the introduction of my breast cancer less turbulent in Harry’s therapy than it was in the other patients’ treatments discussed earlier? Why was Harry’s gift acceptable to me, in contrast to Sharon’s? I suggest that Harry and I were both working at the boundaries of our relationship, with my problems (as his mother had), but in my care not to repeat his experience with his mother, I told him very little. Harry, who feared, when he first was told of my health problems, that I would prove to be an “old” object (his mother), discovered me as a “new” object, who did not intrude (see Greenberg, 1986).

Harry was close, but he also gently allowed me the space I needed to maintain my security. In his resolve to be different from his mother he was careful not to intrude on what he intuited as my need for privacy. The boundaries between us, heeded but not avoided, allowed Harry to perceive and experience new relational possibilities. His gift to me—the scrap of paper on which he wrote the name of a homeopathic medication—may have signaled the development of an increased capacity to give. Reports of decreased tension between him and his wife suggest this expanded relational capacity.

For several others of my patients, my breast cancer has not appeared to play as large a role as it has with Barbara, Sharon, or Harry. With some patients, my self-disclosure protected them from having to worry about me. With some, my boundary needs and my need to see myself as perfectly able to carry on may have somehow silenced them. Many of these patients have witnessed my transformation. They watched me evolve from apparent health, to illness, and, I hope, to returned health. Many patients appear relieved to witness my return to health and have inelastic hope—that with a modicum of determination, they may be able to prevail in facing some of the obstacles they face.

**REFERENCES**


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