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When Cancer Hits Home: Providing a theoretical foundation for defining self-disclosure of personal cancer coping experience in oncology social workers' helping relationships

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Abstract

The American Cancer Society estimates that by 2020 cancer survivors in the United States will increase by 31%, rising from 13.7 million in 2012 to nearly 18 million, *if cancer incidence and survival rates remain stable*. This does not include others indirectly impacted by a diagnosis, such as family caregivers. Health care workers, including oncology social workers, are also increasingly finding themselves among those diagnosed with and / or caring for someone who has cancer. As cancer increasingly "hits home", oncology social workers in such situations are also acquiring potentially valuable personal cancer coping experience. This theoretical dissertation explored how personal experiences with cancer (as patient or caregiver) influence oncology social work services. Social workers have had significant roles in research and theory development of therapist self-disclosure. Recently developed decision-making models aid in effective self-disclosure, with attention to specific populations. Recent research has correlated therapist self-disclosure with patient's increased treatment satisfaction and a positive treatment outcome. However, to date, no such work addresses the unique needs of and opportunities for oncology social workers with personal cancer experiences, their patterns of self-disclosure and / or related potential educational needs. Such therapist self-disclosure could become a valuable clinical resource and merits investigation.

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When Cancer Hits Home:

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of personal cancer coping experience in oncology social workers'

helping relationships

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Table of Contents

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And finally, thank you to my husband, Al, for never giving up on me or letting me give up. For the countless hours spent discussing data, being my sounding board, and ultimately my personal cancer care-giver.

ABSTRACT

WHEN CANCER HITS HOME:
PROVIDING A THEORETICAL FOUNDATION FOR DEFINING SELF-DISCLOSURE
OF PERSONAL CANCER COPING EXPERIENCE IN ONCOLOGY
SOCIAL WORKERS' HELPING RELATIONSHIPS

Kimberly A. Lawson, MSW, LCSW

Allison Werner-Lin, PhD, LCSW

The American Cancer Society estimates that by 2020 cancer survivors in the United States will increase by 31%, rising from 13.7 million in 2012 to nearly 18 million, *if cancer incidence and survival rates remain stable*. This does not include others indirectly impacted by a diagnosis, such as family caregivers. Health care workers, including oncology social workers, are also increasingly finding themselves among those diagnosed with and / or caring for someone who has cancer. As cancer increasingly "hits home", oncology social workers in such situations are also acquiring potentially valuable personal cancer coping experience. This theoretical dissertation explored how personal experiences with cancer (as patient or caregiver) influence oncology social work services. Social workers have had significant roles in research and theory development of therapist self-disclosure. Recently developed decision-making models aid in effective self-disclosure, with attention to specific populations. Recent research has correlated therapist self-disclosure with patient's increased treatment satisfaction and a positive treatment outcome. However, to date, no such work addresses the unique needs of and opportunities for oncology social workers with personal cancer experiences, their patterns of self-disclosure and / or related potential educational needs. Such therapist self-disclosure could become a valuable clinical resource and merits investigation.

I.   Introduction

A. Statement of the Problem

The American Cancer Society (ACS) estimates that on January 1, 2014 there were nearly 14.5 million cancer survivors alive in the United States (US) and that over 1.6 million more people will be diagnosed in 2015 (ACS Facts & Figures, 2015). Further, the five-year relative survival rate for all cancers diagnosed from 2004-2010 was 68%, up from 49% in 1975-1977 (ACS Facts & Figures, 2015). Finally, it is predicted that through the year 2024, if US cancer incidence and survival rates *remain stable* survivor numbers will increase by approximately 31%, rising to 19 million (ACS Cancer Treatment and Survivorship Facts & Figures, 2015; National Cancer Institute, 2011). Indeed, the challenges inherent in learning to live as a cancer survivor are increasingly impacting the lives not only of fellow Americans, but of people across the globe in every living environment – home, work, school and play – and in significant numbers. With such disease prevalence and no population immune, all health and mental health care workers, including oncology social workers (OSWs), are also increasingly finding themselves among those diagnosed *with* cancer and/or as cancer caregivers in their personal lives.

B. Purpose of the Dissertation

As oncology social workers increasingly experience cancer "hitting home" they are also, albeit unwittingly, accumulating personal cancer coping experience. This paper explores an understudied area in oncology social work, with increasing relevance to an aging and sandwich generation workforce, namely, how might (and how could) personal experiences with cancer (as patient or as caregiver) influence the ways in which oncology social work services are delivered? Do oncology social workers disclose information

regarding their personal cancer coping experience to clients with whom they work? If so, why? If not, why not? Are oncology social workers with personal cancer coping experience prepared to make decisions about how, when, why and to whom to self-disclose in the most therapeutically strategic, effective manner possible? In today's fiscally-constrained health care environments, are oncology social workers losing potentially valuable clinical resources if they are *not* self-disclosing what could be therapeutically advantageous information because they do not feel adequately prepared to do so? What are the opportunities to harness and harvest personal cancer coping experience? In doing so, could a valuable, additional resource for those impacted by cancer be cultivated?

There is a paucity of literature on self-disclosure in oncology social work, including regarding personal cancer coping experience. This dissertation will maximize a unique opportunity to cultivate potentially valuable clinical resources for both oncology social workers and students considering a career path in oncology. The literature search provides a robust foundation as well as theoretical support and rationale for this inquiry. This review could serve to inform the potential development of an evidence-based oncology-specific self-disclosure decision making framework.

C. Research Questions

This dissertation explored conceptions of theoretically guided therapist self-disclosure by oncology social workers, focusing specifically on those who are themselves cancer survivors and/or those who have been primary caregivers to someone with cancer and who may or may not be open to utilizing therapist self-disclosure regarding personal cancer coping experience in their helping relationships. This dissertation will, specifically, explore mechanisms for understanding self-disclosure or the lack thereof in professional

helping relationships regarding personal cancer coping experience acquired as a result of these cancer experiences, including how social workers may themselves define therapist self-disclosure. This work will inform understanding and future study of the degree to which participating oncology social workers feel or have felt clinically and/or academically prepared to effectively self-disclose about personal cancer coping experience will also be investigated.

The review has "set the stage" for the development of the dissertation, which will lead to rigorous research addressing the following questions:

1) "How do oncology social workers and/or oncology social work interns with personal cancer coping experience, either as survivors themselves or having been cancer caregivers, define self-disclosure in helping relationships?"

2) "Do oncology social workers and/or oncology social work interns with personal cancer coping experience, whether as a survivor or as a caregiver, self-disclose in clinical helping relationships regarding this experience?"

3) "Whether or not they utilize therapist self-disclosure in helping relationships, do oncology social workers and/or interns with personal cancer coping experience consciously decide to self-disclose or not?"

4) "Do oncology social workers and/or oncology social work interns with personal cancer coping experience feel academically and/or clinically prepared to effectively self-disclose regarding that experience in therapeutic helping relationships?"

5) "Is there a significant difference between those oncology social workers and/or interns who are cancer survivors and those who have been cancer caregivers and

the manner in which they do or do not utilize therapist self-disclosure of personal cancer coping experience?"

D. Significance and Contextual Practice Framework

Oncology social workers have an ever-increasing role in health care now, not only as mental health experts in cancer care, but also in leadership at both the multidisciplinary team and organizational levels. As the topic of oncology social work and therapist self-disclosure of personal cancer coping experience in helping relationships is proposed for exploration, examining this dissertation's significance is important to do within a practice context framework as well as a theoretical framework. Following is a brief summary of the practice context regarding the evolution, significance and current relevance of oncology social work as a sub-specialty within the profession.

Oncology social work initially gained recognition as a specialization in the early 1970s (Lauria, Clark, Hermann & Stearns, 2001). Ruth Abrams (1974), a social worker at Massachusetts General Hospital in Boston, in her book entitled, *Not Alone with Cancer*, is credited with the first published acknowledgement of the psychosocial concerns of adult cancer patients, around the same time chemotherapy was initially showing promise (Lauria, Clark, Hermann & Stearns, 2001). In the early 1980's, pioneers in the profession founded the Association of Oncology Social Work (AOSW), a professional organization, now also a 501C3 non-profit organization, providing services and education regarding psychosocial oncology issues and resources not only to its members but to oncology patients, families and cancer caregivers worldwide. AOSW has grown to have an annual average membership of 1100 – 1200 oncology social workers internationally. Since the 1970s, the role of the oncology social worker has evolved from being one found only in

acute (inpatient) care, primarily with discharge planning responsibilities, to one now in

many oncology subspecialties both in acute and ambulatory (outpatient) settings such as

chemotherapy or "medical oncology" settings, radiation oncology clinics, bone marrow

transplant, gynecologic oncology, neuro-oncology, pediatric oncology and multiple other

site-specific cancer clinics dedicated to the care of patients with breast, colorectal, prostate

and skin cancers, to name just a few. Additionally, oncology social workers are now

commonly found in community-based support and fundraising organizations, and

increasingly, in private practice. In academics, oncology social work has also experienced

increasing recognition and visibility such as with the University of Louisville in Louisville,

Kentucky, establishing the first Endowed Chair of Oncology Social Work in the United

States in 2011. Universities are now attracting faculty members specializing in

psychosocial oncology and with research interests focused within the subspecialty. Other

signs of oncology social work's increasing visibility include resources such as

www.socialworkdegree.com now having dedicated pages to this social work specialty

(http://www.socialworkdegreeguide.com/faq/what-is-oncology-social-work/, 2015). Each

of these areas represent significant growth of the subspecialty of oncology social work and

recognition of the need for structured, specialized educational opportunities for students

interested in it.

More recently, the increasing and evolved presence of oncology social work has also

been significantly impacted by the publication of the seminal 2007 Institute of Medicine

report: *Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs* (Adler, et al,

2007). This report, the first of its kind, brought international attention to and a call for

action upon the psychosocial needs of cancer patients, families and caregivers. Since its

publication, oncology social work opportunities are growing, with those social workers increasingly exposed to work with patients, families and caregivers at every stage of the cancer continuum, from the newly diagnosed, through active treatment, recurrence, into survivorship, and palliative and end-of-life care. The profession is now comprised predominantly of masters or doctoral-level social workers, with most credentialed and meeting state licensure requirements as mental health professionals, if not also AOSW's more recently implemented Oncology Social Work Certification (OSW-C). Each of these developments represents the growing recognition of the impact of psychosocial needs of cancer patients, families and caregivers and has contributed to the increasing prominence of oncology social work as a central and key role on multidisciplinary cancer care teams. Acting now not only as patient and family advocates, resource facilitators, in program development, counseling and psychosocial support, oncology social workers are now commonly looked to for mental health expertise for both clients *and* health care team members as well as for leadership in cancer care, whether in a health care setting, the community or private practice. Oncology social workers are joining the ranks of cancer care professionals meeting these global psychosocial and oncology leadership needs. Simultaneously, cancer survivor populations are growing, with OSWs included in those increasingly impacted personally by cancer, particularly as the profession ages alongside the general population. This demographic evolution of the service delivery population brings an increasing need for further specialized education and growing expertise in oncology social work and psychosocial oncology at large. To better understand how these two worlds of professional knowledge and experience coupled with personal cancer coping experience may intersect and potentially (hopefully) grow and flourish to better meet the

needs of cancer survivors and caregivers everywhere would advance the psychosocial

oncology knowledge base and practice skill sets tremendously. It is imperative that every

potential resource available to patients, families and caregivers be harnessed by oncology

social workers to facilitate optimal adjustment. The profession and its therapeutic tools

must continue to grow and evolve much the same way cancer care does. A flexible, but

context-specific therapist self-disclosure framework related to personal cancer coping

experience which could guide oncology social workers who have had or will have such

experiences is increasingly necessary. To this point, as Dixon, et al (2001), state in their

"Reexamination of Therapist Self-Disclosure" (an organizational effort by the

Psychopathology Committee of the Group for the Advancement of Psychiatry),

> *Although the dangers of boundary violations are genuine, self-disclosure may be underused or misused because it lacks a framework. It is useful to consider the benefits of self-disclosure in the context of treatment type, treatment setting and patient characteristics. (Dixon, et al, 2001).*

To date there is a dearth of literature in psychosocial oncology regarding therapist

self-disclosure, with no study identifiable within psychosocial oncology or the professional

literature at large. This theoretical dissertation will be the first to examine the current

landscape and prevalence of the use of therapist self-disclosure of personal cancer coping

experience, as well as the potential value in and cautions about this practice on the part of

those professionals actually delivering oncology social work services. Grant-funded by the

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this author endeavors to make a significant contribution to the oncology social work and

psychosocial oncology literature, informing practice, research and teaching, with concepts

serving as a basis for related future research and practice, including the ongoing honing of

guidelines development.

E. Theoretical Support, Rationale and Framework

A review of the literature reveals rich theoretical support, as well as ongoing debate and cautions about, the efficacy of therapist self-disclosure in psychotherapy work with clients. A recent systematic review regarding the use of self-disclosure (Henretty & Levitt, 2010), however, also reflects an undeniable trend in recent years toward support for the deliberate, strategic and judicious use of self-disclosure by counseling professionals. Drawing upon the literature review as well as clinical and academic experience to date, solid conceptual footing for this research may be found within the relational school of psychodynamic theory, particularly in self psychology and intersubjectivity theory (Berzoff, Flanagan & Hertz, 2011). These are the theoretical frameworks which will be explored in this dissertation. Additionally, it is worthwhile to note that the concept of therapist self-disclosure is closely tied to several other psychodynamically-oriented constructs, such as countertransference, the therapeutic use of self and the therapeutic or working alliance, to name just a few (Bordin, 1979; Edwards & Bess, 1998; Goldstein, 1994; Hill & Knox, 2001; Maroda, 2004). These phenomena and others are foundational within psychodynamic theory as a whole, and understanding the role of each as they relate to therapist self-disclosure is an integral component in the education and informed practice of mental health professionals. However, for the purposes of this dissertation the focus is narrowed to that of therapist self-disclosure from the self psychology and intersubjective perspectives.

Contrary to traditional psychoanalytic theory, in the relational school, of which both self psychology and intersubjectivity theories find their origins - albeit with unique distinctions - the therapist is not a "blank screen" (Berzoff, Flanagan & Hertz, 2011, p. 223)

and therapeutic self-disclosure is accepted (Berzoff, Flanagan & Hertz, 2011; Henretty &

Levitt, 2010). It is suggested that in the relational school and therapy contexts that the

therapist and client are "two people and two psyches" (Berzoff, Flanagan & Hertz, 2011, p.

222) always interacting in clinical situations, the therapist with his or her "own contents"

of mind, but with unique dynamics being "activated and enacted" between therapist and

client (Berzoff, Flanagan and Hertz, 2011, p. 223). In this context, a primary focus within

the therapy relationship is on these dynamics. Berzoff writes that relational theories:

> *hold that there is more that is the same about client and therapist than is different.*
> *This is a shift away from seeing the client as the pathological one and the helper as*
> *healed. Instead, both therapist and client are seen as trying to make sense of things as*
> *best they can… (Berzoff, Flanagan & Hertz, p.222).*

The relational school relies on ideas "about how clients and therapists mutually

influence each other" (Berzoff, Flanagan & Hertz, 2011, p. 222), as opposed to, in traditional

psychoanalytic theory, the focus being of the therapist on the client's psychic dynamics,

history and unresolved conflicts or issues. With regards to the potential use of therapist

self-disclosure as a therapeutic intervention, Berzoff (Berzoff, Flanagan & Hertz, 2011)

suggests that whereas once therapist neutrality played a key role in the psychoanalysis

relationship,

> *now the therapeutic work involves attending to two people's distortions, projections*
> *and displacements, and feelings. Where once classical theory overly attended to*
> *analyzing the contents of the client's mind, much more attention is paid to the mind of*
> *the therapist in interaction with the client's. Where the therapist's mind was once seen*
> *as empty, now the therapist's associations, musings, and reveries are often seen as a*
> *part of the clinical conversation. (p. 223).*

Further, Berzoff (Berzoff, Flanagan & Hertz, 2011) comments on the importance in

relational work of therapists needing "to be open to feeling and naming in (herself), and

then in the relationship, what the client may not have the words to say" (p. 224). This

"mutuality" or, as Berzoff (2011) references in quoting Ferenczi, one of the first early

psychoanalysts to understand and discuss the importance of mutuality, "the client and

therapist were always caring for one another, mutually participating in the interactions

between them" (Berzoff, Flanagan & Hertz, 2011, p. 224). It is also in this context that

therapist self-disclosure is considered a more acceptable, if not expected, therapeutic

intervention (Bloomgarden & Mennuti, 2009). However, essentially all authors

contributing to the self-disclosure literature caution that therapist self-disclosure be

approached thoughtfully and used infrequently (Berzoff, Flanagan & Hertz, 2011;

Bloomgarden & Mennuti (Eds.), 2009; Maroda, K. 2010; Stricker & Fisher (Eds.), 1990).

Berzoff further explains that therapists working within a relational perspective do not self-

disclose simply for the sake of being transparent (Berzoff, Flanagan & Hertz, 2011). Instead

she advocates awareness about "what our clients perceive, and to consider when conscious

self-disclosure may be in the service of clinical work" (Berzoff, Flanagan & Hertz, 2011, p.

231). It would seem, given what can be admittedly individual, but also universally common,

struggles in a cancer experience, that therapists with personal cancer coping experience

now working with oncology clients who may be exploring the usefulness of self-disclosure

of this personal experience, could draw upon relational perspectives with confidence in

seeking theoretical guidance, support and to some degree, liberation, albeit with caution

and thoughtfulness.

In further exploring theoretical rationale and constructs supporting the use of

therapist self-disclosure by oncology social workers with personal cancer coping

experience, valuable additional clinical guidance and direction can be found in more closely

studying both self psychology and intersubjectivity theory perspectives. Following, key

constructs of and distinctions between each of these theories are outlined, including how they may support oncology social workers with personal cancer coping experience who are in in therapeutic relationships with clients at varying stages of the cancer continuum, from the newly diagnosed through end-of-life care.

As oncology social workers who have acquired personal cancer coping experience look to psychodynamic theory for guidance in self-disclosure practices, self psychology provides a strong theoretical practice framework. Heinz Kohut first developed self psychology with his primary body of works, published in the 1970s – early 1980s (Berzoff, Flanagan & Hertz, 2011). Self psychology focuses on the understanding that the self needs to "develop into a vibrant, creative, loving, and especially, cohesive whole". Another foundational aspect of self psychology, the empathic environment, is addressed by Cornett (1991) when he writes that

> *the technical emphasis of self psychology has become the creation and maintenance of an empathic environment which allows clients to work through selfobject deficits via the interpretive process (p. 53).*

Each of these aspects of self psychology offer an approach to client/patient care most conducive to oncology social work practice particularly in today's more patient-centered, holistic health care environment (Berzoff, Flanagan & Hertz, 2011, p. 158) Self psychology is an approach requiring a more immediate outward compassion than, for example, the traditional, distanced and "blank screen" (Henretty & Levitt, 2010, p. 63) or neutral approach a traditionally-trained psychotherapist might take. Enhanced openness in the therapeutic relationship may be seen as essential in working with those impacted by cancer regardless of the disease stage in which clients find themselves and for a variety of

reasons, not the least of which is the fear and isolation experienced by so many impacted by this disease.

Another main construct of self psychology which can be found most useful in oncology social work is that of Kohut's "selfobject", particularly as it relates to opportunities for therapist self-disclosure of personal cancer coping experience (Berzoff, Flanagan & Hertz, 2011, p. 162). As defined by Flanagan (Berzoff, Flanagan & Hertz, 2011, p. 162) a selfobject is a caregiving other who may contribute to the development of a "healthy self" as they aid in meeting the "specific needs of the emerging self" (Berzoff, Flanagan & Hertz, 2011, p. 162). Cancer patients, families and caregivers often have many psychic issues emerge upon diagnosis and throughout treatment – issues relating not only to the unknowns of the current cancer experience, but also often to historical anger, loss, fear, abuse and/or failed relationships to name but a few. Establishing a healthy "selfobject" in a professionally trained oncology social worker, particularly one who has acquired personal cancer coping experience, could be optimally advantageous, as this common ground, if disclosed, potentially lends itself to a more immediate, if not intimate, connection in the counseling relationship (Berzoff, Flanagan & Hertz, 2011, p. 162). In the context of a selfobject relationship, Flanagan (2011) writes that Kohut sees rage, anger & aggression – emotions common to a cancer experience at any stage – no longer as "intrinsic forces flowing from distinct, innate drives, but rather as reactions to unmet needs" (Berzoff, Flanagan & Hertz, 2011, p. 162). Such a perspective, utilized for work with those impacted by cancer would lend itself well to the empathic approach needed for optimal therapeutic support in an oncology context. Indeed, Kohut saw the role of empathy as essential in

clinical work and actually "elevated it to a position of supreme importance and considered it to be a primary clinical tool" (Berzoff, Flanagan & Hertz, 2011, p. 165).

Another example of a self psychology key construct which provides a "best fit" for oncology social workers with personal cancer coping experience, particularly so within the context of therapist self-disclosure regarding this experience, is that of "twinship" (Berzoff, Flanagan & Hertz, 2011, p. 174; Cornett, 1991, p. 49). Twinship is one of three "poles" in Kohut's "tri-polar self" and although each pole is considered essential in its own right, the focus of this writing warrants a concentration on twinship (Berzoff, Flanagan & Hertz, 2011, p. 174, Cornett, 1991). Flanagan (2011) writes that twinship "refers to the need to feel that there are others in the world who are similar to oneself" (Berzoff, Flanagan & Hertz, 2011, p. 174). Additionally, Cornett (1991) in a somewhat pioneering article entitled, "The Risky Intervention: Twinship Selfobject Impasses and Therapist Self-Disclosure in Psychodynamic Psychotherapy", reflects on Kohut's original twinship selfobject writings, explaining he (Kohut)

> *proposed that the alterego/twinship component of selfobject mirroring involved a need to feel a connection to the human condition. In essence this involvement confirmed, as Harry Stack Sullivan once said, that 'We are all more human than anything else' ". (p. 54).*

Isolation is often one of the primary psychosocial challenges of a cancer experience (Adler, et al, 2007) and patients, families and caregivers often express a desire, demonstrate a need for and/or are referred to a variety of peer-focused services such as support groups (face-to-face and/or online), role-specific (patient, family or caregiver, peer-focused) education classes and survivor or peer matching services in an effort to cultivate an enhanced sense of identity with and belonging to others (Ashbury, et al, 1998; Campbell, Phaneuf & Deane, 2004; Giese-Davis, et al, 2006; Girgis, Lambert & Lecathelinais, 2011;

Given, Given & Kozachik, 2001; Leimeister, Ebner & Krcmar, 2014; Molassiotis & Blair, 2011; Spiegel, Bloom & Yalom, 1981; Zebrack & Isaacson, 2012).

However, based on the literature review as well as this researcher's clinical experience over two decades, it seems less likely to date that oncology social workers who may also have or are acquiring personal cancer coping experience have felt adequately equipped to utilize such theoretical frameworks as twinship in self-disclosing about such experiences, let alone feeling equipped to utilize such coping experience with clients in a therapeutic manner (Gibson, 2012; Wells, 1994), It could be that in the name of caution or simply lacking sufficient clinical education or expertise, oncology social workers are losing opportunities for theoretical constructs such as twinship to be appropriately integrated into practice. Such strategies involving therapist self-disclosure of personal cancer coping experience may not only support the therapeutic relationship through impasses, but also facilitate client relationship development overall (Cornett, 1991). Flanagan writes that Kohut considered twinship to be a "mutual recognition" wherein one finds a "sameness in a pal or a soul mate or a philosophy or a political movement", which provides another kind of "universal sustenance" from selfobjects (Berzoff, Flanagan, & Hertz, 2011, p. 174). Approaching the use of therapist self-disclosure regarding personal cancer coping experience thoughtfully and judiciously within the context of Kohut's twinship construct, seems an appropriate and solid theoretical framework for social work in an oncology context.

Coupled with well-informed other therapeutic insights – such as will be discussed below regarding intersubjectivity theory – it would seem self psychology, with its essential focus on empathy, selfobjects and twinship as examples of compatible therapeutic

constructs, provides a particularly useful theoretical framework for oncology social workers considering self-disclosure of personal cancer coping experience.

Just as self psychology provides rich theoretical support and guidance for the potential self-disclosure of personal cancer coping experience by oncology social workers, likewise does intersubjectivity theory, another relational theory. Maroda (1999) writes that Stolorow and Atwood define intersubjectivity as "any psychological field formed by interacting worlds of experience, at whatever developmental level these worlds may be organized" (p. 476). In other words, drawing upon intersubjectivity theory, oncology social workers considering therapeutic self-disclosure of personal cancer coping experience may approach such an opportunity attuned to the subjective dynamics of the client's perspective, truly attempting to understand what it is like "to walk in his/her shoes" while assessing if there may be benefit *to the client* in sharing personal cancer coping experience (Berzoff, Flanagan & Hertz, 2011, p. 276).   Intersubjective theorists also encourage the examination of the therapist's subjectivities – intrapsychic and interpersonal – and how they may be impacting the client relationship with regards to dynamics such as privilege, power, race, class and other "signifiers". (Berzoff, Flanagan & Hertz, 2011, p. 236). Berzoff distinguishes intersubjectivity theory from relational theory in writing:

> *While relational theories were interested in the dynamics in the room, in the interpersonal domain, in self disclosure, enactments, and creating a third space, they were less interested in interrogating the complexity of subjectivity: power, privilege, and multiple identifiers that client and clinician bring to the encounter. Intersubjectivity attends to those dynamics. (Berzoff, Flanagan & Hertz, 2011, p. 236)*

This perspective finds particular meaning, for example, in the concept of powerlessness for cancer patients, families and caregivers – a common psychic struggle in this population (Sand, Strang & Milberg, 2008). Patients who may have adjusted well to an initial cancer

diagnosis, but now find themselves "betrayed" by a recurrence of the illness, may feel particularly powerless, as an example. Berzoff writes that intersubjectivity theory guides clinicians to "always be thinking of the ways our multiple subjectivities interact with our clients in the contexts of power and powerlessness." (Berzoff, Flanagan & Hertz, 2011, p. 236.) A diagnosis of cancer and powerlessness go hand-in-hand and are often, combined with the many unknowns of a cancer diagnosis, at the root of anxiety and other emotional challenges for patients. An oncology social worker who, for example, is a survivor of recurrent breast cancer, may find therapeutic opportunity, cautious not to "compare" diagnoses, per se, but in identifying a commonality related to adjustment to recurrent cancer, in offering such a patient a "model" of successful adjustment experience in coping with cancer recurrence.

In further examining intersubjectivity theory and its compatibility with issues of therapist self-disclosure of personal cancer coping experience in oncology social work, further relevant Berzoff (2011) writings focus on the importance of attending to "ambiguity and to not knowing" (Berzoff, Flanagan & Hertz, 2011, p. 239) in a therapy relationship. In this context, Berzoff (2011) acknowledges the uncertainty in a therapy relationship – uncertainty which can find common ground in the life of most anyone facing a cancer experience. She goes on to reflect that both relational and intersubjective theories "give voice" (Berzoff, Flanagan & Hertz, 2011, p. 239) to such uncertainty – a voice which oncology social workers could utilize constructively when considering the self-disclosure of personal cancer coping experience. Disclosure of personal cancer coping experience by an oncology social worker to a client could serve to minimize uncertainty for those impacted by cancer. Learning that an oncology social worker may have such personal experience, in

the best of therapeutic contexts, could provide hope, encouragement and modeling of the ability to adjust to such a crisis.

It is important to consider teaching implications of all of the theoretical approaches discussed in this paper for students wishing to pursue a career path in oncology social work. In their lifetimes, these students will have between a 33% - 66% chance of developing cancer (American Cancer Society, 2014) and an even greater risk of being faced with caring for someone they love through a cancer experience. Two predominant teaching implications, as they relate to therapeutic self-disclosure within an oncology context, include: 1) the importance of students learning foundational psychodynamic concepts and 2) the importance of students clearly understanding that therapist self-disclosure is best used infrequently and with constant attention to boundaries and prioritizing the client's needs (Berzoff and De Lourdes Mattei, 1999; Berzoff, Flanagan & Hertz, 2011). I will discuss this further later in this proposal, but offer at this time that oncology social work students need first to master the foundational concepts of psychotherapy. I agree with Berzoff (Berzoff, Flanagan & Hertz, 2011, p. 238) on the importance of any relational practitioner first being well educated and experienced in traditional psychoanalytic concepts before progressing to utilize what could be considered more complex (and potentially freeing) theoretical frameworks such as relational theory, self psychology or intersubjectivity theory. Without the education of foundational psychodynamic concepts, less experienced oncology social work students utilizing a relational perspective may be too quick to self-disclose. This is an important caution. Although authenticity in our work is an essential component to clinical effectiveness, Berzoff writes of Ehrenberg's statement:

The issue is not simply one of being 'authentic'. There are ways of being authentic that can burden our patients unnecessarily and we can derail, rather than advance, the process (Berzoff, Flanagan & Hertz, 2011, p. 238).

Often our clients need us to have power and may not want to hear about a related experience we have and, therefore, a transparent relationship with an oncology social worker revealing commonalities may not be the most therapeutic intervention at that moment (Berzoff, Flanagan & Hertz, 2011, p. 238). This is when essential knowledge of other key theoretical schools is not only helpful, but necessary, as is the ability to distinguish when one theoretical framework is more appropriately utilized than another. Berzoff cautions that:

there is the danger of excessive self-disclosure, or of relativism, a kind of 'anything goes', or of seeing the client and therapist as equals when in fact – in the context of the therapeutic relationship – they are not. (Berzoff, Flanagan & Hertz, 2011, p. 238).

Drawing upon each of the proposed theoretical frameworks – relational theory, self psychology and intersubjectivity theory, it is the hope that, combined with dissertation research results, this student may lay a foundation for a proposed theoretical and practice-applicable decision-making model for effective therapist self-disclosure of personal cancer coping experience in oncology social work helping relationships.

II.   Critical Review of Literature, Theoretical Work and Research Findings

An expanded literature review was undertaken utilizing several search engines including: Google Scholar, ProQuest, PubMed, PsychInfo, Social Work Abstracts and Social Service Abstracts. Key search terms utilized included "therapist self-disclosure", "therapist self-disclosure in oncology social work", "therapist self-disclosure in counseling and/or psychoanalysis", "ethics and therapist self-disclosure", "intersubjectivity and self-disclosure" and "self psychology and therapist self-disclosure". As stated earlier, this

search reveals rich theoretical support for, but also primarily historical, though some more contemporary, debate about, the efficacy of self-disclosure by mental health providers in the therapeutic relationship. The search resulted in the identification of approximately 70 peer-reviewed journal articles, including systematic reviews, historical and theoretical overviews, approximately 20 research studies of therapist self-disclosure both qualitative and quantitative dating from 1965 to 2012, and many books focused on therapist self-disclosure or with relevant chapters.   However, despite this abundance of therapist self-disclosure literature, gaps in the available literature to date were quickly identified related to therapist cancer or personal cancer coping experience and self-disclosure. Following is a summary and critical analysis of the literature findings.

Most research studies had multiple foci (i.e.: prevalence and need for education, etc.). Following is a summary of those identified with primary areas of focus related to therapist self-disclosure, including: prevalence (Borenzweig, 1981; Bradmiller, 1978; Shulman, 1978), need for education about (Borenzweig, 1981; Carew, 2009; Knight, 2012; Wells, 1994), impact of and either support for therapist self-disclosure (Barrett & Berman, 2001; Bundza & Simonson, 1973; Burkard, et al, 2006; Knox & Hill, 2003; Nilsson, Strassberg & Bannon, 1979), cautions about the use of therapist self-disclosure (Curtis, 1982), or mixed results both favoring and cautioning against therapist self-disclosure (Audet & Everall, 2010; Myers & Hayes, 2006; Wells, 1994), practice differences between mental health disciplines and/or theoretical backgrounds (Carew, 2009; Jeffrey & Austin, 2007), different types of therapist self-disclosure (Bradmiller, 1978; McCarthy & Betz, 1978); decision-making models or guidelines for therapist self-disclosure regarding specific practice areas (Hill & Knox, 2001; Gibson, 2012; LaPorte, Sweifach & Linzer, 2010;

Maroda, 2004; Satterly, 2007) and considerations of therapist self-disclosure based on

cultural issues (Lee, 2014). Overall, most of the research studies, both qualitative and

quantitative, resulted in findings in support of the strategic, judicious use of therapist self-

disclosure, though some did not, or as indicated earlier, offered both support for and

cautions about the utilization of therapist self-disclosure.

There was also a small body of literature, either research or self-report by a

therapist, of case examples examined and analyzed regarding self-disclosure practices

and/or its impact or perceived impact (Dewald, 1980; Lee, 2014; Morrison, 1994 and

Sherby, 2005), two of which (DeWald, 1980 and Morrison, 1994) are discussed later in this

review.

Finally, there was also a small body of literature reviews regarding therapist self-

disclosure (Cozby, 1973; Gibson, 2012; Henretty & Levitt, 2010; Strassberg, Roback,

D'Antonio & Gabel, 1977 and Watkins, 1990) and most every article referenced has some

historical and/or theoretical overview of the conceptual frameworks behind either

support for and/or cautions about the use of therapist self-disclosure.

Of the research studies identified on therapist self-disclosure, the following merit

discussion or summary either due to their impact on the therapist self-disclosure literature

at the time or the relevance. Noteworthy is that several are authored by social workers.

Bundza and Simonson (1973), the authors of one of the earliest identifiable studies

on therapist self-disclosure, examined several variables including the "relationship

between therapist self-disclosure and clients' willingness to self-disclose to the therapist"

(p. 215). Their hypothesis on this stated variable was that "a self-disclosing therapist would

elicit more willingness to self-disclose on the part of subject clients than a non-self-

disclosing therapist" (p. 215.). The results indicated that "therapist self-disclosure is one way to both project therapist nurturance and facilitate client self-disclosures", (p. 216).

Shulman (1978) performed a quantitative study in Canada wherein he studied the "internal dynamics of the model of the (social work) helping process" (p. 274) through the clients of approximately 118 social workers at two social welfare agencies, utilizing two separate questionnaires. The questionnaires included The Social Work Behavior Questionnaire and the Service Satisfaction Questionnaire and clients identified as study subjects completed one or the other questionnaire. Correlations of the Workers' Skills questionnaire results with the Relationship and Helpfulness questionnaire resulted in "sharing personal thoughts and feelings" as the highest rated skill or intervention on each questionnaire. In other words, therapist self-disclosure of personal thoughts and feelings was found to be the most helpful intervention by clients in this study regardless of which of the two questionnaires they completed (Shulman, 1978).

Nilsson, Strassberg and Bannon (1979) found, in an analogue study utilizing videotaped, simulated counseling session vignettes with counselor self-disclosure manipulated and then rated by subjects across a variety of professional and personal dimensions, study results revealing that "disclosing counselors are evaluated significantly more favorably than counselors who do not self-disclose" and further, that there was "no evidence that disclosing counselors are viewed as less competent or less 'mentally healthy' as suggested in previous research" (p. 399).

Borenzweig (1981), at the time a faculty member of the University of Southern California's School of Social Work, believing, as he describes it, that there was a "discrepancy between the conventional wisdom about self disclosure and its occurrence in

the practice of clinical work" (p. 432), conducted a random sample study of 200 California

social workers via mail, exploring the concept of therapist self-disclosure via self-report

utilizing a 14-question survey. He obtained a 40% return rate and the "open-ended

questions revealed that all the respondents in our sample, save one, self disclosed" (p. 444).

He described the results as revealing the most common areas of increased therapist self-

disclosure as surrounding grief, loss, parenting, and the developmental tasks of adulthood"

(p. 444). Borenzweig offers the following insights in analyzing the study results and future

implications for social work practice:

> *"If it (therapist self-disclosure) has become an ingredient of therapy in general and clinical social work in particular it behooves us to develop the appropriate use of self-disclosure. If we do it, let us do it well." (p. 450).*

Other recent research (Knox & Hill, 2003) as described by Jeffrey and Austin (2007),

has "shown that when information is disclosed sensitively and appropriately, the

disclosure can enhance the therapeutic relationship and in some ways provide healing for

the client" (p. 95). Jeffrey and Austin (2007) conducted a study comparing marriage and

family therapists' (MFTs) and clinical social workers' (CSWs) "views on and use of clinician

self-disclosure" (p. 95). The results showed that CSWs are less likely to disclose personal

information to clients, although MFTs and CSWs disclose on similar topics when they do

self-disclose. Jeffrey and Austin (2007) further describe, as they discuss implications for

training, that "it is therefore essential that, despite differing views on self-disclosure, some

discussion and training take place about this intersection" (p. 104), as they discuss the

potential benefits to therapist self-disclosure decision-making in clinical supervision.

Wells (1994), a social worker, in a qualitative study of eight (8) client reports of

experience in therapy, found that therapist self-disclosure "has both positive and negative

treatment implications" (p. 23) and that "there is a need for therapists to explore with clients the range of meaning their disclosure has for each individual" (p. 23). Wells recommended then that "clinical training programs integrate guidelines on the appropriate use of therapist self-disclosure into their curricula" (p. 23).

Finally, among the many studies on therapist self-disclosure which were identified, Knight (2012) most recently, selected 500 social workers from the National Association of Social Workers' Maryland Chapter, from among those identifying direct practice as part of their practice scope, for participation in a quantitative study. She utilized a self-constructed survey instrument incorporating two others used in the past to measure "social workers' attitudes towards and engagement in self-disclosure with adults" (p. 300). With 192 returned surveys or a 38% response rate, worth reflecting in this writing regarding the study results, and in analysis of this literature review due to the correlation to this proposed dissertation research, is a significant portion of Knight's (2012) abstract:

> *Consistent with theory and research, participants limited their use of personal self-disclosure but were more willing to be transparent with clients. Yet, the social workers in this study did not always feel prepared by their education to appropriately engage in self-disclosure nor did they believe their use of this skill was grounded in theory or research. Many of the participants also didn't feel comfortable talking about self-disclosure in supervision or with colleagues. Findings suggest that more attention should be devoted to teaching social work students about appropriate use of self-disclosure, particularly its different manifestations and its indications and contraindications. The findings also underscore the need for more open and direct discussion of this set of skills in supervision and consultation. (p. 297).*

There was just one self-reported case study (Morrison, 1997) regarding a social worker in private practice while facing metastatic breast cancer (Goldstein, 1997; Henretty & Levitt, 2010; Morrison, 1997; Sherby, 2005). In this case both the therapist (Morrison, 1997) and her husband, a psychotherapist with whom she shared a home office (Gerson (Ed), 1996) published individually regarding each of their experiences, particularly as they

related to therapist self-disclosure, with the wife enduring this long breast cancer battle. These case studies merit brief overviews in the context of this psychosocial oncology-based research proposal.

In her publication and account of the experience Morrison (1997), also cited in several other publications (Goldstein, 1997; Henretty & Levitt, 2010; Sherby, 2005), who ultimately succumbed to her disease after 10 years of practicing while under treatment, focused on her struggle with and ultimate mastery of her own internal debate of if, when, and how much to disclose to her clients (not necessarily cancer patients, though some with cancer coping experience) regarding her illness and impending death, until very close to the time of her death. Her success in developing seemingly effective self-disclosure practices during her own illness experience has significant implications for oncology social workers with personal cancer coping experience and encourages further exploration of the topic such as with this proposed research.

In his own effort to summarize the spousal experience from that of a therapist's perspective and also particularly as it relates to therapist self-disclosure, Morrison's husband, A. P. Morrison, published the book chapter, "Trauma and Disruption in the Life of the Analyst: Enforced Disclosure and Disequilibrium in 'The Analytic Instrument'" (Gerson, (Ed), 1996). In this writing A. P. Morrison (1996) offers a compelling case (as he discusses contemplation of whether or not he should have taken a break from working during this caregiving experience) for the careful, albeit in his case, "enforced" (due to their home-based offices) self-disclosure (Gerson (Ed), 1996, p. 42) of this "environmental trauma" (Gerson, (Ed), 1996, p. 42) which he believes can result in client benefit. Of this experience, A. P. Morrison (1996) writes:

Environmental trauma – in this case, illness and loss of a loved one – inevitably exerts a destabilizing impact on the self-state (or sense of self) of the analyst and shakes up the calibrations on that delicate appliance, "the analytic instrument." From my own experience, this destabilization does not automatically mandate a break by the analyst from his work. Rather, I suggest that deliberate and focused attention to this dimension of the analyst's person – the cohesion, stability, energy, and equilibration, of his sense of self (that is, the self-state of the analyst [italics original to the author]) – enables the analyst to place himself into the analytic matrix as he interacts with, responds to and has feelings about the expressions of his patients. This awareness by the analyst of his own contribution to the intersubjective moment with his patient can often be turned to major benefit for the therapeutic process (Gerson (Ed), 1996, p. 44).

Another self-reported case study from the literature review on therapist self-disclosure (Dewald, 1980), is valuable for this dissertation proposal preparation and subsequent work and merits brief discussion. In this article, originally presented at the fall meeting of the American Psychoanalytic Association in New York in December 1980, the author, a training psychoanalyst, chronicles, primarily from his clients' transference and his own countertransference perspectives, the experience of encountering a serious and, at times, life-threatening illness, from onset through his convalescence and return to private practice many months later. This work is enlightening in that Dewald (1980) specifically discusses the various stages of his own adjustment as well as his clients' which involved therapist self-disclosure, albeit "enforced" to a great degree (Gerson (Ed.), 1996, p. 42), and how his clients' varying transference and his own countertransference reactions impacted to whom, what, how much and when he self-disclosed to them. This work seems particularly valuable as a resource to inform this dissertation research in that, from his *training* analyst perspective, Dewald details very specific psychodynamic concepts which could also be relevant to an oncology social worker with personal cancer coping experience such as "role reversal" (p. 350), suggested levels of information disclosure and the potential impact on clients' "transference fantasies" (p. 349), the therapist's denial of

"invulnerability" (p. 351) and his own psychic regression and then regression reversal over the course of his illness and recovery. These are just a few of the concepts which would seem compatible with the struggles an oncology social worker facing a similar challenge with a personal cancer experience (Dewald, 1980).

No therapist self-disclosure literature resources were identified relating specifically to practice in psychosocial oncology, oncology social work or to the practice of oncology social work as a cancer survivor and/or a current or former cancer caregiver. However, several findings (as indicated below), reflected support for self-disclosure more generally. In their 2010 qualitative systematic review on therapist self-disclosure, Henretty and Levitt found significant evidence of mental health providers with a "client-centered" perspective – one that is also foundational in the delivery of social work services and conducive to the positioning of self psychology and the intersubjective perspectives, particularly in today's health care environment – who advocate that by

> *cautiously modeling openness, strength, vulnerability, and sharing of intense feelings,*
> *the therapist who uses therapy-relevant self-disclosure invites the client to follow the*
> *lead and cultivates trust, perceived similarity, credibility, and empathic understanding*
> *(Henretty & Levitt, 2010, p.64).*

These results and those cited previously in this literature review suggest that an oncology social work research endeavor at the nexus of personal experience and professional service delivery, following similar client-centered perspectives, is both timely and much needed.

Next offered is a summary and critical appraisal of the more historical and primarily psychodynamic literature on therapist self-disclosure which, given the changing tides in psychotherapy regarding the use of therapist self-disclosure (Gaztambide, 2012), may most usefully be done by reviewing the evolution of therapist self-disclosure perspectives within the history of psychodynamic theories, as they relate to both the previously offered

theoretical rationale for this research, and its positioning and utility for oncology social

workers who themselves have personal cancer coping experience. However, for the

purposes of this research proposal first offered is a working definition of, in the context of

this proposed study, of what is meant – and to some degree what is not meant - by

"therapist self-disclosure".

A. Therapist Self-Disclosure Defined

Therapist self-disclosure has been defined in the literature by several authors in

varying degrees and detail including Anderson & Mandell, 1989; Cohen, B., 2005; Goldstein,

E. G., 1994; Jeffrey & Austin, 2007; Maroda, 1999 and Norcross & Hill, 2004, to cite a few.

For the purposes of this research project, drawing from these sources, therapist self-

disclosure will be defined as: "the intentional or deliberate, verbal self-disclosure by an

oncology social worker regarding some aspect of a personal cancer coping experience,

whether as survivors themselves or as cancer caregivers, for the purposes of advancing the

therapeutic cause in a client relationship and for the sole benefit of the client and/or the

therapist /client relationship" (Anderson & Mandell, 1989; Cohen, B., 2005; Goldstein, E. G.,

1994; Jeffrey & Austin, 2007; Maroda, 1999; Norcross & Hill, 2004).

B. Evolution of Therapist Self-Disclosure Theoretical Literature and Perspectives

The concept of therapist self-disclosure, including its potential merits and

challenges, has been deliberated for decades, beginning with Sigmund Freud, the "founder

of psychoanalysis" (Palombo, Bendicsen & Koch, 2009. P. 1). In 1912 Freud wrote, "The

doctor should be opaque to his patient and, like a mirror, should show nothing but what is

shown to him" (Freud, 1912, pg. 118; Raines, 1996; Sherby, 2005). Rosenblum (1998)

believes the "idealization" (p. 538) of Freud and his teachings contributed to a "resistance"

(p. 538) in the mental health professions of the use of self-disclosure. Likely also

contributing to this resistance are well publicized and more recent cautions, licensing

requirements and mandatory continuing education regarding attention to appropriate

boundaries in clinical work (Gutheil & Gabbard, 1998; Walker & Clark, 1999). Rosenblum

(1998) further details that Freud "maintained that the avoidance of self-disclosure was

necessary for the development and resolution of a transference neurosis" (p. 538) and that

in Freud's 1915 *Recommendations on Analytic Technique* (p. 538), he (Freud) "explicitly

warns against self-disclosure in any form" (p. 538). Rosenblum proceeds in this same

publication (a special issue of *Psychoanalytic Inquiry: A Topical Journal for Mental Health*

Professionals, dedicated to therapist self-disclosure in psychoanalysis) to explain Freud's

then position on self-disclosure and his particular cautions against younger, less

experienced therapists utilizing self-disclosure with patients (p. 539). Rosenblum repeats

Freud's positional statement:

> *Young and eager psychoanalysts will no doubt be tempted to bring their own*
> *individual feeling into the discussion…this technique achieves nothing towards the*
> *uncovering of what is unconscious to the patient (p. 539).*

Finally, Rosenblum (1998) summarily conveys Freud's stance against the use of therapist

self-disclosure, writing that he (Freud):

> *concludes his essay, claiming 'the resolution of transference is made more difficult by*
> *an intimate attitude on the doctor's part. The doctor should be opaque to the patient*
> *and show them nothing but what is shown to him, (p. 539).*

Indeed, this concluding statement by Freud bears repeating because it essentially served as

a prohibition on the use of therapist self-disclosure at the time, not only molding Freud's

generation of followers' self-disclosure perspectives and practices, but impacting

psychoanalysts in subsequent generations including to current times, such as Meissner

(2001) and Rosenblum (1998).

However, it is plausible that over time Freud's own practice began to evolve away

from the distant, more neutral model of psychotherapy. Gaztambide (2012), in his paper

titled, "A Psychotherapy for the People: Freud, Ferenczi and Psychoanalytic Work with the

Underprivileged", in writing of the dialogue between these two psychotherapy pioneers in

the wake of World War I, describes Freud as then "inspired" to (p. 141) and making a "call

for greater psychoanalytic engagement with the poorest and most vulnerable" (p. 141) in

his 1918 opening keynote speech at the Budapest Congress, entitled, "Lines of Advance in

Psychoanalytic Therapy" (p. 142). Gaztambide (2012) writes that in this address Freud

> *explored the modification and application of psychoanalysis to poor and*
> *underprivileged persons who, until the 1920s, were generally marginalized from*
> *psychoanalytic treatment" (p. 142).*

Lending additional evidence to Freud's growing shift in perspective on therapist self-

disclosure, Lynn and Valliant (1998), in a review of 43 of Freud's cases from 1907 – 1939,

found "substantial disparity" (p. 163) between Freud's writings and actual "methods" (p.

163), with evidence of "significant extra-analytic relations between Freud and 31 (72%) of

the analysands", or cases studied. This suggests the possibility that Freud, himself, may

have ultimately considered some therapist self-disclosure beneficial to the therapeutic

relationship, though, as Lynn and Valliant (1998) write, "Freud's actual method was never

explicitly described in his writing and cannot be replicated" (p. 163). Critical appraisal of

these historical events in the evolution of psychotherapy suggest that Freud was most

likely beginning then to advocate for a more cost-efficient, but most importantly, more

available model of psychotherapy that could reach the previously underserved and was

perhaps not as distant and neutral as his original ideas with regards to the stance of the psychotherapist.

It is also useful, as one attempts to understand the roots of Freud's (at least initial) more "anti" position on therapist self-disclosure, to consider his roots in medicine (Maroda, 1999). In her writing, Maroda (1999) offers a valuable reflection in identifying the origins of Freud's perspective in medicine, where he started his career and where processes must be "uncontaminated" (p. 475). Additionally, Meissner (2002) references Freud's recommendations for "surgeon-like objectivity" (p. 828). One interpretation of these statements, as we attempt to understand Freud's perspective on self-disclosure, could be regarding the importance of any professional, be it psychoanalyst, physician or electrician, that most professionals are best served by first mastering foundational concepts of any occupation "with a clean slate", before exploring opportunities for exceptions "off the beaten path", as was discussed earlier regarding teaching implications. This is certainly the case in the training of new social workers who must master assessment, for example, in a structured manner, before diverging from a process and practices established with confidence by a field instructor with years of experience. Certainly, as Maroda (1999) so insightfully shares, "it made sense that if the analytic therapist was conversing regularly about her own inner experience, this could be partially or entirely disruptive to the whole analytic endeavor" (p. 475). Also in support of caution regarding the use of therapist self-disclosure, Berzoff and De Lourdes Mattei (1999) drive home the importance, for example, of students learning foundational concepts before progressing to more specific assessment and intervention perspectives in writing:

> *We think that beginning students in clinical social work practice need to learn classical analytic theories that illuminate the clients' structure, character,*

developmental struggles, pathology, and strengths. We see continuing value in understanding the nature of a client's human psychological conflicts, and the methods the client employs to deal with them. We think it essential that students learn to assess systematically their clients' capacities to form part of whole object relationships so as to recognize the ways in which the client may need to use the therapist differently. (p. 380).

Freud's influence on the use of therapist self-disclosure continues to current times, although the literature reflects an evolved perspective on it by Freud and others "in the wake of World War I" (Gaztambide, 2012, p. 141) and "psychoanalysis's encounter of poverty and destitution" (Gaztambide, 2012, p. 141). World War I had a significant impact on Freud's life and practice and there is evidence from his own case studies in which he eventually advocated for "experimenting with clinical technique" (Gaztambide, 2012), p. 141; Sherby, 2005). Indeed, it is at this point in psychoanalytic history and its literature, including regarding therapist self-disclosure, that it seems Freud's own perspective on therapist self-disclosure may have begun to evolve.

Enter Sander Ferenczi, a Hungarian psychoanalyst and forerunner of relational psychoanalysis known for his "experimentation with psychoanalytic technique" (Britannica, 2014) and his interest in mutuality in the therapeutic relationships (Berzoff, Flanagan & Hertz, 2011). Ferenczi met Freud in 1908 and their dialogue explored trying to create a more "flexible" psychoanalysis, "experimenting with clinical technique" (Gaztambide, 2012, p. 141). It is said Ferenczi was of the first psychoanalysts to explore therapist self-disclosure as a potentially useful practice (Maroda, 1999), and which would have been in keeping with his relational perspective. Berzoff (Berzoff, Flanagan & Hertz, 2011) offers the following regarding what were likely, at the time, Ferenczi's avant-garde perspectives:

Rather than look only at the patient, Ferenczi was interested in exploring both the client's and the therapist's wishes to cure and their failures to do so. In fact, Ferenczi saw pure objectivity on the therapist's part as a way of distancing from the client, including from the client's traumatic experiences. Instead, he was interested in how traumatic experiences played out relationally between therapist and client, and how the therapist needed to feel in her bones what the client was conveying unconsciously. In Ferenczi's view, the patient and therapist had to live through, together, the client's experiences of trauma and to face them with honesty and authenticity. (p. 224).

This view of Ferenczi's pioneering efforts in relational psychotherapy offers significant foundations for oncology social workers who acquire personal cancer coping experience and who may later wish to utilize therapist self-disclosure about it to a client.

The therapist self-disclosure literature also reveals that, of the many contributors following Ferenczi, Sidney Jourard, an Associate Professor of Psychology at the University of Florida in the 1950's, was likely one of the first to publish regarding the use of self-disclosure in his still frequently-cited work, *The Transparent Self: Self-Disclosure and Well-Being* (Jourard, 1964). With this publication, Jourard ensured the door to therapist self-disclosure would remain open for further exploration, including continued debate. Chapters within this work reflect an evolving self-disclosure perspective, with such titles as, "Self-Disclosure as a Psychological Fact", "The Importance of Self-Disclosure in Human Experience" and the "Role of Authenticity in Helping Others", to name but a few of the foci of this seminal work. Jourard also seemingly paved the way with this publication for one of the more contemporary and first identifiable public blessings to a health profession for self-disclosure – nursing – with his chapter entitled, "A New Way of Being for Nurses", closing this chapter with "The Invitation to Authenticity" (Jourard, 1964, p. vii – viii). Jourard's emphasis promoted a greater authenticity on the part of the therapist, including his or her "'transparency' and willingness to self-disclose in contrast to the 'opaqueness of the traditional analytic stance'" (Cohen & Schermer, 2001). Perhaps theorist clinicians such

as Ferenczi and Jourard constituted the pioneers of theoretical framework also relevant to

and upon which oncology social workers with personal cancer coping experience can draw

when considering the potential for self-disclosure of personal cancer coping experience.

 Since then the practice theory of psychoanalysis has evolved and the relational

psychoanalytic school and its more contemporary perspectives including self psychology

and intersubjectivity theory have laid solid footing for the use of therapist self-disclosure in

the mental health professions. Stolorow, Atwood and Brandchaft (1994) could be

considered the fathers of intersubjectivity theory, identifying a key concept as contrasting

to that of Freud's "rule of abstinence" (Stolorow, Atwood & Brandchaft, 2011, p. xi) stating

that an intersubjective perspective:

> *allows for much greater flexibility, so long as the analyst consistently investigates the impact of his technique, style and theoretical assumptions on the patient's experience and on the course of the therapeutic process. This great flexibility frees analysts to explore new modes of intervention and to discover hitherto unarticulated dimensions of personal experience. (p. xi).*

 At the time Stolorow, Atwood and Brandchaft were pioneering intersubjectivity

theory several other, related new perspectives were unfolding within the relational

paradigm in psychoanalysis. These included relational-model theorizing (which provides

an "umbrella theory for intersubjectivity") and a dyadic systems perspective based on

infant research and social constructivism (Stolorow, Atwood & Brandchaft, 1994).

 Further review of contemporary therapist self-disclosure literature reflects

continued debate and cautions about, but overall favors the strategic, judicious use of

therapist self-disclosure (Anderson and Mandell, 1989; Bridges, 2001; Cohen, 2005; Cohen

& Schermer, 2001; Edwards & Bess, 1998; Gibson, 2012; Goldstein, 1997; Henretty &

Levitt, 2010; Jacobs, 1992; Knight, 2010; Knox & Hill, 2003; Maroda, 2010; Meissner, 2002;

Raines, 1996; Satterly, 2007; and Tsai, et al, 2010; Watkins, 1990 and Wells, 1994).

Watkins conveys in a 1990 systematic review, "self-disclosure has been regarded as

essential" and a clinical technique which therapists "must be willing to engage in if

counseling is to occur". Alternatively, however, Meissner (2002), a revered psychoanalyst

and Jesuit priest who died in 2010, cautions in a work entitled, "The Problem of Self-

Disclosure in Psychoanalysis" that

> *the major risk in self-disclosure is the tendency to draw the analytic interaction into
> the real relation between analyst and patient, thus diminishing or distorting the
> therapeutic alliance, mitigating transference expression, and compromising
> therapeutic effectiveness" (p. 827)*

This is just one example of more contemporary cautions. Further exploration of Meissner's

(2002) cautions reveals the he felt the use of self-disclosure was lacking useful guidelines

for practitioners - likely true - as many of the guidelines have only since been published

(Hill & Knox, 2001; Gibson, 2012; Maroda, 2004; Satterly, 2007). Meissner's position on

self-disclosure, though seemingly conservative as it called for continued "neutrality" –

remnants of Freud's perspective - (p.829 - 830) did also support, within the concept of the

therapeutic alliance, appropriate therapist self-disclosure. Meissner goes on to argue

positive attributes of neutrality within a therapeutic stance – a "mixed model" of sorts

regarding the judicious use of therapist self-disclosure, stating,

> *Neutrality designates the mental stance from which the analyst considers, reflects on
> and decides on interactions and interventions with the patient, according to the best
> available understanding at any given point of the patient and how best to advance or
> facilitate the analytic process (p. 830 – 831).*

Meissner began to reveal an evolution in his own perspectives, conveying that neutrality

and therapist self-disclosure were not only compatible, but that neutrality "serves an

essential role in providing the basis for discerning whether self-disclosure is

therapeutically indicated or advantageous." (p. 830). Indeed, of the five recommendations

Meissner (2002) makes regarding the thoughtful use of therapist self-disclosure among

them he states:

> *Blanket recommendations of either unrestrained self-disclosure or rigid nondisclosure*
> *and insistence on total anonymity amount to forms of countertransference enactment*
> *that do not serve the analytic process well, but lead to corresponding forms of*
> *misalliance. (p. 860).*

Meissner goes on to offer the following support for therapist self-disclosure, "To the

extent that self-disclosure helps to establish, maintain, reinforce, or constitute the alliance,

it is more likely to be of therapeutic benefit." (p. 860). This perspective, entrenched within

a relational theoretical perspective, not only reflects the evolving stance on therapist self-

disclosure in the more current literature (even from more cautionary theorists and

practitioners such as Meissner), but in doing so also offers further sound guidance to the

development of a therapist self-disclosure framework for oncology social workers with

personal cancer coping experience.

The literature review also revealed the 2001 publication of the Psychopathology

Committee of the Group for the Advancement of Psychiatry, published in Psychiatric

Services and entitled: "Reexamination of Therapist Self-Disclosure" (Dixon, et al, 2001).

This report was the result of psychiatry's exploration into the evolving clinical perspectives

on therapist self-disclosure and a need to publish a position statement grounded in theory,

to define therapist self-disclosure and to offer direction to current and future mental health

practitioners (Dixon, et al, 2001). The Committee references Winnicott's influence on self-

disclosure's changing perspective, stating that Winnicott "viewed therapy as a creative

process that could not move forward unless the patient felt some attachment to the

therapist" (p. 1491). The report also offers a caution regarding "excessive" (Dixon, et al,

2001, p. 1491) self-disclosure conveying that it could "initiate a downward spiral into more serious boundary violations, such as sexual involvement" (Dixon, et al, p. 1491).

Of particular significance to this research and literature review is that at least two "special issues" of journals were identified which focused on themes relevant to this research and which have and will surely inform this dissertation work into the future. One publication, of the *Journal Psychoanalytic Inquiry: A Topical Journal for Mental Health Professionals*, published in 1998, was entirely dedicated to therapist self-disclosure. The other, of the *Smith College Studies in Social Work Journal* was entitled, "Perspectives on Intersubjectivity" and included an article dedicated to self-disclosure from an intersubjective context (Maroda, 1999). In analyzing changing perspectives on therapist self-disclosure in the literature, it is worthwhile to acknowledge that a changing tide – from therapist neutrality to one more supportive of self-disclosure – is reflected in the former publication's epilogue, authored by the editor, Michael Miletic, MD. In it Dr. Miletic acknowledges that although the issues' authors represented a wide divergence of perspectives on therapist self-disclosure, they had "surprising findings emerge" (p. 601) as they discovered that "the ways these authors describe of treating their patients begin to converge in the following ways", which also bear repeating in this literature review:

1. *Each author cautions against making any a priori assumptions about self-disclosure and against any preconceived theoretical ideas about talking about one's self per se;*
2. *Each author has found speaking about himself/herself to patients at specific times to be potentially helpful to the patient;*
3. *Speaking directly about one's self can be helpful when it is done in the interest of the patient and of the analysis, regardless of where the analyst is positioned conceptually;*
4. *These moments of self-disclosure utility often occur at times when dealing with difficult resistances in new ways, or when accessing areas that previously have been inaccessible;*

> 5. *It is important to pursue, examine and discuss the meaning of self-disclosure to the patient and to the analyst over time; and*
> 6. *These meanings of the self-disclosure cannot be predicted in advance of their occurrence. (p. 601).*

Dr. Miletic proceeds to challenge mental health professionals to "work out the vicissitudes of these interactions" (p. 601) by pursuing more "fully detailed clinical reporting of what we actually say about ourselves to our patient and how we say it" (p. 601) to aid future research. Oncology social workers seeking guidance in the appropriate use of self-disclosure of personal cancer coping experience would be served well by these findings which could be considered in the development of oncology-specific self-disclosure guidelines.

Additionally, Maroda (1999), in the *Smith College Studies in Social Work's* special issue on intersubjectivity, offers in her article, "Creating an intersubjective context for self-disclosure" the beginning of a justifying framework for therapist self-disclosure as authored by Gorkin (1987), which could also inform an oncology-specific framework for self-disclosure. Maroda writes that Gorkin cites the following reasons for therapist self-disclosure:

> 1. *To confirm the patient's sense of reality.*
> 2. *To establish the therapist's honesty or genuineness.*
> 3. *To establish the therapist's humanness.*
> 4. *To clarify both the fact and the nature of the patient's impact on the therapist, and on the people in general.*
> 5. *To end a treatment impasse or breakthrough a deeply entrenched impasses. (p. 477).*

The authors' commonalities in the Psychoanalytic Inquiry special issue, despite differences in their theoretical perspectives, as well as Gorkin's criteria for therapist self-disclosure cited by Maroda (1999), inform not only this proposed research, but all mental health

professionals seeking heightened awareness of the appropriate use of therapist self-disclosure.

Also noteworthy is that this literature review revealed a significant presence and increasingly prominent role of social work as a discipline in the research on and writing about therapist self-disclosure, including on theoretical construct development (Edwards & Bess, 1998; Gibson, 2012; Goldstein, 1997; Jeffrey and Austin, 2007; Knight, 2012; Morrison, 1997; Satterly, 2007; Strean, 1999). Overall, these social workers advocate for the intentional, but cautious use of therapist self-disclosure and have had a significant impact on contemporary therapist self-disclosure theory and practice. They have explored therapist self-disclosure from an ethical perspective (Peterson, 2002), from an ego psychology perspective (Goldstein, 1994 and 1997), from the perspective of terminal illness in the therapist (the case study referenced earlier, Morrison, 1997), from the perspective of sexuality with proposed guidelines for gay, male therapists and students who may wish to self-disclose their sexuality (Satterly, 2007) and finally, with suggestions for whether or not and when therapist self-disclosure is the most appropriate therapeutic tool to utilize in a helping relationship (Edwards & Bess, 1998; Cornett, 1991; Gibson, 2012; Goldstein, 1997; Jeffrey and Austin, 2007; Knight, 2012; Morrison, 1997; Peterson, 2002; Satterly, 2007 and Strean, 1999).

Understanding that therapist self-disclosure is fraught with clinical relationship risks, it is also relevant to discuss therapist self-disclosure guidelines which have been established to date (Bridges, 2001; Hill and Knox, 2001; Knox and Hill, 2003; Norcross, 2004; Raines, 1996; Satterly, 2007). There are several "sets" of guidelines, but those of Hill and Knox (2001), succinct yet comprehensive, may, at this time, offer a "best fit" to inform

this research with seemingly clear boundaries and support for thoughtful therapist self-disclosure. They offer what seem the most applicable guidelines to date for oncology social workers who have personal cancer coping experience and who may be exploring the usefulness and wisdom in self-disclosing about these experiences:

1. *Therapists should generally disclose infrequently.*
2. *The most appropriate topic for therapist self-disclosure involves professional background, whereas the least appropriate topics include sexual practices and beliefs.*
3. *Therapists should generally use disclosures to validate reality, normalize, model strengthen the alliance, or offer alternative ways to think or act.*
4. *Therapists should generally avoid using disclosures that are for their own needs, remove the focus from the client, interfere with the flow of the session, burden or confuse the client, are intrusive, blur the boundaries or overstimulate the client.*
5. *Therapist self-disclosure in response to similar client self-disclosure seems to be particularly effective in eliciting client disclosure.*
6. *Therapists should observe carefully how clients respond to their disclosures, ask about client reactions, and use the information to conceptualize the clients and decide how to intervene next.*
   It may be especially important for therapists to disclose with clients who have difficulty forming relationships in the therapeutic setting. (p. 418 - 419).

The results of this review will hopefully serve to more specifically inform potential guidelines, the goal being the tailoring of current guidelines such as those above specifically for oncology social workers with personal cancer coping experience. To date there is a dearth of literature regarding therapist self-disclosure of personal cancer coping experience in oncology social work and no such decision-making framework has been established for the profession (for those with personal cancer coping experience or otherwise) or social work students pursuing an oncology career path.

C. **Therapist Self-disclosure Themes Emerging in the Literature**

Several themes within the topic of self-disclosure emerged in this literature search. Numerous historical overviews and literature reviews within the past 40 years, including

as recently as 2013 (Ziv-Beiman) provided informative summaries of the historical

underpinnings as well as the current state of the art of therapist self-disclosure, including

ongoing discourse, growing support for and ramifications of its utilization in counseling

relationships (Edwards & Bess, 1998; Gaztambide, 2012; Jeffrey & Austin, 2007; Meissner,

2002; Morrison, 1997; Sherby, 2005; Tsai, Plummer, Kanter, Newring & Kohlenberg, 2010;

Ziv-Beiman, 2013). In analyzing the literature it is useful to consider these emerging

themes:

1) **Historical debate:** The historical – and somewhat continued - debate about therapist

self-disclosure, primarily based on Freud's teachings (Gaztambide, 2012; Meissner, 2001;

Sherby, 2005)

2) **Shifts in recent therapist self-disclosure perspectives:** A shift in more recent years

towards acceptance of the judicious, strategic use of therapist self-disclosure, its merits,

benefits and theoretical support for (Cornett, 1991; Edwards & Bess, 1998; Gibson, 2012;

Knox & Hill, 2003; Sherby, 2005; Ziv-Beiman, 2013);

3) **Many and varied therapist self-disclosure definition attempts:** Attempts by nearly

all theorists and clinicians to define therapist self-disclosure (Goldstein, 1994, 1997; Jeffrey

& Austin, 2007; Maroda, 2003 and 2010);

4) **Apparent clinician lack of preparedness** for the effective use of self-disclosure

(Carew, 2009; Gibson, 2012; Knight, 2012; Jeffrey & Austin, 2007; Wells, 1994);

5) **Ethical issues related to the use of therapist self-disclosure** (Cohen, 2005; Peterson,

2002);

6) **Need for guideline development:** The development of guidelines for the appropriate

utilization of therapist self-disclosure (Bridges, 2001; Dixon, et al, 2001; Edwards & Bess,

1998; Goldstein, 1994, 1997, 1999; Hill and Knox, 2001; Knox and Hill, 2003; LaPorte, Sweifach & Linzer, 2010; Myers & Hayes, 2006; Raines, 1996); and, more recently

7) **<u>Practice or population-specific decision-making models:</u>** Specific decision-making models, including for specific therapist sub-cultures or practice contexts (such as with gay male therapists – Satterly, 2007) or situated in or from specific theoretical constructs (twinship selfobject needs – Cornett, 1991) for "intention and reflection" (Satterly, 2007, p. 187) regarding the optimal use of therapist self-disclosure in counseling relationships (Cornett, 1991; Geller, 2003; Maroda, 2010; Satterly, 2007).

Literature analysis reveals trends of the past 40 years reflecting not only increasing acceptance of, but advocacy and theoretical support for the cautious, intentional and strategic use of therapist self-disclosure (Borenzweig, 1981; Cohen & Schermer, 2001; Curtis, 1981 and 1982; Gibson, 2012; LaPorte, Sweifach & Linzer, 2010; Raines, 1996). This shift in the culture of service delivery as it relates to therapist self-disclosure coupled with the call for development of practice and context-specific guidelines and decision-making models (Dixon, et al, 2001), lends credibility to the potential for therapist self-disclosure of personal cancer coping experience as a valid investigation, with promise not only for scholarly but valuable clinical practice impact in oncology social work and for those affected by cancer.

IV.   Discussion: Implications for Social Work

Understanding that therapist self-disclosure is fraught with clinical relationship risks, the guidelines and decision-making frameworks developed to date by several mental health professions, social workers among them, aid clinicians in the effective, strategic use of self-disclosure with the goal of client benefit foremost in mind (Bridges, 2001; Hill and

Knox, 2001; Knox and Hill, 2003; Norcross, 2004; Raines, 1996; Satterly, 2007). These

guidelines and models offer guidance - clinical "maps" of sorts - for internal, intentional

reflection about if, when and why a mental health provider might decide to self-disclose.

However, no guidelines or decision-making frameworks developed to date are specific to

psychosocial oncology or oncology social work, nor do they consider specific nuances

unique to situations such as a patient's specific treatment plan and accompanying

challenges, prognosis or historical cancer or other experiences influencing a client's cancer

coping style. These are just a few variables unique to direct practice in psychosocial

oncology. While the general self-disclosure literature is robust, the absence of a

psychosocial oncology focus for such guidelines and decision-making models lays fertile

ground for further evidence-based exploration and potential applicability to oncology

social work, particularly when the practitioner is considering disclosing personal cancer

coping experience (Bridges, 2001; Hill and Knox, 2001; Knox and Hill, 2003; Norcross,

2004; Raines, 1996; Satterly, 2007), such as is proposed with this research study.

Additional implications for the field of social work at large include opportunities to then

further the advancement of such research and practice guidelines to other subspecialty

areas within the field such as child welfare and a variety of medical and/or psychiatric

illnesses to name just a few, in an effort to aid in better understanding the nuances of other

subspecialty fields when the social workers practicing in them have, themselves, had such

experiences and may struggle with therapist self-disclosure issues which, if disclosed

appropriately, could provide further client benefit and strengthen the working alliance. The

question is: "How does the profession of social work support clinicians in professional

growth via the constructive integration of most any personal life experience into practice,

by educating them about and guiding them through the "healthy" application of therapist

self-disclosure for optimal patient benefit for a specific practice niche?" This research study

aims to explore one such growing subspecialty area – oncology – and lays the groundwork

for just such practice advancement.

Bibliography and Citations

Abrams, R. D. (1974). Not Alone with Cancer. Charles C. Thomas: Springfield, Illinois.

Adler, N. et al (2007). Cancer Care for the Whole Patient: Meeting Psychosocial Health
  Needs. Institute of Medicine. National Academies Press: Washington, D. C.

American Cancer Society, 2014 Facts and Figures Annual Report. Retrieved from:
  http://www.cancer.org/acs/groups/content/@research/documents/webcontent/acspc-
  042151.pdf

American Cancer Society, 2015 Facts and Figures Annual Report. Retrieved from:
  http://www.cancer.org/acs/groups/content/@editorial/documents/document/acspc-
  044552.pdf American Cancer Society (2014-2015). Cancer Treatment and Survivorship
  Facts and Figures. Retrieved from:
  http://www.cancer.org/acs/groups/content/@research/documents/document/acspc-
  042801.pdf

Anderson, S. C. and Mandell, D. L. (1989). The use of self-disclosure by professional social
  workers. Social Casework, 70 (5), May, 259 – 267. Retrieved 8.2.14 from:
   http://v2k3db01.library.upenn.edu/illiad/PDF/853770.pdf

Asbury, F. D., Cameron, C., Mercer, S. L., Fitch, M. and Nielsen, E. (1998). One-on-one peer
  support and quality of life for breast cancer patients. Patient Education and Counseling,
  35, pp. 89 – 100. DOI: 10.1016/S0738-3991(98)00035-4

Barbour, R. (2007). Doing Focus Groups: The Sage Qualitative Research Kit. Sage Publishers: Los
    Angeles.

Barrett, M. S. and Berman, J. S. (2001). Is psychotherapy more effective when therapists disclose
    information about themselves? Journal of Consulting and Clinical Psychology, 69,
  4, pp. 597 – 603. DOI: 10.1037//0022-006x.69.4.597.

Berzoff, J. and De Lourdes Mattei, M. (1999). Teaching intersubjectivity: Paradox and
  Possibility. Smith College Studies in Social Work, 69, 373 – 387. DOI:
  10.1080/00377319909517560

Berzoff, J., Flanagan, L. M. and Hertz, P. (2011). Inside Out and Outside In, Third Edition,
   Psychodynamic Clinical Theory and Psychopathology in Contemporary Multicultural
  Contexts. Rowman and Littlefield Publishers, Inc.: New York.

Bloomgarden, A. and Mennuti, R. B. (Eds.) (2009). Psychotherapist Revealed: Therapist Speak
  About Self-Disclosure in Psychotherapy. Routledge Taylor and Francis Group: New York.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working
  alliance. Psychotherapy: Theory, Research and Practice, 16, 252 – 260. DOI:
  10.1037/h0085885

Borenzweig, H. (1981). The use of self disclosure of clinical social workers. Journal of Social Work and Social Welfare, pp. 432 – 460. Retrieved via Interlibrary Loan Request from the University of Pennsylvania Van Pelt Library.

Bradmiller, L. (1978) Self-disclosure in the helping relationship. Social Work Research and Abstracts, 14, 2, p. 28 – 35. DOI: 10.1093/swra/14.2.28

Bridges, N. A. (2001). Therapist's self-disclosure: Expanding the comfort zone. Psychotherapy, 38, Spring, 21 – 30. DOI: 10.1037/0033-3204.38.1.21

Britannica, Encyclopedia (2014). Sandor Ferenczi. Retrieved 11.15.14 from: http://www.britannica.com/EBchecked/topic/204592/Sandor-Ferenczi.

Bundza, K. A. and Simonson, M. R. (1973). Therapist self-disclosure: Its effect on impressions of therapist and willingness to disclose. Psychotherapy: Theory, Research and Practice, 10, 3, pp. 215 – 217. DOI: 10.1037/h0087578

Burkard, A. W., Knox, S., Groen, M., Perez, M. and Hess, S. A. (2006). European American therapist self-disclosure in cross-cultural counseling. Journal of Counseling Psychology, 53, 1, 15 – 25. DOI: 10.1037/0022-0167.53.1.15

Campbell, H. S., Phaneuf, M. R. and Deane, K. (2004). Cancer peer support programs – do they work? Patient Education and Counseling, 55, pp. 3 – 15. DOI: 10.1016/j.pec.2003.10.001

Carew, L. (2009). Does theoretical background influence therapists' attitudes to therapist self-disclosure? A qualitative study. Counselling and Psychotherapy Research, 9, 4, 266 – 272. DOI: 10.1080/14733140902978724

Cohen, B. D. and Schermer, V. L. (2001). Therapist Self-Disclosure in Group Psychotherapy from an Intersubjective and Self Psychological Standpoint. Group, 25, 41 – 57. DOI: 10.1023/A:1011068623404

Cohen, B. D. (2005). The Intimate Self-Disclosure. The San Francisco Jung Institute Library Journal, 24, May, 31-46. DOI: 10.1525/jung.1.2005.24.2.31

Cornett, C. (1991). The "risky" intervention: Twinship selfobject impasses and therapist self-disclosure in psychodynamic psychotherapy. Clinical Social Work Journal, 19, 1, pp. 49 – 60. Retrieved via Interlibrary Loan Request from the University of Pennsylvania Van Pelt Library.

Cozby, P. C. (1973). Self-disclosure: A literature review. Psychological Bulletin, 79, 2, pp. 73 – 91. DOI: 10.1037/h0033950

Curtis, J. M. (1982). The effect of therapist self-disclosure on patients' perceptions of empathy, competence and trust in an analogue psychotherapeutic interaction. Psychotherapy: Theory, Research and Practice, 19, 1, pp. 54 – 62. DOI: 10.1037/h0088417

Dewald, P. A. (1980). Serious illness in the analyst: Transference, countertransference, and

reality responses. Journal of the American Psychoanalytic Association, 30, 2, 347 – 363. DOI: 10.1177/000306518203000202

Dixon, L., et al. (2001). Reexamination of therapist self-disclosure. Psychopathology Committee Of the Group for the Advancement of Psychiatry, Psychiatric Services, 52, 1489 – 1493. Retrieved 10.26.14 from:

http://proxy.library.upenn.edu:2604/doi/full/10.1176/appi.ps.52.11.1489.

Edwards, J. K. and Bess, J. (1998). Developing effectiveness in the therapeutic use of self. Clinical Social Work Journal, 26, 89 – 105. DOI: 10.1023/A:1022801713242

Finlay, L. (2002). "Outing" the researcher: The provenance, process and practice of reflexivity. Qualitative Health Research, 12, 4, 531 – 545. DOI: 10.1177/104973202129120052

Freud, S. (1912). Recommendations to physicians practicing psychoanalysis. Standard Edition, 12, 109 – 120.

Gaztambide, D. J. (2012). "A psychotherapy for the people": Freud, Ferenczi, and psychoanalytic work with the underprivileged. Contemporary Psychoanalysis, 48:2, 141 – 165. Retrieved 7.27.14 from: http://www.wawhite.org/uploads/Journals/CPS-48-1.pdf.

Gibson, M. (2012). Opening Up: Therapist Self-Disclosure in Theory, Research and Practice. Clinical Social Work Journal, 40, 287 – 296. DOI: 10.1007/s10615-012-0391-4

Giese-Davis, J., Bliss-Isberg, C., Carson, K., Star, P., Donaghy, J., Cordova, M. J., Stevens, N., Wittenberg, L., Batten, C. and Spiegel, D. (2006). The effect of peer counseling on quality of life following diagnosis of breast cancer: An observational study. Psycho-Oncology, 15, pp. 1014 – 1022. DOI: 10.1002/pon.1037

Girgis, A., Lambert, S. and Lecathelinais, C. (2011). The supportive care needs survey for partners and caregivers of cancer survivors: development and psychometric evaluation. Psycho-Oncology, 20, pp. 387 – 393. DOI: 10.1002/pon.1740

Given, B. A., Given, C. W., and Kozachik, S. (2001). Family support in advanced cancer. CA: A Cancer Journal for Clinicians, 51, pp. 213 – 231. DOI: 10.3322/canjclin.51.4.213

Goldstein, E. G. (1994). Self-disclosure in treatment: What therapists do and don't talk about. Clinical Social Work Journal, 22, 417 – 433. DOI: 10.1007/BF02190331

Goldstein, E.G. (1997). To tell or not to tell: The disclosure of events in the therapist's life to the patient. Clinical Social Work Journal, 25, 41 – 58. DOI: 10.1023/A:1025729826627

Gorkin, M. (1987). The Uses of Countertransference. Northvale, New Jersey: Aronson.

Gutheil, T. G. and Gabbard, G. O. (1998). Misuses and misunderstandings of boundary theory in clinical and regulatory settings. American Journal of Psychiatry, 155, 409 – 414. Retrieved 11.26.14 from: http://proxy.library.upenn.edu:2601/doi/pdfplus/10.1176/ajp.155.3.409.

Henretty, J. R. and Levitt, H. M. (2010) The role of therapist self-disclosure in psychotherapy: A qualitative review. Clinical Psychology Review, 30, 63 – 77. DOI: 10.1016/j.cpr.2009.09.004

Hill, C. E. and Knox, S. (2001). Self-disclosure. Psychotherapy: Theory, Research, Practice, Training, 38, 413 – 417. DOI: http://proxy.library.upenn.edu:2092/10.1037/0033-3204.38.4.413

Hill, C. E., Mahalik, J. R., and Thompson, B. J. (1989). Therapist self-disclosure. Psychotherapy, 26, 290 – 295. DOI: 10.1037/h0085438

Jacobs, L. (1992). Insights from psychoanalytic self psychology and intersubjectivity theory for gestalt therapists. The Gestalt Journal, 15. Retrieved 11.28.14 from: http://www.gestaltpsychotherapie.de/jacobs3.pdf

Jeffrey, A. and Austin, T. (2007). Perspectives and practices of clinician self-disclosure to clients: A pilot comparison study of two disciplines. The American Journal of Family Therapy, 35, 95 – 108. DOI: 10.1080/01926180600814528

Johnson, J. M. and Rowlands, T. (2012). The interpersonal dynamics of in-depth interviewing, in The Sage Handbook of Interview Research: The Complexity of the Craft, by Gubrium, J. F., Holstein, J. A., Marvasti, A. B. & McKinney, K. D. (Eds.) (2012). Sage: Los Angeles.

Jourard, S. M. (1964). The Transparent Self: Self-Disclosure and Well-Being". D. Van Nostrand Company, Inc.: Princeton, New Jersey.

Knight, C. (2012). Social workers' attitudes toward and engagement in self-disclosure. Clinical Social Work Journal, 40, 297 – 306. DOI: 10.1007/s10615-012-04-8-z

Knox, S. and Hill, C. E. (2003). Therapist self-disclosure: Research-based suggestions for practitioners. Journal of Clinical Psychology, 59, 529 – 539. DOI: 10.1002/jclp.10157

Krieger, S. (1991). Social science and the self: Personal essays on an art form. New Brunswick, NJ: Rutgers University Press.

Laporte, H. H., Sweifach, J. and Linzer, N. (2010). Sharing the trauma: Guidelines for therapist self-disclosure following a catastrophic event. Best Practice in Mental Health, 6, 2.

Lauria, M. M., Clark, E. J., Hermann, J. F. and Stearns, N. M. (2001). Social Work in Oncology: Supporting Survivors, Families and Caregivers. American Cancer Society: Atlanta, Georgia.

Leimeister, J. M. Ebner, W. and Krcmar, H. (2014). Design, implementation and evaluation of trust-supporting components in virtual communities for patients. Journal of Management Information Systems, 21, 4, pp. 101 – 131. DOI: 10.1080/07421222.2005.11045825

Lynn, D. J. & Vaillant, G. E. (1998). Anonymity, neutrality and confidentiality in the actual methods of Sigmund Freud: A review of 43 cases, 1907 – 1939. American Journal of Psychiatry, 155, 2, pp. 163 – 171.

Maroda, K. J. (2004). The Power of Counter-Transference: Innovations in Analytic Technique, Second Edition, Revised and Enlarged. The Analytic Press: Hillsdale, N.J.

Maroda, K. J. (2010). Creating an intersubjective context for self-disclosure. Smith College Studies in Social Work, 69, 474 – 489. DOI: 10.1080/00377319909517566

McCarthy, P. R. and Betz, N. E. (1978). Differential effects of self-disclosing versus self-involving counselor statements. Journal of Counseling Psychology, 25, 4, 251 – 256. DOI: 10.1037/0022-0167.25.4.251

Meissner, W. W. (2002). The problem of self-disclosure in psychoanalysis. Journal of the American Psychoanalytical Association, 50, 827 – 867. DOI: 10.1177/00030651020500031501

Molassiotis, A., Wilson, B., Blair, S., Howe, T. and Cavet, J. (2011). Unmet supportive care needs, psychological well-being and quality of life in patients living with multiple myeloma and their partners. Psycho-Oncology, 20, pp. 88 – 97. DOI: 10.1002/pon.1710

Morrison, A. P. (1996). Trauma and disruption in the life of the analyst: Enforced disclosure and Disequilibrium in "The Analytic Instrument", in Gerson, B. A. (1996), The Therapist as a Person: Life Crises, Life Choices, Life Experiences, and Their Effects on Treatment (1996). Routledge, Taylor and Francis Group: New York and London.

Morrison, A. (1997). Ten years of doing psychotherapy while living with a life-threatening illness: Self-disclosure and other ramifications. Psychoanalytic Dialogue: The International Journal of Relational Perspectives, 7, 225 – 241. DOI: 10.1080/10481889709539178

National Cancer Institute, (2011). Cancer costs projected to reach at least $158 billion in 2020; New NIH Study projects survivorship and costs of cancer care based on changes in the US population and cancer trends. Retrieved 9.21.14 from:
http://www.cancer.gov/newscenter/newsfromnci/2011/CostCancer2020/print

Nilsson, D. E., Strassberg, D. S. and Bannon, J. (1979). Perceptions of counselor self-disclosure: Analogue study. Journal of Counseling Psychology, 26, 5, 399 – 404. DOI: 10.1037/0022-0167.26.5.399

Norcross, J. C. and Hill, C. E. (2004). Empirically supported therapy relationships. The Clinical Psychologist, 57, 19 – 24. Retrieved 11.28.14:
http://petercollorimd.com/wp-content/uploads/2013/01/Norcross-2004-.pdf

Palombo, J., Bendicsen, H. K., and Koch, B. J. (2009). Guide to Psychoanalytic Developmental Theories, p. 1 – 45. Springer, New York.

Peterson, Z. (2002). More than a mirror: The ethics of therapist self-disclosure. Psychotherapy: Theory/ Research/Practice/Training, 39, 21 – 31. DOI: 10.1037/0033-3204.39.1.21

Raines, J. C. (1996). Self-disclosure in clinical social work. Clinical Social Work Journal, 24, 357 –

375. DOI: DOI: 10.1007/BF02190743

Rizzuto, A. (2010). W. W. Meissner obituary. Accessed online 10.5.14 from:
     http://www.psywww.com/psyrelig/obits/meissner.html.

Sand, L., Strang, P. and Milberg, A. (2008). Dying cancer patients' experiences of powerlessness
     and helplessness. Supportive Cancer Care, 16, pp. 853 – 862. DOI: 10.1007/s00520-007-0359-z

Satterly, B. (2007). The intention and reflection model of self-disclosure: Social work
     education for student identity management in gay men. Journal of Social Work Education,
     43, 187 – 204. DOI:10.5175/JSWE.2007.200500522

Sherby, L. B. (2005). Self disclosure: Seeking connection and protection. Contemporary
     Psychoanalysis, 41, 499 – 517. DOI:10.1080/00107530.2005.10747261

Shulman, L.. (1978). A study of practice skills. Social Work, 23(4), 274–280. Retrieved from
     http://www.jstor.org/stable/23711317.

SocialWorkDegree.com (2015). Oncology Social Work Degree web page, retrieved from:
     http://www.socialworkdegreeguide.com/faq/what-is-oncology-social-work/

Spiegel, D., Bloom, J. R. and Yalom, I. (1981). Group support for patients with metastatic breast
     cancer: A randomized prospective outcome study. Archives of General Psychiatry, 38, pp.
     527 – 533. DOI: 10.1001/archpsyc.1980.01780300039004

Stolorow, R. D., Atwood, G. E. and Brandchaft, B. (Eds.) (1994). The Intersubjective Perspective.
     Jason Aronson, Inc.: Northvale, New Jersey.

Strean, H. S. (1999). Resolving some therapeutic impasses by disclosing countertransference.
     Clinical Social Work Journal, 27, 123 – 140. DOI: 10.1023/A:1022866606074

Stricker, G. and Fisher, G. (eds.) (1990). Self-Disclosure in the Therapeutic Relationship. Plenum
     Press: New York.

Tsai, M., Plummer, M. D., Kanter, J. W., Newring, R. W. and Kohlenberg, R. J. (2010) Therapist
     grief and functional analytic psychotherapy: Strategic self-disclosure of personal Loss. Journal
     of Contemporary Psychotherapy, 40, 1 – 10. DOI: 10.1007/s10879-009-9116-6

University of South Alabama (2015). Strengths and weaknesses of qualitative research.
     Retrieved from:
     ehttp://www.southalabama.edu/coe/bset/johnson/oh_master/Ch14/Tab14-02.pdf

Walker, R. and Clark, J. J. (1999). Heading off boundary problems: Clinical supervision as risk
     management. Psychiatric Services, 50, 1435 – 1439. DOI: 10.1176/ps.50.11.1435

Watkins, C. E. (1990). The effects of counselor self-disclosure: A research review. The
     Counseling Psychologist, 18, 477 – 500. DOI: 10.1177/0011000090183009

Web Center for Social Research Methods, Qualitative Validity page, accessed 4.6.16 from:

http://www.socialresearchmethods.net/kb/qualval.php

Wells, T. L. (1994). Therapist self-disclosure: Its effects on clients and the treatment relationship. Smith College Studies in Social Work, 65, 23 – 41.

DOI:10.1080/00377319409517422

Zebrack, B. and Isaacson, S. (2012). Psychosocial care of adolescent and young adult patients with cancer and survivors. *Journal of Clinical Oncology*, 30, 11, pp. 1221 – 1226. DOI: 10.1200/JO.2011.39.5467