Practitioner Perspective

Planning for our death/incapacitation as therapists

By Mike Hackett

Ethics, client-care and posthumous attending: preparing for therapist incapacitation or death in service, a practice based issue

Introduction

Therapists, like their clients, die. The myth of the untroubled therapist (Adams, 2013) is shattered all too soon with the unexpected and shocking news of the death of a therapist following a short illness or due to incident or accident. These kinds of unplanned terminations have been demonstrated to result in a range of damaging effects on clients including evoking feelings of "ultimate abandonment … [triggering] complex mourning … rage … betrayal of trust … denial … expressions of hostility … anger … the client became stranded … despair … depersonalization and somatization" (Beder, 2003, p. 28; Lord, Ritvo, & Solnit, 1978; Garcia-Lawson, Lane, & Koetting, 2000; Alexander, Kolodziejski, Sanville, & Shaw, 1989). Further, Barbanel (1989) found that therapists who 'inherit' clients whose previous therapist died, often experienced negative comparisons to the deceased therapist and that therapeutic attachment was not as secure.

Likely due to the negative impact of unexpected termination on clients, codes of ethics in Ireland and internationally mandate that provisions are made in the event of the sudden death or incapacitation of therapists/supervisors (American Counseling Association (ACA), 2014; American Psychological Association (APA), 2017; European Association for Counselling (EAC), 2015; Irish Association for Counselling and Psychotherapy (IACP), 2018). However, only the APA provides tools and resources which therapists can use to deliver on this obligation (APA, 2014).

Practical and legal matters also arise on the death of a therapist. These include the implications of intestacy (Citizens Information Board, 2016) and the demands on surviving family members to notify key individuals, as well as their obligations and duties as executor/administrator of the deceased clinician's estate.

Autobiographically, my own lived experience of incapacitation following an accident (leading to hospitalisation and several weeks of convalescence), faced with my own mortality I was challenged to consider the broader implications had my accident resulted in my death. What would have happened to my clients and supervisees? What burden would I have placed on my family to wind-up my practice when already bereft? What are my legal, ethical and practical responsibilities? What do I need to have in place in the event of my incapacitation/death? What

does the literature offer regarding solutions to this personally and professionally challenging issue? The aim of this paper is to explore these questions with the objective of developing a practice-based solution to the issue of unexpected termination due to therapist death or incapacitation.

Unexpected termination: Impact on the client

A major theme from the literature (predominantly in the psychoanalytic tradition) describes the impact on the client of therapist-initiated unexpected termination due to incapacitation or death. These range from transference dynamics (Abend, 1982); shock, disbelief, protest, despair and mourning (Alexander et al., 1989); sudden death traumatising the client (Beder, 2003); breach of trust due to failing to plan for client confidentiality post-mortem (Bradley, Hendricks, & Kabell, 2011); feeling abandoned (Bram, 1995) and; burdening clients with the dual tasks of independent functioning and assimilation of a shocking loss (Chwast, 1983). Similarly, secondary reactions of hostility toward the deceased therapist from patients family and friends are also indicated in the literature (Shwed, 1980).

In only one study, however, is the voice of the client affected by the loss of her therapist to be heard. In her first-person account of her own experience of loss, Deutsch (2011) describes how "I missed not just my analyst, but also my analysis. I had lost contact with that part of me that had come to think in certain ways, to access fleeting thoughts and feelings and share them with another" (p. 527). As a result, "the protected position of analyst and analysand alone isolates the bereaved analysand." (p. 528), the impact of which persists for months or years.

Codes of ethics also emphasise the need for informed consent. Clients must consent to participation in therapy and must acknowledge that they understand the limits of confidentiality and their rights within the therapeutic relationship

The impact of the sudden loss of the therapeutic relationship accompanies the loss of the therapist. The client, therefore, loses twice. In the aftermath, their loss is amplified because unlike other bereavements where society prizes rituals, social interactions and various opportunities for public mourning, the client/therapist relationship is a private (often secret) one with "no socially sanctioned role for the analysand as mourner" (Galatzer-Levy, 2004, p. 1011). Recognising these various impacts on clients and despite them, the same paper found that most therapists "made no provision to notify patients of their death" (p. 1010). Perhaps the fear of death within the therapist trumps the emphasis on the therapeutic relationship and as a result, represents a counter-transference, an emergent property of the defense of death denial within the therapist (Dattner, 1989). The Galatzer-Levy study goes on to present the startling reality for most clients faced with the unexpected death of their therapist in that "Analysands learned of their analyst's death through newspaper notices, arriving for appointments to find a note on the analyst's door, word of mouth from colleagues, and telephone calls from clerical personnel or members of the analyst's family" (p. 1010).

The ethical imperative for preparing for therapist incapacitation/death

Within the very earliest of care-providing relationships, that of physician and patient, the rights of the vulnerable and the obligations of the provider to uphold several ethical standards are enshrined. The Hippocratic Oath, circa 275 CE (Edelstein, 2000) constitutes the cornerstone of modern medical ethics which in turn advances foundational elements for codes of ethics in the related fields e.g. psychology and by extension, psychotherapy (Miller & Thelen, 1987). *Confidentiality* is one of these bedrock ethical doctrines and is explicitly stated as vital to the therapeutic relationship itself e.g. "Definition of Counselling & Psychotherapy" (IACP, 2018). However, confidentiality requires a basic assumption – that a living therapist is the gatekeeper of the client's story described in their case notes, and is thus the ultimate *keeper of their secrets*. But what about post-mortem confidentiality? Though most of the literature focusses on the care of client records after their death (Berg, 2001; Bradley et al., 2011; Maixner & Morin, 2001), a small number of papers describe the various nuances of client confidentiality on the death of the therapist including; the requirement to have a plan for cessation of their practice and the appointment of a records custodian (Bradley, Hendricks, & Kabell, 2012). A second group of papers recommend the development of tools, resources and protocols, essentially, a Professional Will (Gamino & Ritter, 2010; Rutzky, 2000; Steiner, 2002a, 2002b, 2011).

Burke (1995) highlights one case in the USA where a therapist released session audio recordings to the executor of the estate of a former client, a well-known poet. The ensuing controversy led to the then head of the American Psychiatric Association, Jeremy Lazarus, declaring "A patient's right to confidentiality survives death. Our view is that only the patient can give that release. What the family wants does not matter a whit" (Stanley, 1991 as cited in Burke, 1995, p. 278).

Codes of ethics also emphasise the need for *informed consent*. Clients must consent to participation in therapy and must acknowledge that they understand the limits of confidentiality and their rights within the therapeutic relationship. This raises several questions typically overlooked by therapists (particularly those in private practice where the support of an organisation or service is absent) including: what happens to case files, emails, text messages etc. in paper files, computer documents and on mobile devices left stranded following their death/incapacitation; who has access to this material; who will dispose of it in compliance with ethical and legal obligations and what are the implications for insurance company obligations for data retention?

A final challenge to addressing the ethical obligation of client data confidentiality is due to the limits imposed by the recent European and Irish statutes relating to data protection and extending to the rights of clients with respect to appropriate collection, storage, processing and disposal of personal data. Though the European statute declares (when referring to the principles of data protection) "This Regulation does not apply to the personal data of deceased persons." (European Parliament, 2016, p. 5), the Irish Parliament has enacted its right to amend this statement and when passed in 2018, the statute now declares that "Article 32 of the Data Protection Regulation shall apply to a deceased individual's relevant information (individual) as it applies to a living individual's relevant information (individual)." (Government of Ireland: Office of the Attorney General, 2018, p. 175). Neither the legislation nor the practical guidance from the Irish Data Protection Commission offers input as to how to achieve this requirement for professionals in the field.

A final ethical consideration is that of continuity of client care

A final ethical consideration is that of *continuity of client care*. This ethical requirement is stated explicitly as a therapist obligation by the IACP and requires therapists to "make suitable arrangements for the responsible care of clients and the management of records in the event of the practitioner's ill-health, retirement and termination of practice" (IACP, 2018, Section 2.4, Item E). It offers no advice or guidance however on how this may be accomplished and indeed begins the statement with "Where possible…" thus inviting the question When would it *not* be possible to plan for one's own death/incapacitation? Indeed Pope & Vasquez (2016) advance the idea of the best time to prepare a professional will as being "now rather than later" (p. 123).

Thus the ethical and practical considerations highlighted by the literature provide a solid basis for the necessity for Irish therapists to focus on planning and preparing for the unfortunate event of unexpected therapy termination. The good news is that the literature developed by US-based clinicians offers much in terms of solutions to these ethical dilemmas. In particular, the work of Dr Ann Steiner contributes significantly to this crucial element of ethical practice in her development of a suite of tools and resources culminating in The Therapist's Professional Will – A Backup Plan Every Clinician Needs (Steiner, 2011).

The Professional Will

Several authors espouse the ethical, practical, legal and personal need for clinicians to make a Professional Will (Becher, Ogasawara, & Harris, 2012; Bradley et al., 2012; Cooper & Ramage, 2006; Fair & Bressler, 1992; Garcia-Lawson & Lane, 1997; Pope & Vasquez, 2016; Rutzky, 2000). A Professional Will is defined variously as: "a plan for what happens if we die suddenly or become incapacitated without warning" (Pope & Vasquez, 2016, p. 123); "details your wishes for the treatment of your patients in your absence … whether due to serious illness, retirement, or death" (Steiner, 2011, p. 35) and is described as "a document designating and instructing an individual or individuals to terminate or continue counselling services to a client in a manner that provides for the needs of a client" (Bradley et al., 2012, p. 309).

Steiner (2002a) introduces the concept of a therapist's Emergency Response Team (ERT) as a resource when planning to address responses to unplanned death or incapacitation. Indeed, the idea of some kind of committee to oversee practice disposition had been suggested in literature from the USA since the 1980s (Shwed, 1980).

This committee, or team approach, provides for a clear identification of the various roles necessary in the execution of a Professional Will which in turn facilitates easier allocation of tasks to each role identified. By building on this idea, it is possible to clearly separate the professional and personal domains of the clinician, thereby creating clear boundaries which safeguard them, their family, executors, clients and supervisees. Building on this work, the ERT can be conceptualised for a clinician (Peter Bonnington) as shown in Figure 1.

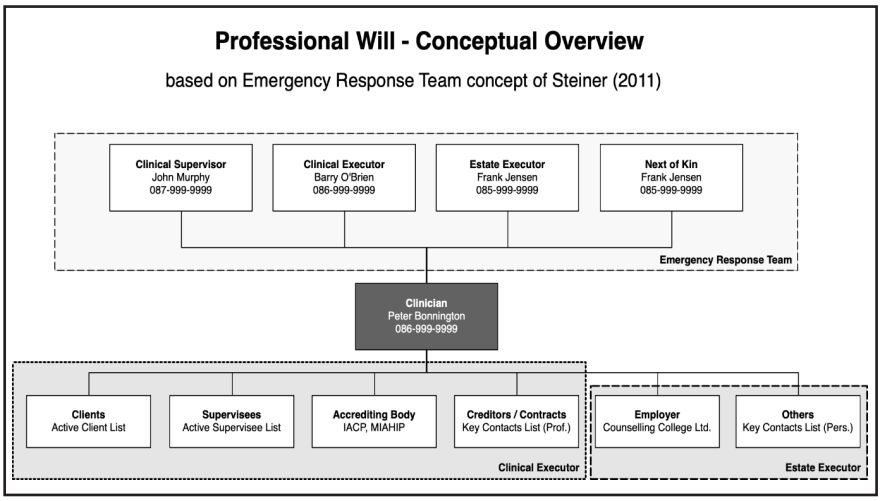

Figure 1: Professional Will - Conceptual Overview.

As well as the ERT, the literature on preparing a Professional Will exposes several themes and sub-themes clinicians should consider when preparing the document(s) (Bradley et al., 2012; Cooper & Ramage, 2006; Rutzky, 2000; Steiner, 2011). These provide a reliable ethical, legal and practical basis from which to meet the requirements of codes of ethics of professional bodies for the care of clients and support the necessary planning for therapist incapacitation/death. These practical plan elements are summarised in Table 1.

Final Reflections

Counselling and psychotherapy are essentially relational activities involving (at least initially) a vulnerable person; the client, and a trained professional; the therapist. Both are human beings subject to the same vicissitudes of life, the whims of fate, of illness and infirmity. As the professional in the room, it is the duty of the therapist to contain the work in what is often described in the therapeutic encounter as "a safe emergency" (Perls, Hefferline, & Goodman, 1951, p. 63). Containment begins with the first contact with the client and ends during the termination phase (Schlesinger, 2014). But not all terminations are planned and when those terminations are sudden, unexpected and shocking (as in the unexpected cessation of therapy due to therapist incapacitation or death) the impact on the client, as has been seen earlier, can be significant.

In their 2011 book *The Resilient Practitioner*, Skovholt & Trotter-Mathison describe a simple, four-phase cycle of caring, mirroring the relational foundation of the work and the essence of practice as a therapist; empathic attachment; active involvement; felt separation and re-creation. They describe the therapist as "a highly skilled relationship maker who constantly attaches, is involved, separates well [emphasis added], then steps away from the professional intensity, then does it again with a new person." (2011, p. 21). Other writers have emphasised the importance of therapeutic endings and the need to safeguard the therapeutic encounter (Davis & Younggren, 2009; Dewald, 1982; Fair & Bressler, 1992; Norcross, Zimmerman, Greenberg, & Swift, 2017). By attending to the possibility of unexpected, unplanned termination due to incapacitation/death, clinicians can confront their own mortality and make responsible preparations to safeguard the welfare of the various clients/supervisees under their care.

Finally, by creating a Professional Will, clinicians safeguard the integrity of the profession of counselling/psychotherapy by upholding ethical standards designed to protect the vulnerable. By attending to their limitations, recognising their own mortality and making responsible preparations for the suspension or termination of their practice due to unexpected incapacitation or death, they demonstrate a posthumous kindness and care for their families, colleagues, clients and supervisees when they themselves are no longer able to do so in life.

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Table 1 – Summary of key considerations – Making a Professional Will

PLAN THEMES	PLAN STEPS
1. Identifying and preparing an Emergency Response Team (ERT)	1.1. Identify key individuals (other professionals) who will act on your behalf in the event of incapacitation/death. 1.2. Identify a 'Professional Executor' and name that person in a clause or codicil in your personal will (with contact details). 1.3. Assign roles/actions to each individual e.g. contacting clients/supervisees, 1.1. disposal of records etc. consider backups. 1.4. Contract with these individuals, explain roles and document key tasks and 1.1. assignments based on roles identified. 1.5. Identify preferred referral sources and/or a Bridge Therapist. 1.6. Create a master "Files, Passwords and Contacts List" (FPC List).
2. Organise access to premises	2.1. Make copies of keys necessary to access your practice and any locked storage containing client/supervisee information. 2.2. Update FPC List with office address, alarm codes, file stores, passwords for computers / phone(s) / voicemail. 2.3. Package these into a sealed envelope and ensure the location of this package is described in your personal will.
3. Organise client/ supervisee data	3.1. Update FPC List with names and contact details of all active clients and supervisees as well as those who have left within the last year (they may wish to return having taken a break). 3.2. Include only that information which is necessary for your ERT to affect your wishes (consider data protection legislation). 3.3. Organise email into folders in your email client (MsOutlook, Mail etc.). Note locations and passwords on FPC List. 3.4. Organise computer files into folders on your computer. Note locations and passwords on FPC List.
4. Organise business data	4.1. Update FPC List to include key business contacts who will need to be contacted; insurance company; landlord; service providers (light, heat, phone etc.). 4.2. Identify and document any open/ongoing business transactions which need to be closed/ended. 4.3. Identify any billing arrangements with clients/supervisees which may require some follow up (e.g. refunds to supervisees who pay monthly in advance etc.). 4.4. Consider what should happen with your online footprint (your website, Facebook, Twitter and other social media accounts).
5. Legal Review	5.1. Send copy of professional will to solicitor for reviews, witnessing and signoff. 5.2. Distribute sealed copies to Emergency Response Team members.
6. Prepare 'In the event of' materials	6.1. Create instructions for contacting clients/supervisees on FPC List. 6.2. Identify location and version of current appointments book. 6.3. Create a list of onward referrals for clients/supervisees. 6.4. Indicate which client records are to be disposed of and how safe disposal should be affected. 6.5. Put aside a sum of money to reimburse professional executor (to cover their expenses and their time). 6.6. Save a copy of your professional will with your personal will as a codicil and ensure your solicitor has a copy of both. 6.7. Provide a sealed, dated copy of your professional will to your professional executor. 6.8. Indicate that your business mobile phone should be securely wiped of all information before disposal/reuse. 6.9. Document your preferences for formal communication/notices e.g. death notice, cessation of practice, etc.

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