

Sudden Unexpected Death of the Therapist: Reconciling Ethical and Clinical Concerns for Providing Continuing Care

Melanie Merola O'Donnell
Antioch New England Graduate School

The sudden unexpected death of a therapist is examined with consideration given to ethical, clinical, and legal implications for therapists in planning for the possibility of their deaths. A vignette is provided for illustration. The Code of Ethics (APA, 2002) is reviewed for relevant guidance, and the professional literature is summarized. It is concluded that while the Code of Ethics only dictates minimal activity in preparation for death, the professional literature makes a strong case for more elaborate planning in order to reduce harm to clients. A summary of recommendations for therapists in planning for their sudden unexpected deaths is provided.

As usual, Dr. Molinari arises at 5:30 a.m. to start her day. It is another full day. She will attend her morning exercise class, return home to eat breakfast and shower, and head to the office for her prompt 8:00 a.m. arrival. On her professional agenda for the day are three individual psychotherapy sessions, one couples session, one hour of supervision with a student at the local graduate school, and a meeting with colleagues about a program that is being developed for at-risk youth. She is prepared for each session but her mind is focused on a former client who terminated several years ago. This client is on her mind because it is the tenth anniversary of the day that the client quit drinking. She has been sober since. Dr. Molinari saw this client in treatment intermittently for approximately six years, and she knows that this is a day of celebration for that person. As Dr. Molinari leaves her neighborhood in the pre-dawn darkness, her car is struck by an eighteen-wheeler and she is killed instantly. Within a few hours Dr. Molinari's body has been identified and her family and one colleague have been notified. If you were the colleague of Dr. Molinari that was notified of her death, how would you proceed with the dispensing of her professional responsibilities? What issues might arise as Dr. Molinari's practice is terminated?

The case described above forces consideration of the ethical, clinical, and legal obligations that therapists have in making plans for their own unexpected deaths. Recent data suggest that such planning is not common. A survey conducted with therapists involved in the resolution of professional responsibilities for deceased therapists indicated that 90% of the deceased therapists had no preplanned

procedure to assist their clients with the transition following their deaths, and that 94% of clients were not provided with referrals (Garcia-Lawson, Lane, & Koetting, 2000). Such statistics reinforce the need for clarity on the ethical responsibilities of therapists in planning for their clients should the therapists die unexpectedly.

Culling the Ethics Code

There are few ethics codes proposed by the American Psychological Association (APA) that speak directly to the question at hand. *Standard 3.12, Interruption of Psychological Services* states:

Unless otherwise covered by contract, psychologists make reasonable efforts to plan for facilitating services in the event that psychological services are interrupted by factors such as the psychologist's illness, death, unavailability, relocation, or retirement or by the client's/patient's relocation or financial limitations. (APA, 2002, p. 1066)

Fisher (2003) interprets this standard to mean that a trusted colleague should be prepared to contact clients in the event of unplanned interruptions and that a therapist's "reasonable efforts" reflect the reality of the unpredictable nature of life.

Standard 6.02c, Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work states: "Psychologists make plans in advance to facilitate the appropriate transfer and to protect the confidentiality of records and data in the event of psychologists' withdrawal from positions or practice" (APA, 2002, p. 1067). In Fisher's (2003) clarifying comments, the psychologist's death is specifically mentioned as one such reason for withdrawal, and the methods of record transfer are identified as in person, by mail, by fax, through the Internet, or through private company networks, as long as confidentiality is maintained.

Less than two weeks after submitting this article for publication, the author died in an automobile accident. She was 33 years old. Her husband, George O'Donnell, completed the edits for this article prior to publication.

Correspondence concerning this article should be addressed to George O'Donnell, 55 Birch Street, Saratoga Springs, NY, 12866; email: geodonnell@yahoo.com.

Aside from these two specific references to death, therapists can only speculate as to whether or not other standards apply in the case of the sudden unexpected death of the therapist. For example, does *Standard 3.04, Avoiding Harm* (APA, 2002, p. 1065) apply? It indicates that psychologists take reasonable steps to avoid harm to clients. Is harm caused to a client when his or her therapist dies unexpectedly, and no plan is in place to continue care? Does *Standard 10.09, Interruption of Therapy* (APA, 2002, p. 1073) apply? It indicates that psychologists at the outset of employment establish a plan for continuity of care in the event of employment termination. Does *Standard 10.10c, Terminating Therapy* (APA, 2002, p. 1073) apply? It indicates that psychologists provide pretermination counseling and suggest alternative service providers to clients prior to termination. Should therapists at the outset of therapy discuss the possibility of their untimely death and provide emergency referrals at that time?

As if these questions were not enough to consider, some standards complicate the handling of notification and transitional services for clients. Most notably, psychologists are bound by *Standard 4.01, Maintaining Confidentiality* (APA, 2002, p. 1066). Yet the allowances for breaking confidentiality do include circumstances in which the therapist has died unexpectedly and another person contacts the client for notification of the death or to offer transitional services.

In summary, the ethics code indicates that psychologists have a responsibility to plan for their unexpected deaths to the extent of facilitating transitional services. These services can include identifying a colleague to notify clients of the therapist's death and to have a plan in place for the confidential transfer of client files. The answers to other questions, such as whether or not harm is done or a breach of confidentiality has occurred if plans for continued care are not implemented, are unclear. Further, the interaction of these responsibilities with others, such as maintaining confidentiality, is left to interpretation. A look to the literature may be useful for further clarification.

Culling the Literature

In turning to the literature on the handling of professional responsibilities following the sudden unexpected death of a therapist, an interesting point emerges. Several authors have noted that there is very little in the literature about this topic (Beder, 2003; Cohen, 1983; Garcia-Lawson et al., 2000). Garcia-Lawson et al. suggest that this silence may be tied to a broader discomfort with the topic of death and dying, and specifically resistance to considering one's own death. Cohen echoes that speculation, and adds that other factors specific to the psychotherapeutic setting may influence such silence. For example, Cohen argues that the practice of psychotherapy can be isolating and can lead therapists to experience a sense of separateness from others. Contemplation of issues around death may exacerbate this experience and raise anxiety. Further, Cohen argues that

psychotherapy often carries with it a sense of timelessness that may blur the realities of life, such as the inescapability of death. Whatever the reason, the dearth of writing on the topic is notable. This is especially true when considering the implications drawn from reviewing the existing literature.

On Interruption of Services

Most of the literature on handling the interruption of services following a therapist's death implies that he or she has a clinical obligation—above and beyond the ethical obligation—to identify a colleague who will notify clients of the death. The literature that refers specifically to the handling of notification raises several points. First is the issue of how a client is informed of the death. The foundation demonstrating the relevance of this issue comes from studies that suggest that the psychological impact on the client of the unexpected death of his or her therapist is influenced by the death notification received (Beder, 2003; Tallmer, 1989). Garcia-Lawson et al. (2000) found that notification has been received by clients via widely different sources, including from colleagues of the deceased therapist, from the therapist's spouse, from their own friends, from a member of their therapy group, by being present at the time of death, and by reading an obituary. They further note that many clients reported being confused about who, if anyone, was responsible for handling the information.

Several authors have suggested methods for a more appropriate handling of the death notification. Garcia-Lawson et al. (2000) suggest (a) changing the therapist's answering machine message immediately to note the cancellation of all future appointments; (b) posting a note on the therapist's door noting the cancellation of all future appointments and providing a number to call to get further information; and, (c) providing the doorman and elevator operator (if they exist) with similar information. Cohen (1983) suggests that a colleague of the deceased therapist maintain phone numbers for the therapist's clients along with instructions on what to tell them about the death. Others suggest that the list need not be kept by a colleague but in an accessible place of which colleagues are aware (Bram, 1995). If therapists rely on an appointment book for listing clients, and that book holds initials only (in an attempt to maintain confidentiality), a separate list would need to be located in an accessible location so that colleagues have the full names of the individuals that they will need to contact (Freedman, 1990).

A second related issue that is addressed in the literature has to do with what, if any, services should be provided to clients upon learning that their therapist has died unexpectedly. Bram (1995) argues that all therapists should ensure that clients will be taken care of in the event of their therapist's unexpected death. Garcia-Lawson et al. (2000) suggest that the care come in the form of providing options to the client, such as entering treatment immediately with an-

UNEXPECTED DEATH OF THERAPIST

other therapist to process grief; waiting a time period and returning to therapy with a new therapist; or, not attending therapy again in the foreseeable future. Garcia-Lawson et al. argue that there is often a need to share and process reactions to loss, and clients should be offered the option to do so with another therapist. Cohen (1983) takes this argument further, stating that therapists should maintain clinical directions for each client so that the therapists' colleagues have some information on how to proceed. It is further noted that these directions should be provided directly to the colleagues, rather than be recorded in a will that may not be read for some time following the death. Others have echoed this suggestion (Freedman, 1990).

In the study conducted by Garcia-Lawson et al. (2000), 56% of clients of deceased therapists were offered a consultation session within one month of the deaths and most accepted the invitation. In addition, some authors have cited the offer of a referral, or lack thereof, as an influencing factor in the psychological impact of the therapist's death on the client (Tallmer, 1989). These findings suggest that the offering of some form of intervention is useful. Should such an intervention be offered, several authors have suggested that therapists to whom clients are referred be educated on special issues that may be present for these clients. This may include education on clients initially being difficult to treat and having mixed transferences (Garcia-Lawson et al., 2000); the loss associated with losing the unique role of a therapist in a client's life (Beder, 2003); and, a client's feelings of disloyalty to the deceased therapist (Garcia-Lawson & Lane, 1997). Though not mentioned in the literature, it also seems relevant to consider any impediments to providing unbiased care that may arise should the client be referred to a therapist who is a close friend of the deceased therapist, and therefore grieving as well.

On Disposing of Confidential Records

The study by Garcia-Lawson et al. (2000) indicated that 90% of the clients from the sample were not provided their records following the deaths of their therapists. Despite this, the literature seems to indicate that it is good practice to offer clients their records at the time of the death notification (McGee, 2003). Others indicated that files be protected by a colleague of the deceased therapist until a future date when they could be transferred to a referring therapist or destroyed (Cohen, 1983; Garcia-Lawson et al., 2000).

On Avoiding Harm

As stated previously, the ethics code is unclear as to whether or not a psychologist is considered to be causing harm if he or she does not make plans for clients in the event of the psychologist's sudden unexpected death. The professional literature, however, makes a strong statement about the clinical obligation to do so. For example, Beder

(2003) notes that positive treatment outcomes may be eliminated as a result of a poor termination. Cohen (1983) agrees, suggesting that such an occurrence can be psychologically devastating to the client. These premises suggest a clear tie to causing harm. Several authors have reviewed the common client reactions to the unexpected termination of therapy. These include intense grief reactions with feelings of anger, despair, depersonalization, and somatization (Garcia-Lawson et al., 2000); rage, feelings of abandonment, and betrayal of trust (Beder, 2003); guilt, disappointment, and bitterness (Garcia-Lawson & Lane, 1997); loneliness (Levin, 1998); and, the retriggering of previous experiences of separation (Freedman, 1990; Levin, 1998). In addition, some positive reactions were found, such as learning to cope better with tragedy, separation, and loss (Garcia-Lawson et al., 2000), and making a break from therapy that was otherwise difficult for the client to do on his or her volition (Garcia-Lawson & Lane, 1997).

Speculation on the reasons for such impact has focused predominately on the unique nature of the therapeutic relationship (Cohen, 1983; Garcia-Lawson & Lane, 1997; Garcia-Lawson et al., 2000). In addition it has been noted that the sudden unexpected termination of therapy robs the client of a termination phase wherein the object loss may be confronted directly (Garcia-Lawson et al., 2000). As such, several authors imply that there is a clinical and ethical obligation to plan for sudden unexpected death as one way of avoiding harm (Cohen, 1983; Freedman, 1990; Garcia-Lawson, et al., 2000; Koocher, 2003; McGee, 2003). It is worth noting that most of the literature on this issue comes from practitioners of psychoanalysis or psychoanalytic therapy. As Bram (1995) notes, this may relate to several factors specific to psychoanalytic therapy, including (a) the focus on the relationship between client and therapist; (b) the tendency towards longer treatment periods; and, (c) the emphasis on issues of separation and loss.

On Talking About Death in Advance

One of the areas of most disagreement surrounds the topic of whether or not clients should be confronted with the possibility of the sudden unexpected death of the therapist during therapy. Some authors suggest that preplanned instructions to assist the client in the event of an unexpected death be included in the framework at the start of therapy (Garcia-Lawson, et al., 2000; McGee, 2003), such that termination begins with the first session (Garcia-Lawson & Lane, 1997). Other authors suggest that nothing be said at the start of therapy, though plans should be in place in case death occurs (Cohen, 1983; Freedman, 1990). Cohen suggests that information about the therapist's possible death at the start of therapy could hinder the client in his or her treatment. The lack of clarity on the topic has led to the suggestion that further data be collected to determine the most appropriate way of handling such conversations, and the level of detail to discuss (Abend, 1982).

On Confidentiality

The issue of handling confidentiality while simultaneously trying to avoid harm is murky at best. Cohen (1983) is the most extensive in attention to this issue. He acknowledges that preparing a client list with treatment recommendations is a breach of confidentiality. The alternatives to handling the situation which do not involve such a breach are listed as (a) choosing to do nothing, (b) leaving a note on the door, and (c) asking advance permission to break confidentiality in the event that death occurs. Cohen argues that each of these situations would be highly anxiety-provoking for the client, possibly harmful, and therefore inappropriate. In addition, Cohen argues that the ethical responsibility of therapists to clients in the unusual event of death overrides the issue of breaking confidentiality. In interviewing several clients who had experienced the death of their therapists, Freedman (1990) reports that all were accepting of the breach in confidentiality given the circumstances. This provides support for Cohen's conclusion. Still, the issue remains that what seems to be ethically and clinically appropriate regarding preparing for a therapist's death is ethically at odds with maintaining confidentiality. As Cohen states, all options should be considered by the therapist, even those that he or she has deemed inappropriate.

Other Issues

The ethical issues reviewed above relate to the standards in the ethics code that appear relevant to the scenario of a therapist's unexpected death. The literature raises several additional points. These points will be considered briefly below. First is the important issue of ensuring that therapists consult state law when considering how to handle the possibility of unexpected death. As McGee (2003) notes, state jurisdictions typically have laws regarding informed consent, confidentiality, the transfer of records, and the amount of time that records are retained. Therapists should be considering all aspects of the issue of possible sudden unexpected death. This includes ethical, clinical, and legal considerations. A related point, made by Cohen (1983), is that therapists should include legal counsel in the planning and preparation for their deaths and the execution of wishes after their death. This helps ensure that both the therapists' and their clients' interests are protected.

Second, it has been suggested that, rather than simply providing referrals to clients or a list of names and treatment recommendations to colleagues, therapists actually appoint a colleague as a professional executor to handle all aspects of their professional responsibilities (Cohen, 1983; McGee, 2003). This would enable better coordination and ensure that nothing is overlooked (e.g., logistics like billing). Third, Freedman (1990) points out that a therapist should maintain notes with the possibility of his or her death in mind. In other words, ensure that what is written is clearly understandable to others—including the client—

without the therapist's verbal input as the therapist may not be around to provide it.

Fourth is the issue of whether or not former clients should be notified when a therapist dies. Cohen (1983) suggests that this determination be part of the advanced planning done by therapists in preparation for death. McGee (2003) provides suggested guidelines for when to contact former clients of a therapist's death. These include contacting (a) individuals who were clients within the past five years, (b) individuals who had especially strong transference feelings, (c) individuals who participated in several periods of therapy, and (d) individuals who participated in long-term therapy.

Finally, several authors suggest advance consideration of whether or not clients will be invited to participate in funeral services or other rituals for the deceased therapist (Beder, 2003; Garcia-Lawson et al., 2000). In the study conducted by Garcia-Lawson et al., 81% of clients participated in either a funeral or memorial service for their deceased therapists. Tallmer (1989) reviewed anecdotal evidence that found that such participation was helpful for some clients and not for others. If the therapist is comfortable with the idea of their clients participating in death rituals, it may be that providing the option to each is most beneficial. Regardless, this decision is best made in advance by the therapist and not left to be sorted by their colleagues.

Conclusion

The Code of Ethics (APA, 2002) provides limited guidance to psychologists looking to address the possibility of their sudden unexpected death. At a minimum it seems to suggest that psychologists select a colleague to notify their clients and plan for the confidential handling of records should such a tragedy occur. It is less clear what provisions are needed to ensure that client harm is avoided and on how to handle client notification without breaching confidentiality. In addition, it is less clear whether or not some form of service should be offered in order to promote continuity of client care.

Suggestions on these topics and others can be found in the professional literature, which touches on the ethical, clinical, and legal considerations in preparing for an unexpected death. The most extensive suggestion entails the designation of a professional executor to handle all aspects of the dismantling of the therapist's practice. This would include the notification of clients, the offering of continuing care, the handling of office logistics such as billing and changing answering machine messages, the handling of records, the oversight of confidentiality, and contact with legal counsel.

In order to do so, therapists must do extensive planning. They must create client lists that are accessible, understandable, and continually updated to include contact information and treatment recommendations. Therapists must keep their death in mind while recording notes such that the notes will be understandable to others in their ab-

UNEXPECTED DEATH OF THERAPIST

sence. They must give instructions on what to tell clients; how to handle former clients; whether or not to include clients in death rituals; whether or not the possibility of death has been addressed in advance; and to whom clients should be referred, keeping in mind how referring therapists will be coping with the therapist's death. They must indicate their desire for the types of services offered to clients (e.g., grief counseling, therapy referral, consultation). They must indicate how they have accounted for confidentiality issues and provide instructions on the handling of records including related limitations of state laws. They must identify legal counsel. Finally, they should educate the executor as to the process and special issues that might arise, such as the difficulty that referring therapists may experience in taking on clients of a deceased therapist. Ragusea (2002) has proposed a sample of a Professional Living Will, which contains much of this information.

If therapists have not considered their feelings about death, and specifically their own deaths, it is suggested that they force themselves to ponder the topic (Garcia-Lawson et al., 2000). The dearth of literature on the topic suggests that many therapists have not done so. Yet if a therapist has not thought through the impact of his or her death on clients, it is unlikely that his or her clients' best interests are being served.

References

- Abend, S. M. (1982). Serious illness in the analyst: Countertransference considerations. *Journal of American Psychoanalysis Association, 30*, 365-379.
- American Psychological Association (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57*, 1060-1073.
- Beder, J. (2003). Picking up the pieces after the sudden death of a therapist: Issues for the client and the inheriting therapist. *Clinical Social Work Journal, 31*, 25-36.
- Bram, A. D. (1995). The physically ill or dying psychotherapist: A review of ethical and clinical considerations. *Psychotherapy: Theory, Research, Practice, & Training, 32*, 568-580.
- Cohen, J. (1983). Psychotherapists preparing for death: Denial and action. *American Journal of Psychotherapy, 37*, 222-226.
- Fisher, C. B. (2003). *Decoding the ethics code: A practical guide for psychologists*. Thousand Oaks, CA: Sage Press.
- Freedman, A. (1990). Death of the psychoanalyst as a form of termination of psychoanalysis. In A. L. S. Silver & H. J. Schwartz (Eds.), *Illness in the analyst: Implications for the treatment relationship* (pp. 299-232). Madison, CT: International Universities Press.
- Garcia-Lawson, K. A., & Lane, R. C. (1997). Thoughts on termination: Practical considerations. *Psychoanalytic Psychology, 14*, 239-257.
- Garcia-Lawson, K. A., Lane, R. C., & Koetting, M. G. (2000). Sudden death of the therapist: The effects on the patient. *Journal of Contemporary Psychotherapy, 30*, 85-103.
- Koocher, G. (2003). Ethical and legal issues in professional practice transitions. *Professional Psychology: Research and Practice, 34*, 383-387.
- Levin, D. (1998). Unplanned termination: Pain and consequences. *Journal of Analytic Social Work, 5*, 35-46.
- McGee, T. F. (2003). Observations on the retirement of professional psychologists. *Professional Psychology: Research and Practice, 34*, 388-395.
- Ragusea, S. A. (2002). A professional living will for psychologists and other mental health practitioners. In L. Vandecreek & T. L. Jackson (Eds.), *Innovations in clinical practice: A source book* (Vol. 20, pp. 301-305). Sarasota, FL: Professional Resource Press.
- Tallmer, M. (1989). The death of an analyst. *Psychoanalytic Review, 76*, 529-542.