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Joseph K. Hovey  
Mortality Practices: How clinical  
social workers interact with their  
mortality within their clinical and  
professional practice

## **ABSTRACT**

This quasi-mixed methods, exploratory study examined the mortality practices of clinical social workers. The study sought to understand how clinical social workers interact with their mortality within their clinical and professional practice—whether they have discussions about their mortality with clients, what attitudes they have about disclosing potentially terminal illness to clients, and how clinical social workers prepare for the potential that they may die or become incapacitated during the process of practicing clinical work. While the literature provides robust support for at least some practices, few studies have examined actual practice implementation.

The present study explored the attitudes and mortality practices of 83 clinical social workers from across the country in the form of an online survey, and eight clinical social workers through a brief phone interview. The sample was largely comprised of white women (as is the profession), with a skew toward older, psychodynamic private practitioners.

The vast majority of clinicians do not prepare professional wills, but a fair number have some sort of “informal arrangements” in place. Clinicians seemed to converge upon the attitude that disclosure of terminal illness and discussion of clinician mortality is advisable with some clients, some of the time. Respondents presented nuanced explorations of both the benefits and pitfalls of such discussions. The study suggests a general, apparently beneficial shift toward acknowledging the real personhood of clinical social workers, but further conversation and training around mortality practice implementation would benefit clinicians and their clients.

**MORTALITY PRACTICES: HOW CLINICAL SOCIAL WORKERS INTERACT WITH  
THEIR MORTALITY WITHIN THEIR CLINICAL AND PROFESSIONAL PRACTICE**

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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2014

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So much of this present study belongs to three individuals who I will list in the order of our final goodbyes...

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Michelle Moran: my first therapist, and a damn fine clinical social worker. I miss her couch. I miss her. I still wonder what a proper goodbye would have looked like; maybe this work is a part of that.

Bert Cohler: my mentor and friend, who gave me Freud and sent me barreling head first toward clinical social work and Smith. I am forever grateful for his guidance and his esteem.

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## **CHAPTER I**

### **Introduction**

The present study will attempt to explore the mortality of clinical social workers, and how clinicians avoid or engage in preparations for and discussions about the ubiquitous potential that they will die eventually and may die during the course of practicing clinical work. Many clinicians, dating back to Freud and his discussions of mourning and the death instinct, have discussed death as it informs and affects the client's experience. The clinician's personal experience of her mortality, though, has received limited attention. Clinician death—untimely, expected, “planned for,” accidental—will inevitably impact the clients, colleagues, friends, and systems with which the clinician has interacted. Practicing clinicians all face the ubiquitous promise of mortality, some more acutely than others—as in old age or terminal illness. All clinicians, therefore, necessarily deny, confront, avoid, or prepare for the eventuality and potential of death as it relates to their practice and their clients.

#### ***Need for the Proposed Study***

The proposed study will help fill a substantial absence of literature addressing this oft-avoided issue. Nearly every paper written on the subject of therapist death and mortality emphatically bemoans the dearth of literature on the subject and urges further study of clinician death and dying (e.g. Bram, 1995; Rendely, 1999; Becher, Ogasawara & Harris, 2012). Minimal to no research has been undertaken to explore the implementation of specific practices around clinician mortality, such as professional wills, which have broad endorsement in the



slight current literature (Bradley, Hendricks, & Kabell, 2012). Further, the literature that has approached the subject of clinician mortality has primarily been produced by and framed around the specific ethics and theories of psychologists (e.g. Bram, 1995), counselors (e.g. Bradley, Hendricks, & Kabell, 2012), psychiatrists (e.g. Chessick, 2013), and marriage and family therapists (e.g. Becher, Ogasawara & Harris, 2012). Clinical social workers' particular perspectives and practices have only been minimally explored; this proposed study will attempt that exploration more explicitly.

### ***Relevance to Social Work***

Clinical social work practice, policy, and education could all benefit from the proposed exploratory study. The discussion of clinician mortality will provide practitioners the opportunity to consider their own practices around mortality. By considering and examining explicitly these practices, the clinician might increase her ability to promote client growth, and even in death to continue to “ripple” positively through her client, minimizing the risk of the clinician's death inadvertently traumatizing her clients (Yalom, 2006). Social work policy might benefit from an overt consideration of whether certain practices—chiefly, a professional will—should be a mandated part of clinical practice, not only to provide optimal clinical care in the event of clinician death, but also to maintain client confidentiality (Bradley, Hendricks, & Kabell, 2012). Similarly, perhaps policies and practices around terminally ill clinical social workers should be clarified and standard recommendations should be developed; this study would be a first step. Social work education would be enriched by a deeper understanding of how to develop students' skills around mortality concerns: Should professional will creation be taught? Should existential and spiritual considerations receive more thorough attention in MSW curricula, especially as to how they might impact clinical work?

### ***Definition of Key Terms***

For the sake of the proposed paper the use of “mortality” will refer to the shared human inevitability of physical death. Mortality is shared by everyone—regardless of beliefs about a spiritual afterlife, and implies the risk that any client’s treatment could be interrupted at any time. In the case where the presence of mortality is more keenly present, that will be specified: terminal illness presents a special case in that the risk of death is named and its timeline is prognosticated. “Ill” will in this paper chiefly refer to acute illness where the prognosis is uncertain or certainly terminal. I will discuss age, but avoid reifying the “aging clinician;” we are all aging, but where specific stages of life are considered I will specify. In considering issues around self-disclosure I will differentiate between implicit disclosures (e.g. the obvious physical deterioration of the ailing and frail clinician) and explicit disclosing utterances (e.g. “I’m dying of cancer”). The “professional will,” discussed above, refers to a legal document which, in part, details what should be done to provide care for and inform past and present clients and what should be done with all past and present clinical documentation, in the event of the clinical social worker’s death (Steiner, 2011). I will use the term “mortality practices” to refer to all clinical behaviors—or lack thereof—which are responses to the ubiquity of death (e.g. the preparation or non-preparation of a professional will, the self-disclosure or non-disclosure of a terminal cancer).

### ***The Research Question***

Most basically this proposed study will explore how clinical social workers interact with their mortality and how that pattern of interaction informs their clinical practice. How, when, and by whom are mortality practices performed, and in what ways do these mortality practices facilitate or inhibit client treatment and wellness—before or after clinician death?

## CHAPTER II

### Literature Review

The present literature review will attempt to capture what has been written about the experiences of both clinicians and clients around clinician mortality, along with discussing what mortality practices are currently in place. The review will examine clinician attitudes about death more generally, as well as clinicians' attitudes on how relevant their real personhood is within clinical work. The literature addressing clinician death and mortality is unfortunately rather sparse, as noted above, and by most commentators on the death and dying of clinicians (e.g. Traesdal, 2005; Bram, 1995; Becher, Ogasawara, & Harris, 2012). Even more, quantitative empirical research on the subject of clinician mortality is very nearly non-existent.

#### *The Clinician's Experience of his or her Mortality*

Death discomforts and pains many people; thusly, society and its members tend to push away from discussions of the topic. Ernest Becker (1973), in an expansive text on the subject of death denial, disagreed with the "healthy-minded" stance which suggests that a fear of death is exacerbated, if not caused, by "bad early experiences." Instead, Becker presented biological, evolutionary and psychoanalytic arguments that "the fear"—even "terror"—"of death is natural and is present in *everyone*, that it is the basic fear that influences all others, a fear from which no one is immune"—including clinicians. As organisms, only the fearful and anxious *survive* successive generations and pass on their genes, but by a similarly ubiquitous, dynamically-oriented twist, only those who can defend against and at least occasionally repress that terror of

death can *thrive* and “function normally” (Becker). Therefore, defending against—indeed, denying—the reality of death, argues Becker, has driven all of civilization and its developments, from the heroics of ancient Greece to modern day capitalism. Death through this defensive denial has become in many ways a taboo, to which psychotherapists are not immune, and which some suggest contributes to the limited nature of the literature on the subject (Becher, Ogasawara, & Harris, 2012). As a prime example, Freud, the father of psychotherapy and psychoanalysis, struggled for 16 years and eventually died from oral cancer, but he wrote nothing at all (and nothing is known) about how his terminal cancer affected his clinical work, work which he continued until weeks before his death (Schur, 1972).

Indeed Burton (1962), found that after sending questionnaires about clinician attitudes toward death, only 51 of 300 psychoanalysts (randomly chosen from the directory of the American Psychoanalytic Association) responded, and he claimed that responses were “occasionally hostile,” evincing a pained reluctance to consider the topic at all. Burton’s study proposed to compare a representative sample of psychoanalysts to a smaller sampling of divinity students, with the hopes of identifying common themes and patterns within and differences between how these two professions understood and approached death (and by relation their mortality). Of relevance to this present discussion, Burton found that the vast majority of psychoanalysts (84.3% of his respondents) viewed death wholly as an “end,” and a similar number (81%) asserted that a “fiction of immunity toward death” was either non-existent or unnecessary for psychological health (Burton). In considering what sorts of preparations one should make for death, a plurality of psychoanalysts (47.1%) endorsed the need to arrange care for dependents, whereas a smaller number (33.3%) explicitly mentioned the importance of arranging the transfer of patients (Burton). A vast majority of the sampling of psychoanalysts

(88%) believed that the subject of death should not be avoided in the analysis, though respondents relayed that “the subject rarely arises” (Burton). Burton’s study is of some obvious interest to the present study, but suffers for its age, and the fact that it only covered the beliefs and opinions of psychoanalysts, mainly psychiatrists, who were over 80% male.

Offering a somewhat updated perspective, and perhaps one that is more representative of clinical social work, Bergin and Jensen performed a religion-focused survey of 425 therapists, who comprised 59% of their “demographically and geographically comparable” sampling of clinical psychologists, psychiatrists, clinical social workers, and marriage and family therapists (1990). While the survey did not explicitly ask about attitudes and beliefs regarding mortality, per se, the results found that 80% of therapists identified a religious preference (less than the 91% of the general public who identified similarly, but still a significant majority). More specific to our present discussion, of the 106 therapists in the survey who were clinical social workers, approximately 90% identified a religious preference, making clinical social work the psychotherapeutic profession with “the second highest level of religiosity” (Bergin & Jensen). While surveys show a slight increase of non-religious identification amongst the general public from 1990 to 2013—9% to 15%—a similar trend amongst clinical social workers would still leave a vast majority of those professionals identifying as religious (Gallup, 2014). As such, one might suppose that the current attitudes of many clinical social workers toward their own mortality might be informed by religious beliefs about an afterlife, or about how one should approach and consider their death (perhaps counter to the analysts in Burton’s study).

Speaking from the perspective of atheistic/humanistic existentialism, Yalom (1980) argued staunchly for an approach to mortality free of any religious or psychological defenses against the “four ultimate concerns: death, freedom, isolation, and meaninglessness.” With death

primary amongst those ultimate concerns, Yalom (2006) identified a resultant “death anxiety” as a universal concern, which pervades all of our lives, even mental health professionals, to one degree or another. He argued that we—and our clients with us—must all confront the painful realities of existence, and through this confrontation we will also be freer to make the most of the *joys* of existence. Confronting mortality and the other “givens of existence” is painful, but ultimately healing (Yalom, 1980). Of some interest to our present discussion—though the sample was biased toward those interested in his work—Yalom anecdotally reports that “generally over 50 percent [of psychotherapist at his lectures] respond affirmatively” when asked if they are “existentially oriented,” potentially providing a rough estimate of how many clinicians might subscribe to these general beliefs about their mortality and the usefulness of conceptualizing it with this existential frame.

Whether death is treated as an “ultimate end” or not, mortality unquestioningly induces transition, change, and termination of direct clinical practice, and as such it has potential relevance for all clinicians and their practices. Reflecting the existential approach toward death, Sands (2009) provided a personal reflection on how her growing proximity to and awareness of death as she ages have actually expanded her sense of self and widened her perspective, bringing greater clarity in life and in her clinical work. Somewhat less optimistic, but still hopeful, Chessick (2013) argues, with illustrative case vignettes, that as the analyst grows older and gains a greater awareness of the closeness of death, he must be intentional about monitoring the potential for destructive (counter-)transferential enactments of denial, avoidance and acting out in his clinical work; death must not be denied for the sake of rosy idealizations and fantasies, as this will hurt clients in the end. One example of such an enactment in Chessick’s work involved a pair of clients who were insistently resistant to discussing referral to another analyst who could

continue their work after Chessick no longer could; Chessick had to be intentional not to allow these patients to feed into his own denial of his mortality, and instead had to mutually confront his and the client's defenses, encouraging the patient and himself to realize that he, like all of us, won't be around forever (2013). Philip (1994) offers a poignant portrait of her own need to terminate her practice due to terminal illness, sharing that she had to provide ample time to allow clients to process and prepare for her death, before she was too impaired to adequately practice therapy any longer. She ultimately found that client reactions varied, along with their decisions of whether or not to maintain contact after termination but before her death; she also found that professional consultation was invaluable to navigating these murky waters (Philip). Indeed, - Lewis (1982) suggested that situations which make the clinician feel vulnerable—like illness and an awareness of mortality—may lead to heightened defenses, but he also believes that consultation and discussion with peers may help attenuate those responses and increase therapeutic competence. Consultation in these instances, according to Lewis, involves seeking advice and general socio-emotional support from trusted colleagues, so as to both ease the clinician's own distress, as well as help the clinician provide optimal care to his clients at a potentially disorienting time for all involved.

The literature suggests that mortality often produces pain and anxiety, which clinicians confront through various belief systems and approaches; at the same time, mortality also provides a potential gateway to professional and personal growth when properly considered and addressed. Worth noting, the literature on this subject is mainly theoretical, psychoanalytically-oriented and based on the subjective experiences of individual analysts and therapists; clearly a need for broader and more empirical exploration is called for.

### *The Client's Experience of Clinician Mortality*

Clients' experiences of their clinician's mortality are usually discussed from the vantage point of those whose therapists have died or are suffering a terminal illness (as opposed to those who are in current treatment wondering more generally about their therapist's mortality). These experiences are generally framed as painfully felt losses, as might be expected. Rendely (1999) provided an autobiographical sketch of her traumatic loss of her analyst, which she believed wasn't treated by the analytic community as the loss of a "real relationship," and thus led her to experience disenfranchised and isolated grief. She therefore argued the need for clinical communities to validate and provide community support for the real grief of the surviving client. Beder (2008) further discussed the loss of the therapist as a "traumatic event," requiring that the "inheriting therapist" both continue addressing the patient's unfinished original work, and also address the new grief and continued experience related to the lost relationship with the original clinician. Traesdal (2005) believes that the loss of the analyst further implies the loss of the process of the "analytic dialogue" itself: that is the loss of a unique and profoundly healing experience which the client may not again be able to pursue—or may not again feel comfortable pursuing.

Sorensen (2009) performed a qualitative exploratory research study with 22 individuals whose therapists or supervisors had died. While there was a bias toward those who had lost supervisors (17 of 22 participants, which also implies a bias toward representing the views of clinicians themselves, and not non-professional clients), instead of therapists, common themes around painful abandonment still emerged; participants reported being glad if preparation and discussion about the therapist's mortality had occurred beforehand (and if it hadn't, they wished



it had). As Sorensen (2009) referenced in that chapter, an earlier study was also performed with an unspecified number of clients of dead therapists, and some salient, shared themes emerged:

“1) The therapist's avoidance or denial of illness (although the client often sensed a problem); 2) The powerful impact on clients of such an experience; 3) Negative feelings towards the therapist, including anger, guilt and selfishness; 4) A reversal of roles which, for the client, could be experienced on a continuum from disorientating to damaging; 5) Clients' questioning of trust in the therapeutic contract; 6) Clients' parallel life experiences of ill health, loss or abandonment; 7) The question of clients' own mortality, brought into sharp relief by their therapists' experience; 8) A sense of isolation for the client whose therapist was less or no longer available” (Voller, 2003).

Echoing some of these themes, Philip (1994) discussed a patient whose therapist died after a prolonged illness, and suffered a destructively painful grief reaction after the fact, leading Philip to argue that earlier termination and closure would have been wise. Philip also reported that over her years of presenting on the subject of clinician death, her general impression of participants at her lectures was that their primary reaction to a clinician's untimely, but presaged death from illness was frustration—even anger—that the clinician hadn't terminated the treatment in a more intentional, timely and client-focused manner. Grief experienced as sadness was secondary to this anger (Philip, 1994). Philip's reports offer an interesting perspective on the subject of clinician mortality and the importance of intentional preparations and terminations, but she is quick to admit that her reports are subjective and not entirely “scientific” (she doesn't even approximate the number of lectures or participants), as well as being biased toward the types of individuals and professionals who attend her lectures on the subject of therapist aging, illness, and death.

Clients who had a forced termination due to death or illness had a significantly higher grief measures on a grief assessment, in a study of 35 clients who had either expected (n=19) or unexpected (n=16) terminations (Garcia-Lawson, Lane, & Koetting, 2000). And while the

majority of those clients with unexpected terminations reported having gone through a great deal of pain, half of them also felt they grew stronger through the experience. This study was biased toward female therapists (~70%), and only included therapists in private practice, though the participants in the two conditions were relatively similar in composition (white and primarily middle class). The small sample size is also a notable limitation of the study, as is the potential difficulty implicit in trying to operationalize the complexity of grief through the “Grief Experience Inventory” (Garcia-Lawson, Lane, & Koetting).

Clearly, clinician death can be an acutely disruptive and painful experience, but the literature suggests that certain practices before (e.g. overt discussion and termination) and after (e.g. continuing care with a pre-arranged therapist) a clinician dies can perhaps soften the blow and lead to healthier reactions and growth in clients.

### ***Mortality Practices***

Mortality practices, as defined above, and as I will consider them here, are whatever practices—active or passive—that connect to the clinician’s mortality. The literature has a varied approach to the subject, which I will discuss generally and then with specific focuses on self-disclosure and the professional will. In a sweeping review of the subject, Bram (1995) argued that clinical decisions about “ill and dying therapists” must address issues of disclosure and preventing client abandonment, all from the stance of upholding the psychologist’s ethics of autonomy, beneficence, nonmaleficence, justice, and fidelity (his review specifically focused on clinical psychologists). Traesdal (2005) proposes the idea of committees within analytic or psychotherapeutic communities which would provide both aid to clients of dead therapists, and provide consultation to clinicians dealing with concerns related to death and dying. Addressing

the results of their study of planned versus unplanned terminations, Garcia-Lawson, Lane, & Koetting (2000) made the following recommendations:

“The data strongly suggests the need for supervisors to discuss feelings about death and illness in supervision, and for universities and training institutes to hold classes and seminars on this topic. The need for preplanned guidelines to assist patients in case of the therapist’s illness or death should be presented at the same time that the frame or ground rules of therapy are discussed. Therapists have an ethical responsibility to plan for any untoward situation, and guidelines are necessary to prevent serious therapy setbacks.”

These authors propose a comprehensive set of standards and preparatory steps to address clinician mortality. Particularly, though, clinician self-disclosure and the use of a professional will have received a great deal of attention in the rest of the literature. I will discuss both in turn.

### *Self-Disclosure*

Most varieties of self-disclosure in clinical practice produce a great deal of theoretical controversy (c.f. Carew, 2009). The most controversial type of self-disclosure can be defined as: “The therapist’s verbal or behavioral sharing of thoughts, feelings attitudes, interests, tastes, values, life experiences, and factual information about himself or herself or others in the therapist’s life” (Goldstein, Miehl & Ringel, 2009). To wit, arguing against shifting attitudes around self-disclosure, Shill echoes the traditional analytic stance towards therapist self-disclosure, which holds that “abstinence and neutrality as ideals facilitate maintenance of an internal holding environment or container for the analyst's countertransference” (2004). Conversely the oft-cited psychotherapist Irvin Yalom, who identifies his frames of practice as “pluralistic... interpersonal and existential,” believes that he has “always facilitated therapy when [he has] shared some facet of [him]self” (2002). Knox and Hill (2001) presented an overview of the literature on general self-disclosure, and noted various trends and consensus, including: self-disclosure usually had a neutral to positive affect on therapy outcomes, self-

disclosure was a relatively infrequent intervention, and its application varies between theoretical orientations (i.e. humanistic therapists disclose more than analytic therapists). The authors further identified professional background information as the most generally appropriate topic of disclosure and they stated that the least appropriate disclosures are about “sexual practices and beliefs;” their review failed to mention anything about the disclosure of mortality, illness, or death (Knox & Hill).

The dilemma between one- and two-person psychologies undergirds any discussion of clinician self-disclosure. The originators of analytic and psychotherapeutic theory constructed conceptualizations of human psychology which suppose the client or patient has an internal world and psyche that might be considered and uncovered by the therapist, who is a separate and independent, and hypothetically objective observer (Shill, 2011). Alternately, as the psychotherapeutic field has developed, “two-person” psychologies have emerged—such as interpersonal and relational paradigms in psychoanalysis, or, for example, Acceptance and Commitment Therapy within the cognitive-behavioral tradition—which suppose that the psyche or psychology of the patient cannot be considered outside of its particular engagement with the “other”—the analyst in the case of psychoanalysis (Aron, 1990; Wilson & Dufrene, 2009). With the consideration of these two-person approaches in mind, it becomes far more important to consider the potential clinical value of acknowledging the real personhood—and mortality—of the clinician within the real relationship of the clinical dyad (Aron).

Bram (1995) presents a good snapshot of the spectrum of views regarding mortality (i.e. terminal illness) disclosures. Some writers, according to Bram (1995), worry that disclosure of illness will harm and worry the client, and that this disclosure serves the clinician’s needs more than the client’s (e.g. Dewald, 1982; Abend, 1982); and others believe that implicit disclosure is

inevitable and explicit disclosure can be important and should be matched to the client and to the type and stage of treatment (e.g. Morrison, 1990). As a testament to the difficulty in reaching a consensus on the topic of whether an ill or dying analyst should disclose this to clients or “maintain a posture of abstinence and anonymity,” one workgroup of the American Psychoanalytic Association met for years—nearly a decade—and in the end could not reach a consensus on the subject, only agreeing that “denial by analysts was prominent,” and this denial should “not be ignored” (Feinsilver, 1998).

Kaplan (1986) discusses his own self-disclosure of his terminal illness to patients, and reports that his patients were able to process their grief reactions, which had an ultimately healing therapeutic effect. Feinsilver (1998) enthusiastically argues the benefit to his patients’ treatment brought about by his intersubjective engagement with the “external realities” of his illness and dying. His case vignettes showed evidence that more psychologically impaired, “sicker” patients needed more explicit and overt clarifications about his condition, while more neurotic patients could deal with it abstractly, and relate it to their own biography; in the end though, for all patients “it is the confrontation with the reality of my illness that initiates the mobilization of [therapeutic] forces.” He argues that explicit self-disclosure was a key element of this therapeutic mobilization, but also reiterates the importance of recognizing the role of past trauma in patients’ current reactions to his illness, as well as the role of identification between client and analyst in the treatment. In the end it might be said that Feinsilver proposes a constant dialectic between exploration of the client’s unconscious dynamics and addressing the external realities brought about by the threat of losing his or her analyst. Henry (2009) offers a similar case study, wherein sharing her potentially fatal diagnosis mobilized treatment with her client, but required Henry to first release her “narcissistic defenses and denials.”

Grunebaum (1993) performed qualitative interviews with 12 psychiatrists, psychologists, and social workers who had suffered severe illnesses while practicing psychotherapy and he found that most clinicians favored being “honest and straightforward,” not least of all in order to model these behaviors for their clients. Still, therapists were more wary of disclosing the more fatal or uncertain diagnoses. This study was admittedly small in scale and only included three social workers, and only four therapists whose illnesses were immediately life-threatening, so it has limited applicability to our current discussion. Lord, Ritvo, and Solnit (1978) performed a questionnaire study of 27 analysts whose analysts had died in treatment, and while half of the questionnaires were actually completed by the clients’ new analysts, evidence was still consistent that if the dying clinician had not self-disclosed or discussed his condition, clients found the loss and subsequent clinical work far more painful and difficult. In general, the literature seems to endorse that at least *some* disclosure, some of the time is far better for clients with regard to client mortality than *no* disclosure, ever.

### ***The Professional Will***

The professional will—another mortality practice—receives almost unanimous endorsement from clinicians who write about clinician death and dying (Bram, 1995; Garcia-Lawson, Lane, & Koetting, 2000; Beder, 2003; Becher, Ogasawara & Harris, 2012). Indeed, professional wills, according to Bradley, Hendricks & Kabell (2012), are an ethical imperative for any practicing clinician. The codes of ethics for every major psychotherapeutic profession encourage—if not compel—the production of a professional will (Steiner, 2011; see the AMA & APA Ethic’s Code, Opinion 8.115 Section I, IV; the AAMFT Code of Ethics, Section 1.11). Of particular note for the current study, the NASW Code of Ethics stipulates that, “Social workers should make reasonable efforts to ensure continuity of services in the event that services are

interrupted by factors such as unavailability, relocation, illness, disability, or death." (Section 1.15)

The professional will receives a great deal of support from professional and legal institutions. For example the Clinical Social Work Association website includes an entire page dedicated to information on producing a professional will, stating that, "Clinicians around the country are now biting the bullet and writing instructions for how to meet the needs of clients and tie up business matters, should the unthinkable happen" (Salzman, 2008). An exhaustive training video for mental health professionals entitled "Legal and Ethical Issues for Mental Health Professionals, Vol. 2: Dual Relationship Boundaries, Standards of Care & Termination," stipulates that a professional will should be considered both an ethical and clinical imperative and in certain jurisdictions is a legal mandate (Sommers, 2008). More specifically providing an overview of laws about professional wills, Steiner (2013) notes that:

Florida law requires therapists to place a newspaper ad announcing their upcoming relocation or retirement, as well as where former patients can get their records. Heirs to deceased therapists are required to place a similar ad, making public the fact that the therapist has died and providing contact information about how patients can obtain their files. Florida was the only state to mandate this system of public notification and transferring of patient records. Oregon law now requires psychologists not only to have a professional will, but to keep their licensing board informed of who has custody of their records and the name and contact information for that person. Other states are likely to make it a legal and ethical requirement to have a professional will.

Further advocating the importance and value of the professional will, the National Association of Social Workers, the largest professional social work organization, produced a "Clinical Social Work Practice Update" that specifically focused on what private practitioners should do to prepare for the possibility of their death, chief among the recommendations being the preparation of a professional will (Coleman, 2009).

The professional will, following Steiner's (2011) comprehensive model, must detail the following information:

What will happen to your group and your practice? Who has access to your office keys, patient contact information, and other details needed in an emergency? Who has your voicemail access code and appointment schedule? Who will cancel or triage your patients? How do you want your patients and their records handled if you are out of commission, either temporarily or permanently?

Additionally, Pope & Vazquez (2011) propose professional wills that cover an even wider swath of considerations: who should (and how should they) tell your clients about your death?; how will they access your office and coordinate and manage care and documentation?; how do clients/colleagues communicate with you, and how do you want your executor to respond to messages or calls (might you pre-record a voicemail message?); how do you want colleagues notified?; and how should expenses related to the execution of the professional will be paid?

The professional will thusly ensures that client care will continue with minimum disruption, as clients are triaged to other previously arranged providers. And while some of these considerations seem purely logistical, having a designated contact with access and instructions for records, for example, helps ensure continued patient confidentiality—a primary ethical tenet of the profession. Despite widespread support for professional wills, no research has been completed on the prevalence of actual implementation of the practice (Bradley, Hendricks, & Kabell, 2012).

### *Synopsis*

The current literature presents a complicated picture of clinician mortality. It seems to be a topic that is often avoided and not fully confronted by many clinicians. When mortality aggressively enters the clinician's life (as in a cancer diagnosis), most writers recommend at least



some discussion and preparation with clients around the clinician's heightened risk of death. "Generic" mortality—that is, the fact that we all may die without warning or expectation—gets minimal attention, except by existentially-oriented authors and those authors who implore universal adoption of mortality practices like the professional will. Less agreement exists, though, around directly discussing universal mortality in practice—as in whether clients should be told what the clinician's professional will stipulates as part of entering into a new therapeutic relationship.

The literature around clinician mortality is generally biased toward psychodynamic concepts and written by dynamic clinicians and thinkers, allowing a rich tapestry of arguments and postulations, but from mainly a specific set of perspectives. Clinician mortality pervades all theoretical disciplines and those other perspectives are notably lacking. The majority of articles on the subject are also generally theoretical, autobiographical, or expansions of case studies. Otherwise the studies tend to be qualitative explorations biased toward middle-class, white clinicians or clients, with small sample sizes. The empirical quantitative literature is the most diminutive regarding clinician mortality. More research is certainly needed.

The present study will attempt to answer some of these gaps in the literature, providing an exploratory, empirical snapshot of the profession, gaining a broad perspective and engaging a larger sample of professionals. It will also address a bias in the literature that seems to neglect any overt attention to the clinical social work profession in particular, with all its specific foci and theoretical underpinnings. My study, with a presumption that the literature generally defends a few common practices, will offer some clarity about whether these mortality practices actually hold any sway with clinical social workers in practice.

## **CHAPTER III**

### **Methodology**

#### ***Research Purpose and Question(s)***

The proposed study will attempt to sketch an exploratory picture of clinical social workers' relationship with their mortality in practice. How do clinicians prepare for the potential that they may die unexpectedly while in the course of treating clients? For example, do they prepare professional wills, or even more do they discuss these arrangements as part of an initial contract with a client? The study will also treat those cases when death may be a more salient presence for the clinician. Do clinicians who work longer, past common ages of retirement, relate to death differently than their younger counterparts, and do they discuss death more directly with their clients? And if a clinician develops cancer, does she disclose to her clients and warn them of her precarious prognosis, does she take an unexplained leave, or does she quietly deteriorate in front of her mutually reticent clients?

The study will also explore clinical social workers' perceptions of how their particular relationships with death affect their clinical practice. If the mortality of the clinician does enter the therapeutic space in explicit conversation, what sorts of enactments result between the therapeutic dyad? Do disclosures of illness harm or help clients? How do clinical social workers respond to the experience of the client who has lost the "real relationship" with his therapist (Rendely, 1999)? And are there accepted mortality "best practices" that have the weight of an ethical imperative, with regards to upholding the well-being, self-determination, and informed

consent of clients in care? And if so—and the literature review of this study suggest that there are—how often are these mortality practices enacted?

In exploring all of these questions, the present study will also examine how certain clinician attitudes and practices around their mortality correlate with various demographic differences, including and beyond age and illness. Do older, clinicians, for example have a greater comfort discussing their death openly with clients? Perhaps different areas of practice (e.g. agency vs private) breed different patterns of mortality practices. Does theoretical orientation inform or predispose toward differing mortality practices?

### ***Research Method and Design***

The proposed study will attempt to answer the above questions through a primarily exploratory quasi-mixed-methods approach. For one portion of the study I performed a qualitative study wherein I interviewed eight clinical social workers to explore how they relate to mortality in their clinical practice. For the sake of consistency and to broaden the potential geographic scope of the study, I performed and recorded qualitative interviews over the phone. They lasted around thirty and forty-five minutes in length. I asked the participants in the study the relatively open-ended questions found in Appendix E, and invited them to discuss each topic in whatever depth they felt compelled to, asking follow-up questions where appropriate. These qualitative interviews were then analyzed for various patterns and themes in responses; this will be discussed below in the Data Analysis section.

A brief online survey, on SurveyMonkey.com, was also distributed to clinical social workers, concurrent with the completion of the qualitative interviews. The survey sought to explore similar themes to the qualitative interviews, but also sought to gain a broader picture of the field, by probing the attitudes and behaviors of more clinical social workers. In the end 83

clinical social workers completed the survey. The questions on the survey can be found in Appendix F.

Statements were rated on a 7-point Likert scale from “Strongly disagree to Strongly agree,” “Extremely harmful to Extremely helpful,” and “Never to Always” where appropriate. Eight questions incorporated open fields where respondents could provide qualitative expansion on their quantitative answers. Other questions were close-ended “Yes, No, or N/A.” But, even these questions were usually followed by space for participants to provide greater, open-ended detail if they wished.

Before both portions of the study, demographic data was also collected, either within the anonymous quantitative survey, or if they were participating in telephone interviews, before the interview they completed a separate SurveyMonkey page that covered demographic information and was linked to their initials, so that the interview and the demographic data could be linked. The following information about the clinical social worker was requested: age, race, gender, geographic region, average length of treatment, theoretical orientation, years of clinical experience, religious and/or spiritual identification, area of practice (e.g. private versus hospital), and client ages.

### **Sampling**

The samples in both portions of the study were similar, but with some differences in my intentionality around representativeness of certain sub-populations. For the entire study the sample universe is comprised of all practicing clinical social workers in the United States, who have at least two years of clinical experience and who are licensed to practice independently within their state of employment or residence. By stipulating these exclusionary criteria, the study endeavored to focus on the particular behaviors and attitudes of the clinical social work

profession, while also querying specifically those individuals who have demonstrated a level of knowledge and expertise regarding clinical practice such that they have been recognized by licensing boards. Therefore the study will not probe all “social workers” en masse, but by exploring licensed clinical social workers specifically, the study will arguably provide some insight into the implications and effects of our current licensing standards.

I specifically tried—but regrettably failed—to ensure that during the qualitative portion of the study there might be a broad representations of various demographics (i.e. both people of color and white, religious and not, male and female), even if representing these populations would have skewed the smaller sample away from being proportionally representative of the sample universe. The sampling strategy for the qualitative portion was non-probability, and relied on a combination of quota and snowball sampling, unsuccessfully seeking to derive a sample of clinicians with a diverse age range and from diverse theoretical backgrounds. I recruited participants by emailing a recruitment email to various professional and personal contacts within clinical social work, asking them to forward the recruitment email to any clinical social workers who might be interested in participating. This recruitment message also included the link to the survey portion of the study. I also posted the recruitment message on the listservs of the American Association for Psychoanalysis in Clinical Social Work and the Washington State Society for Clinical Social Work. Additionally I posted the message on the Facebook pages of the National Association for Social Work, the American Clinical Social Work Association, the New Social Worker magazine, the Clinical Social Work Journal, the Clinical Social Work Association, and Psychoanalysis in Clinical Social Work. Finally, I posted the recruitment message on the LinkedIn message board for the Network of Professional Social Workers, the forum for Child and Adolescent Therapy, the Psychotherapy Network,

Psychodynamic Psychotherapy, Mindfulness and Psychotherapy, and the American Group Psychotherapy Association.

The survey portion of the sample was similarly derived via a combination of snow-ball and convenience sampling. The recruitment to the survey was completed through the emails to the colleagues above and posts to the same Facebook and LinkedIn pages and listservs, as the recruitment message contained information about both aspects of the study. The sample is not a proper probability, representative sample, but has some indications of a quasi-representative sample, with specific characteristics and representative limitations of participants discussed in the Findings chapter.

The representativeness of the interview portion of the study is especially limited, while the survey portion of the study approximates the general clinical social work population in some ways. Some potential participants likely avoided this study as it focuses on potentially difficult issues, especially those clinicians who reject any sort of existential considerations. Also, the snowball methods of gaining participants potentially presented a bias toward like-minded clinicians. All sample members were adult social workers, provided with the opportunity for informed consent, so there were no ethical constraints or concerns.

### **Data Collection**

During prescreening for the qualitative interview portion, I collected demographic data, about years of experience, area and population of practice, gender, age, religion/spirituality and race. During the survey portion, I collected the same demographic data, so as to examine patterns in the quantitative data, and to uncover correlations between this demographic and quantitative data.

The qualitative portion was semi-structured, using the relatively open-ended questions listed in Appendix F. Qualitative data was all collected over the phone, for consistency and so that I could pursue a broader geographic sample, with all participants being interviewed the same way. The qualitative conversations were recorded with consent from the participant. I also took written notes as I interviewed over the phone. Afterward, the interviews were transcribed before being analyzed. I ensured that the qualitative conversations were recorded with clear volume and quality so that I could transcribe and analyze the interviews accurately. Beyond these potential technological issues, interviews over the phone lost the greater depth and breadth of in-person interaction, which was a slight limitation to the data collection.

The survey was structured and brief, and recorded as electronic data, collected over an internet-based survey on SurveyMonkey.com. So that the surveys were completed accurately and fully, I ensured that the survey was concise and clear and topical. The data from the surveys remained deidentified and anonymous. Participants were given the chance to enter a randomized drawing for a \$25 gift card if they completed the survey. Participants submitted an email address at which to be contacted, but this email address was not connected with their survey responses.

### **Data Analysis**

A descriptive analysis of my data was used to assess mainly measures of central tendency, and potential skew. I was interested in assessing whether respondents tended toward certain attitudes toward issues of mortality, disclosure, and death discussions. A descriptive analysis of the demographic data also provided important information about how the rest of the data may or may not be representative of clinical social workers more generally.

Inferential data analysis provided a few intriguing connections between clinician age, theoretical orientation, or area of practice and their willingness to engage in certain discussions or considerations. For example, I explored whether older clinicians were more likely to have discussed their mortality directly with clients (they were). I transformed some of the ordinal data points from the Likert scales and the demographic data on the survey to dummy variables in order to produce bivariate analyses, when t-tests of difference were appropriate, as in dividing clinical social workers between those who have and those who do not have any clients aged 65 or older.

In considering the difference between one-tailed and two-tailed hypotheses, I maintained a focus on two-tailed analysis. It was beyond the scope of this study to determine a directional effect in my data, so instead I merely explored differences between groups of clinicians. For example someone's personal interest in existential concerns and how comfortable they are being open about their mortality in therapy may affect what theoretical orientation and training they pursue, just as their theoretical orientation and training may increase these considerations. Similarly, do clinicians who work in private practice complete professional wills due to their area of practice or would they otherwise still be inclined toward such preparations? With that in mind, I merely attempted to determine in this study *whether* groups differ, not *why*.

I analyzed the qualitative interviews through the lens of grounded theory. I examined the transcripts for common themes and phrases, and coded accordingly. I tried to find patterns and repetitions between different interviewees, and when responses repeatedly occurred, I recorded them and counted how often they occurred between respondents. I extracted especially salient responses by participants and listed them by theme. I used this same method to analyze the free-responses on the survey.



## **CHAPTER IV**

### **Findings**

In the following chapter I will present the findings of my quasi-mixed methods exploratory study: first, I will share and analyze the results of the quantitative survey of 83 clinical social workers; following, I will provide a qualitative analysis of the eight interviews with clinical social workers. While the results of the survey and interviews echo one another, I will present them separately, discussing the unique demographics and findings of each sub-set of data. Ultimately, in the following Discussion chapter I will integrate the qualitative and quantitative data, extracting themes and presenting a picture of how clinical social workers respond to their mortality in clinical and professional practice.

### **The Survey**

83 clinical social workers completed my survey addressing issues regarding how they interact with and address their mortality in their clinical and professional practice. These clinical social workers represent a broad geographic, theoretical, and professional variety. Within the survey, the respondents reported on whether or not they have discussed their mortality directly with clients and how this impacted the clinical work; whether the clinicians have created professional wills and what attitudes they hold about these preparations; and they reported whether they had received a terminal diagnosis at some point during their clinical career, and how they handled this. The survey was administered for primarily exploratory purposes, that is to gain a picture of the profession and how clinical social workers practice, and less to defend

any particular causal hypothesis. That being said, I performed some basic statistical analysis with the survey responses comparing the responses of different clinician groups, using statistical tests of difference. The survey also included eight free-response fields, and those responses have also been analyzed and included below.

### **Demographic Data**

The 83 clinical social workers who completed the survey provided demographic information about their age, years of clinical practice, the age of their clients, the average length of treatment episodes, their gender, theoretical orientation, their geographic location, and any religious affiliation. I will share the demographic responses of survey participants, followed by comparing how well the present sample reflects the broader clinical social work profession.

Participants ranged in age from 24 to 80, with an average age of 56.52, and a median age of 59 (59 was also the modal response). There was a standard deviation of 13.21 years. Participants have worked clinically from 2 to 42 years, with an average response of 22.95 years of experience, and a median response of 24 years. The modal response was 20 years of clinical experience and the standard deviation of the responses was 11.28 years. The measure I used to report client population age resulted in many inconsistent responses, with only 48 of 83 respondents reporting a ratio of clients that added up to 100%. So while I chose not to use this data comprehensively, I did use the data to determine whether or not the clinical social worker reported working with *any* clients who are 65 or older. In total 42 of the 83 clinicians reported working with at least one client who is at least 65 years of age. Clinicians in the study reported working with clients for average lengths of treatment ranging from 1 month to 60 months (5 years). The average clinician worked with a client for 20.29 months, with the median length

being 14 months, and 24 months being the modal response; the standard deviation for responses was 15.51 months.

78 of 83 clinicians (94%) reported White/Caucasian identity, while 71 of 83 (86.75%) reported *only* White/Caucasian ethnicity. Of those 7 clinicians who reported a mixed ethnic identity, 5 reported additional Hispanic/Latino identity, 1 reported additional Black/African American identity, and 1 clinician reported also having American Indian/Alaskan Native identity. In total, partially or completely, 1 clinician identified as American Indian/Alaskan Native, 1 as Asian/Pacific Islander, 5 as Hispanic/Latino identity, and 4 clinicians reported Black/African American identity—that is 11 of 83 (13.25%) identified as people of color. 68 of 83 (81.93%) clinicians identified as female, while 15 (18.07%) clinicians identified as male.

Clinicians reported adhering most closely to the following theoretical paradigms in their practice: 9 of 83 (10.84%) to Cognitive/Behavioral; 46 of 83 (55.42%) to Psychodynamic/Psychoanalytic; 21 of 83 (25.3%) to Eclectic/Integrative; 6 of 83 (7.2%) to Existential/Experiential; and 3 of 83 (3.61%) clinicians report adhering to Systems/Other theories. 65 of 83 (78%) clinicians reported working in private practice, while 7 (8%) work in a group private practice. Three clinicians (4%) reported working in an elementary or middle school, four (5%) work in a high school and one clinician (1%) works at a college. Eleven clinicians (13%) practice at a mental health agency, while six respondents (7%) report working in a hospital and one clinician (1%) works in a residential program. Nine clinicians (11%) report working in two or more settings, meaning that the above counts do not add up to 83.

A plurality of respondents identified themselves as non-religious (n=29, 35%). 21 (25%) respondents identified as Jewish (25%), and 26 (31%) respondents identified as Catholic, Protestant, or Christian. 10 respondents (12%) identified themselves as Buddhist, while 2

clinicians (2%) identified as following a Native American religion. Seven clinicians (8%) identified themselves as Inter/Non-denominational. Geographically, most respondents were from the Northeast region of the country (n=29, 35%) or the West (n=27, 33%). Sixteen clinician were from the Midwest (19%) and 11 were from the South (13%).

The sample of respondents was generally representative of clinical social workers with regard to gender and race, but respondents skewed old and psychodynamic compared to the rest of the clinical social work profession (Practice Research Network, 2003; Prochaska & Norcross, 2003). Private practitioners are vastly over-represented in the present study (Whitaker, Weismiller, & Clark, 2006). While the Northeast and West are oversampled, Southern states are under-represented amongst respondents—the Midwest seems to be proportionally represented—all assuming a distribution of clinical social workers which roughly matches the general population (U.S. Census Bureau, 2014). Jewish, Buddhist and non-religious clinical social workers are over-represented amongst survey respondents, while Christians are under-represented (Bergin & Jensen, 1990). Most demographic data is summarized in Table 1.

**Table 1***Survey Demographics (n=83)*

<i>Gender</i>		
Female		n = 63 (82%)
Male		n = 15 (18%)
<i>Age</i>		
24-32		n = 5 (6%)
33-42		n = 8 (9.6%)
43-52		n = 13 (15.7%)
53-62		n = 25 (30.1%)
62+		n = 32 (38.6%)
<i>Race (choose all that apply)</i>		
White		n = 78 (94%)
Black/African American		n = 4 (5%)
Hispanic/Latino		n = 5 (6%)
Asian/Pacific Islander		n = 1 (1%)
American Indian/Alaskan Native		n = 1 (1%)
<i>Theoretical orientation</i>		
Cognitive/Behavioral		n = 9 (10.8%)
Psychodynamic/Psychoanalytic		n = 46 (55.4%)
Eclectic/Integrative		n = 21 (25.3%)
Existential/Experiential		n = 6 (7.2%)
Systems/Other		n = 3 (3.6%)
<i>Geographic location</i>		
Northeast		n = 29 (35%)
Midwest		n = 16 (19%)
South		n = 11 (13%)
West		n = 27 (33%)
<i>Religion</i>		
Non-Religious		n = 29 (35%)
Christian		n = 26 (31%)
Jewish		n = 21 (25%)
Buddhist		n = 10 (12%)
Inter/Non-denominational		n = 7 (8%)
Native American		n = 2 (2%)
<i>Practice setting (choose all that apply)</i>		
Solo private practice		n = 65 (78%)
Group private practice		n = 7 (8%)
Elementary or middle school		n = 3 (4%)
High school		n = 4 (5%)
College		n = 1 (1%)
Mental health agency		n = 11 (13%)
Hospital		n = 6 (7%)
Residential program		n = 1 (1%)

## Results

The responses to the survey are presented below, with modal and mean responses highlighted. When asked how strongly they agreed or disagreed with the statement that, “My mortality is relevant to consider with regard to my clinical work,” the majority of respondents reported that they “Agree,” as shown in Figure 1, with a mean strength of 4.43/6 (4.0 = Somewhat agree, and 5.0 = Agree).

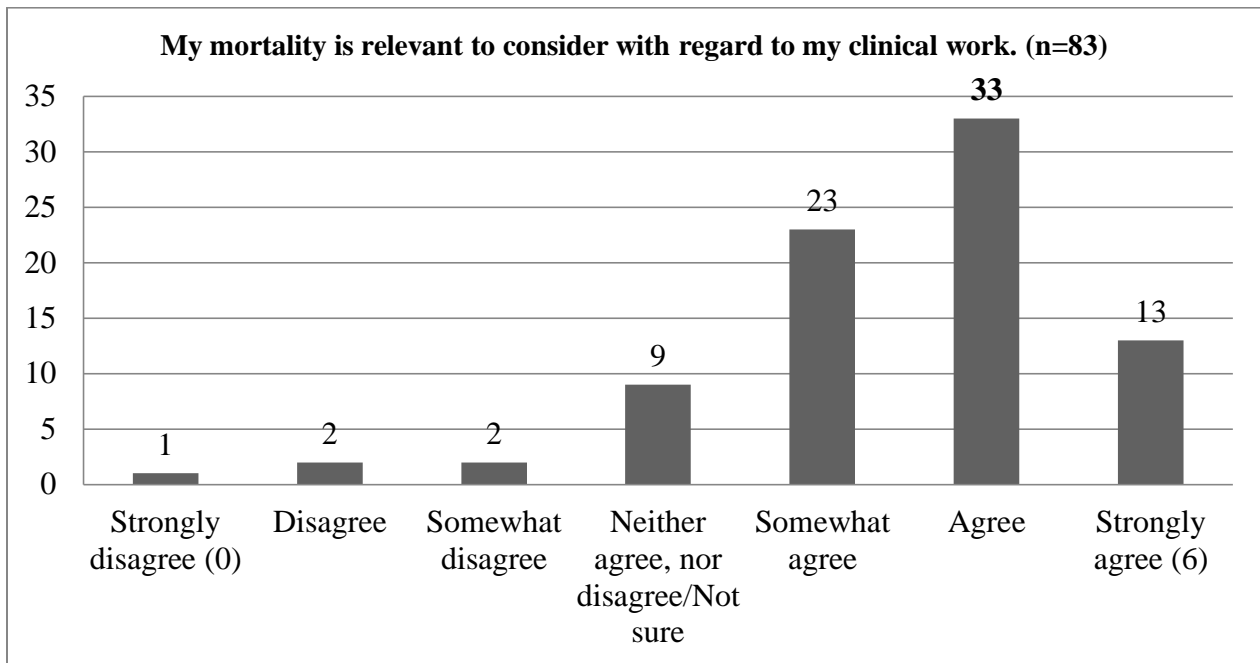


Figure 1. *Mortality relevance to clinical work*

The majority of clinicians (n=53, 63.9%) deny having discussed their mortality with their clients. Of the 30 clinicians (36.1%) who endorsed having discussed their mortality with clients, 28 respondents answered the follow-up question, “How did such discussions affect the clinical work, for the majority of such cases?” All 28 respondents reported that such discussions were either “Somewhat helpful” (n=10, 35.7%), “Helpful” (n=12, 42.9%), or “Extremely helpful” (n=6, 21.4%). Thus, the average helpfulness rating was 4.86/6, just slight of “Helpful” (5.0), the modal response. While a majority of participants denied having had such talks in the past, a

majority of respondents agreed to some degree (n=58, 69.9%) that they “would feel comfortable discussing my mortality with my clients,” as displayed in Figure 2. The most common response was “Agree” (n=28, 33.7%), but the mean strength of agreement was 3.92/6, just below “Somewhat agree” (4.0).

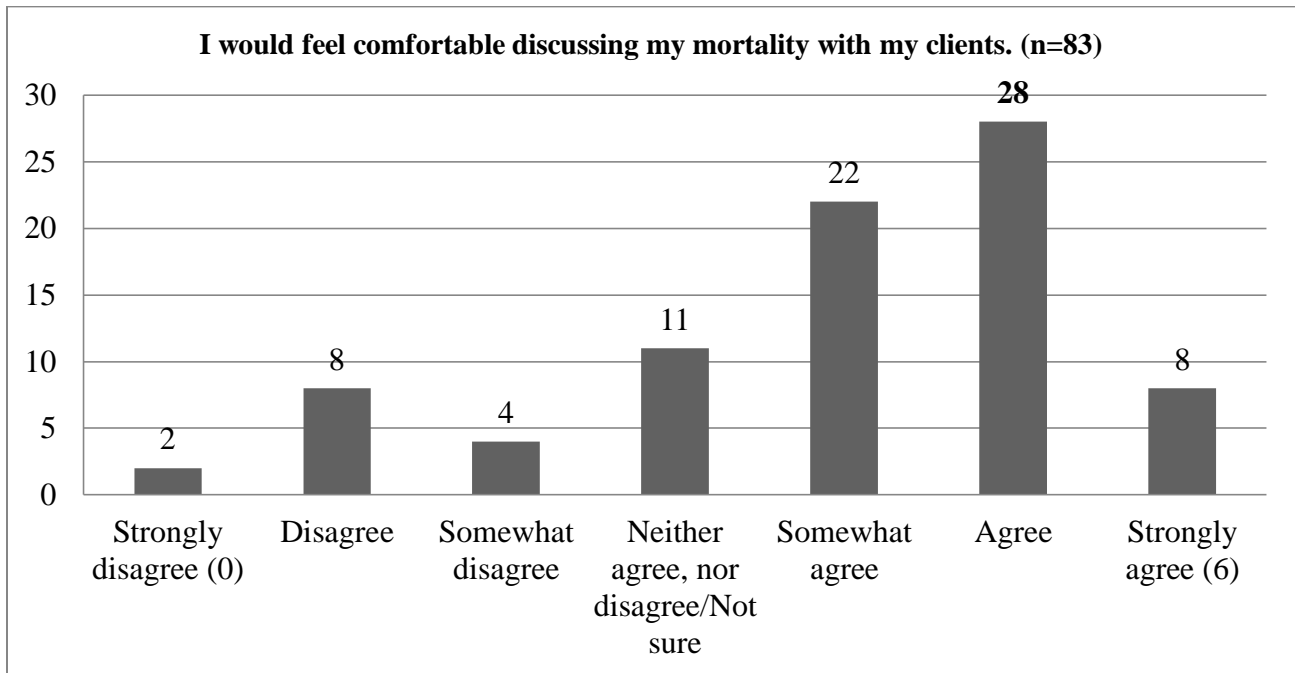


Figure 2. *Comfort with discussing clinician mortality with clients*

Only nine clinical social workers in the survey (10.8%) had “received a potentially terminal medical diagnosis at some point while practicing clinical work.” Of these nine respondents, four clinicians (44.4%) did not disclose their diagnosis to any clients, while a majority reported their diagnosis to either some (n=3, 33.3%) or all (n=2, 22.2%) clients. While the majority of respondents (n=74, 89.2%) were answering without having had the experience personally, clinicians varied greatly in their opinions about disclosing illness, displayed in Figure 3. About as many clinicians viewed disclosure of a potentially terminal diagnosis as “Never” (n=3, 3.6%), “Rarely” (n=10, 12%), or “Sometimes” (n=29, 34.9%) advisable, as viewed it “Often” (n=14, 16.9%), “Almost always” (n=20, 24.1%), or “Always” (n=5, 6%) advisable.

While the modal response was “Sometimes” (2.0), the mean rating response was 3.13, just above “About half of the time.”

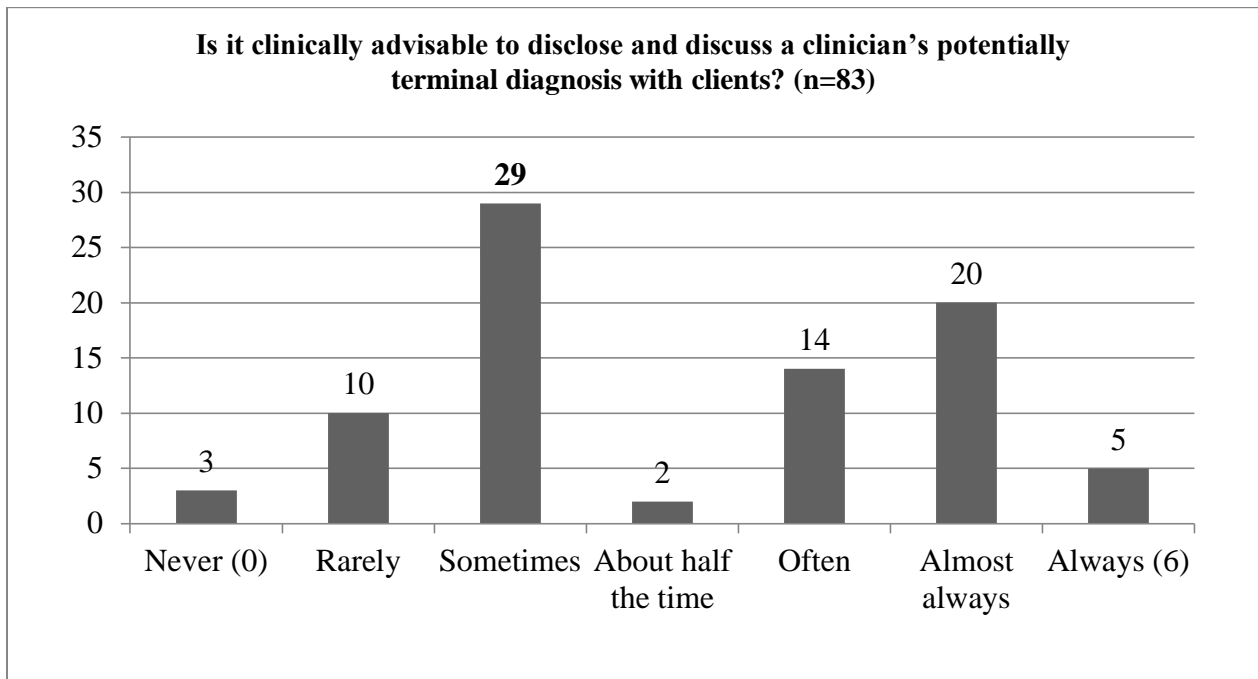


Figure 3. *Advisability of clinician disclosure of terminal illness*

When asked whether they had prepared professional wills, a vast majority of respondents (n=68, 82%) reported that they had not. At the same time, 29 participants (34.9%) reported having made “informal arrangements” short of a professional will. As shown in Figure 4, 47% of respondents (n=39) had made no preparations whatsoever for the event of their unexpected incapacitation or death, while only 15 individuals (18.1%) had prepared actual professional wills.



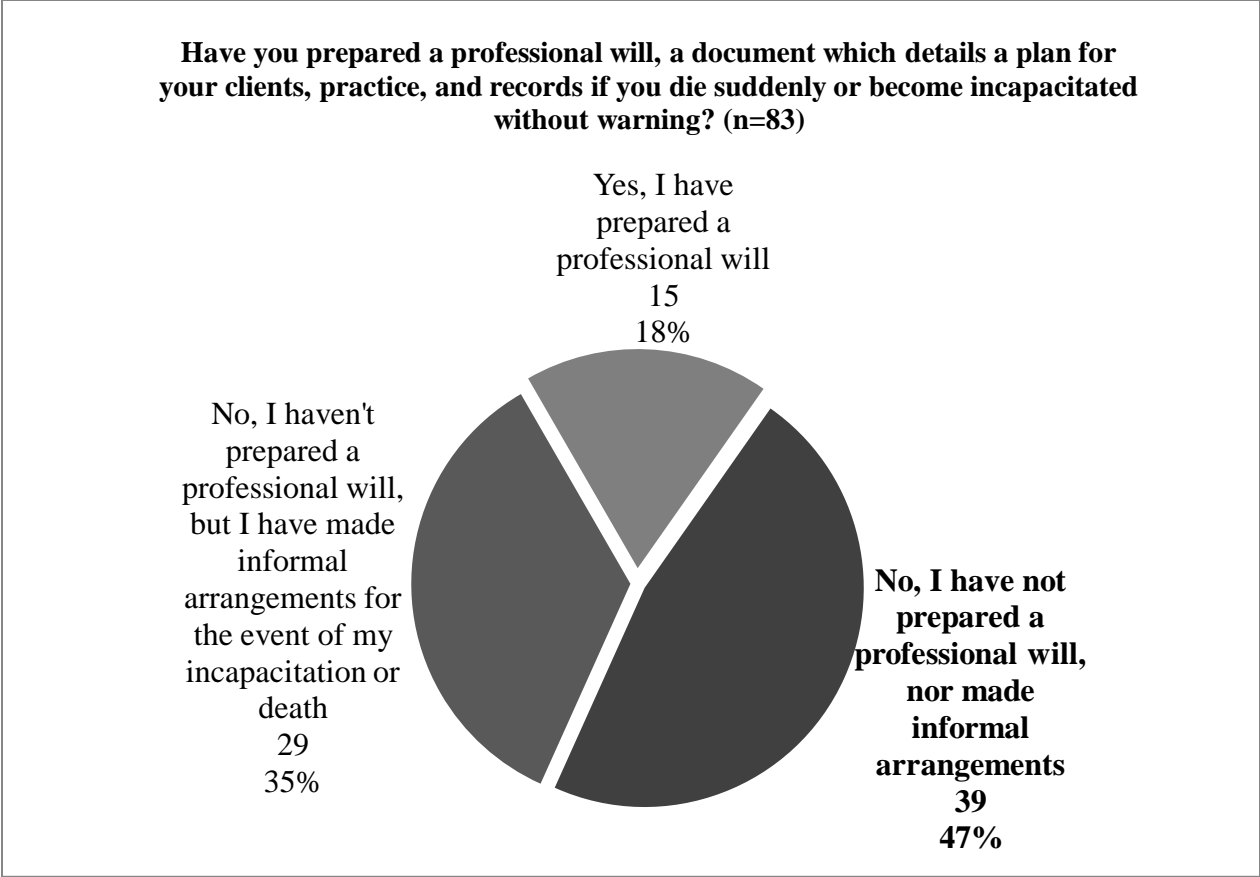


Figure 4. *Mortality preparations*

Of those clinicians who reported having prepared either a professional will or having made informal arrangements (n=44, 53%), 41 respondents answered the question, “Are your clients made explicitly aware of what would happen in the event of your incapacitation or death?” A majority of respondents to that question answered in the negative (n=31, 75.6%), that clients were not made explicitly aware of the client’s professional will or informal arrangements. With almost eerie congruence, 75% (n=18) of clinical social workers who work “in an agency, hospital, school (or other system) or group practice,” (n= 24) reported that they were unaware of “specific policies regarding a therapist's terminal illness, incapacitation, or death.” Almost the same ratio of clients (24%, n=10) were aware of such “policies,” as were clinicians (25%, n=6)!

Despite the low rate of implementation amongst respondents (18%), the vast majority of respondents agreed to some degree that, “Preparing a professional will is an important part of providing care from” both “a clinical/therapeutic perspective” (n=63, 75.9%) and “an ethical perspective” (n=68, 81.9%). While a professional will was generally considered important clinically and ethically, Figure 5 shows the slight variations in distribution of this importance. Where the modal response from a clinical perspective was “Strongly agree” (6.0/6), the mean rating was 4.55/6, while the modal response from an ethical perspective was “Agree” (5.0/6), while the mean rating was slightly higher than the clinical perspective at 4.72/6. Both questions, though, thusly averaged between “Somewhat agree” (4.0) and “Agree” (5.0).

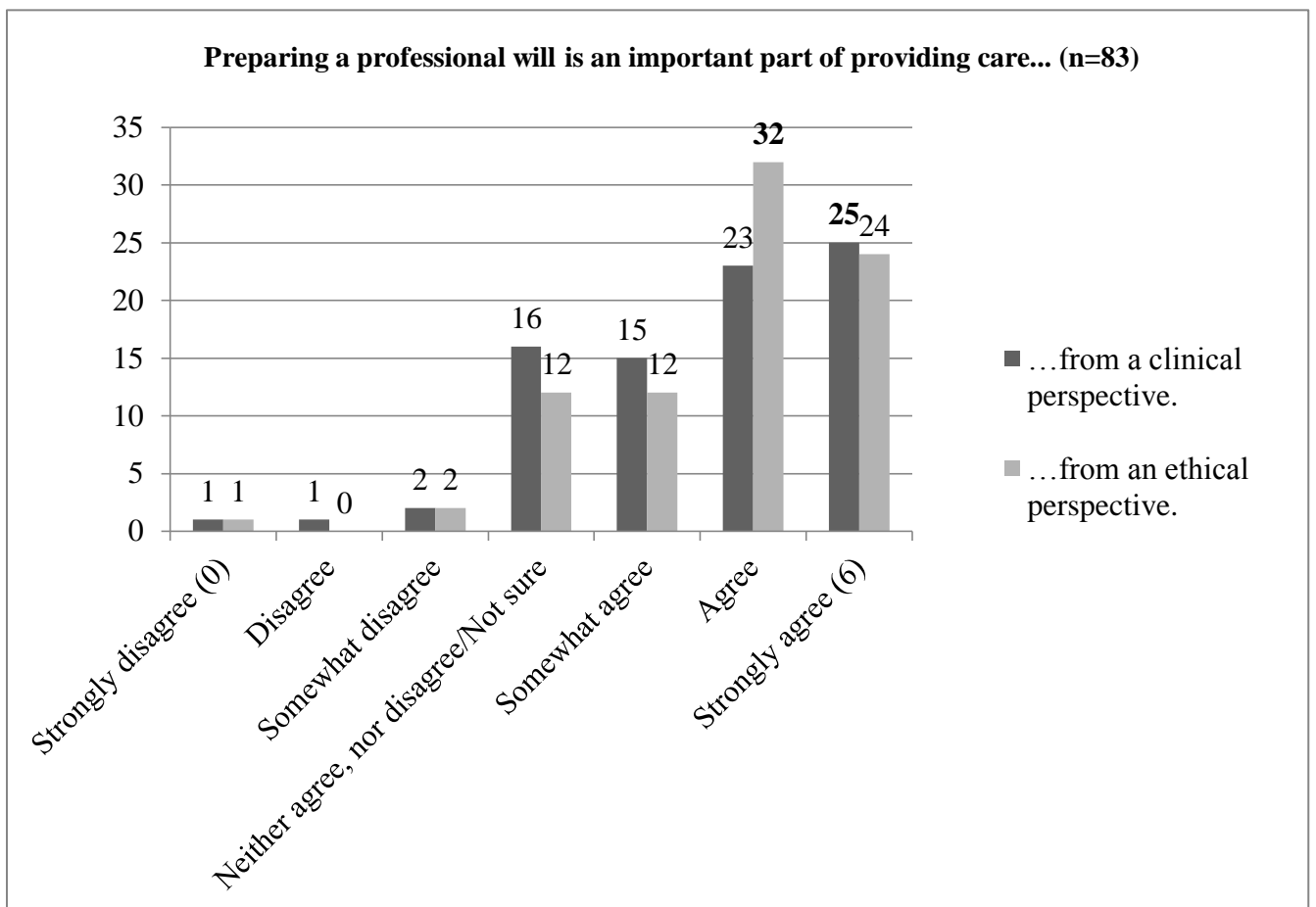


Figure 5. *The clinical and ethical importance of professional wills*

The final survey questions sought to gather a picture of how the survey had or had not impacted participants (including a question in the ‘Open-ended responses’). First, many more clinicians reported having already “Sometimes” (n=37, 45%) or “Often” (n=15, 18%) “thought about what might happen to your clients if you were to die, retire, or become incapacitated suddenly or unexpectedly,” than reported such thoughts “Rarely” (n=19, 23%) or “Never” (n=12, 14%). Still, a majority of respondents (n=53, 64%) reported a belief that the completion of the present survey would “have an effect on your clinical or professional practice.”

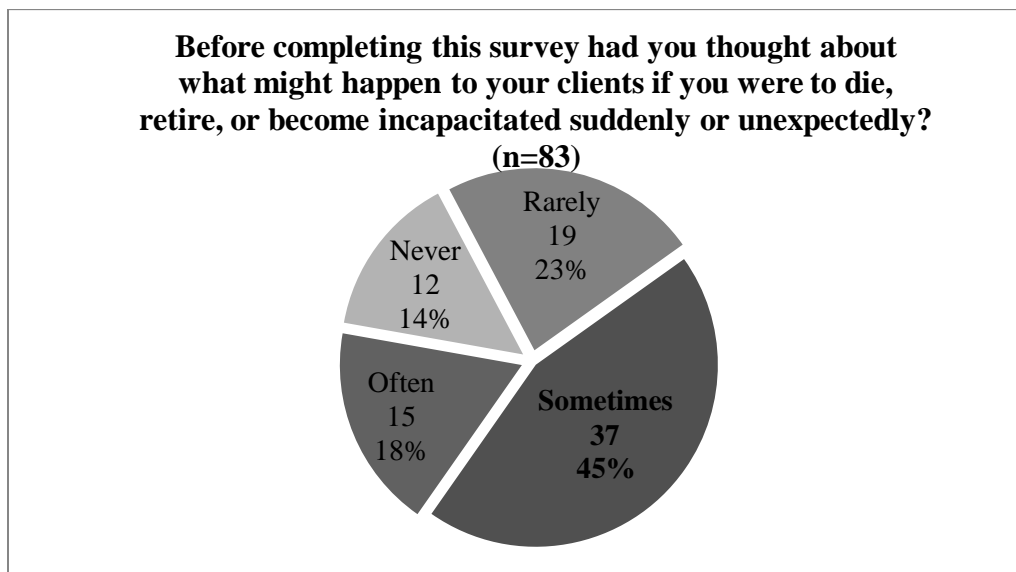


Figure 6. *Pre-existent frequency of mortality thoughts*

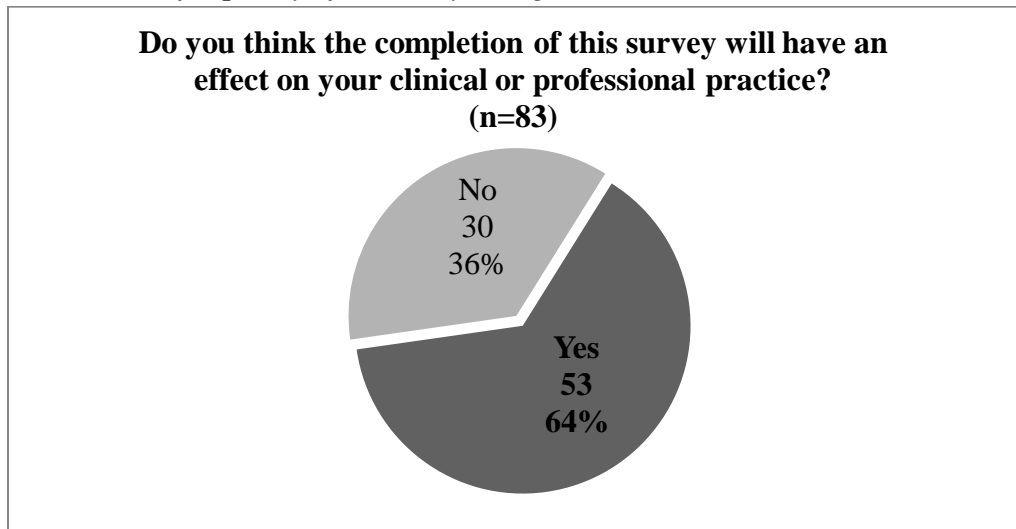


Figure 7. *Impact of survey on practice*

## Statistical Analysis of Survey Responses

Clinical social workers' responses were analyzed, using tests of difference to determine whether certain groups of clinicians—grouped based upon demographic responses or responses to other questions—differed significantly in their attitudes or practices. I used chi-square tests when comparing responses split into two dummy response groups (e.g. agree and strongly agree versus somewhat agree and less), and Mann Whitney U-tests when comparing the ranks in strength of agreement between two groups. Statistical significance was determined at the 95% confidence interval.

In responding to whether they considered their mortality relevant to their clinical work, I found no significant difference between older and younger clinicians. Similarly clinicians who had longer average lengths of treatment (e.g. one year or longer) did not consider their mortality more relevant to their clinical work than those with shorter lengths of treatment. Yet there was a statistically significant difference between clinicians who reported working with at least one client age 65 or older, and how relevant they viewed their mortality to their clinical work ( $U=458.0$ ,  $p=.00024$ , two-tailed, corrected for ties). That is, if they had at least one client age 65 or older, clinical social workers ranked mortality as more relevant to their clinical work—an average rank of 4.95/6.0 versus 3.90/6.0.

Clinicians who were aged 56 or older were more likely to have discussed their mortality with clients than those who were younger than 56 ( $\chi^2(1, N=83)=7.34$ ,  $p=.007$ ). Had both “younger” and “older” clinicians answered at a similar rate, about 13 of the former and 17 of the latter would have reported such conversations; instead, only six clinicians younger than 56 had had such discussions, while 24 clinicians age 56 or older had discussed their mortality with their clients. Clinician's comfort with discussing their mortality with clients did not differ

significantly based on any demographic factors, including years of experience or age. Similarly clinicians did not differ significantly with respect to professional will preparation across demographic categories, including clinician age, years of experience, theoretical orientation, or whether or not they worked in private practice or not. Of those with professional wills or informal arrangements, clinicians with 23 years of clinical experience or more made clients aware of their arrangements at a statistically significant higher rate than the group of clinicians with fewer years of experience ( $\chi^2(1, N=41) = 4.08, p = .043$ ); only one of the ten clinicians who makes his or her clients aware of his arrangements had less than 23 years of clinical experience.

Though on average all participants viewed them as important, clinical social workers ranked a professional will as somewhat more important ethically and clinically if they had 23 years of clinical experience or more, and if they had at least one client aged 65 or older. The group of clinical social workers with 23 years of experience or more ranked professional wills more important clinically ( $U=605.5, p = .02$ , two-tailed, corrected for ties), and ethically ( $U=621.0, p = .029$ , two-tailed, corrected for ties). Those clinicians who had at least one client aged 65 or older ranked professional wills more important clinically ( $U=569.0, p = .008$ , two-tailed, corrected for ties), and ethically ( $U=604.0, p = .019$ , two-tailed, corrected for ties). Interestingly, those clinicians who reported a length of treatment that averaged twelve months or longer ranked professional wills as more clinically important at a statistically significant rate ( $U=557.5, p = .04$ , two-tailed, corrected for ties), but this significant difference was not found regarding *ethical* importance and treatment length.

Clinical social workers who work in private practice thought more frequently about what would happen to their clients if the clinician were to die or become incapacitated suddenly

( $U=318.5$ ,  $p= .0017$ , two-tailed, corrected for ties); average rank 1.84/3.0 (2.0= Sometimes) versus average rank 1.05/3.0 (1.0=Rarely). Yet, years of experience, clinician or client age, and theoretical orientation did not lead to a similar difference in the frequency of such thoughts. Finally, and somewhat surprisingly, those clinicians who didn't have a professional will were not significantly more likely to state the survey would impact their practice; that is, relatively as many who did and as many who didn't already have professional wills reported the survey will impact their practice.

### **Open-ended responses**

Eight of the questions in the survey also included a space to record a free-response. Participants' responses often echoed each other. Below, I have reported those responses which were repeated by at least two clinicians; these responses are grouped thematically, and divided between individual questions. Some respondents included multiple themes or sentiments within a single free-response, meaning that the response counts for a given question will not necessarily add up to the number of individuals who responded to the prompt.

- *My mortality is relevant to consider with regard to my clinical work. Feel free to explain your answer:*

Sixteen individuals responded to this prompt. Six respondents mentioned their age in response to this question, explaining that the relevance of their mortality to their clinical work was mediated by their age; specifically, five of these clinicians discussed their older age, and one respondent stated they were “young and healthy” so their mortality wasn't relevant. Three clinicians reported that they had experiences with near-death accidents or potentiality terminal illness which brought their mortality to the fore (e.g. “I had cancer 2 years ago. It made me painfully aware that my death could impact my clients”). Three respondents reported that the

relative importance of their mortality to their clinical work depended upon where and with whom they worked, for example:

I have worked for years in hospice and pediatric hospice and palliative care. I find that my experience with this before returning to private practice strengthened my ability to be with impermanence and therefore to be with suffering in all of its forms in a non-reactive but supportive way.

- *If you have discussed your mortality with one or more clients, in general, how did such discussions affect the clinical work, for the majority of such cases? Please explain, if you wish:*

Ten clinicians responded to this prompt. Five of these clinicians discussed having discussions about their mortality as it relates to either their aging or a medical condition/procedure, and having discussed these openly—to a degree—with clients. These discussions were reported as generally beneficial to the client, clinician and the work:

I had cancer 5 years ago and took medical leave for 6 weeks. I think it was useful to talk about my condition, in a limited way and to the degree so that clients did not fantasize nor project that my diagnosis was more dangerous than it was. Conversations allowed people to express concern and for us to talk about what concerns it raised for them--both for the therapeutic relationship but as regarding their own feelings of vulnerability and thoughts about their mortality. With client who were receiving medical treatment for cancer, it offered a certain kind of 'being with' that I think allowed them to talk more directly about their experience in a different way.

Two other clinicians reported that discussions about their mortality were caged in humor or optimism (e.g. “Purchased clinical supervision to discern how to not over share or under share my status. For the most part I expressed optimism, but used the cancer word ~50%”).

- *Is it clinically advisable to disclose and discuss a clinician’s potentially terminal diagnosis with clients? Please explain, if you wish:*

Twenty-four individuals responded to this question. A majority of these responses (n=14) explicitly endorsed some level of disclosure to the client as being important or necessary:

I think client's are sensitive to the therapist in many ways and often know there is something that has not yet been articulated. To discuss this in a sensitive way demystifies what they have been intuiting. I also think people need to have an

opportunity to discuss the feelings this brings up in them--about their connection/attachment to the therapist, their previous experiences with death and thoughts about their own death. It is rich territory, and such discussion can have a healing potential--for the therapist and client to walk into this territory together--in conversations that were not had in other important relationships. I have worked with a number of clients who had a previous therapist die and they had sensed something and were informed just before or after the clinician's death, and they had complicated feelings and regrets. It appears to me that being able to have these important conversations with the clinician would have been very healing for them.

Most consistently (n=9) these clinicians also stated the importance of making considerations around disclosure based upon the type of diagnosis, how visible it is or how certainly/imminently terminal the illness might be:

"potentially?" If you are certainly terminal, I think it is essential to discuss it. If you are clearly ill, I also think it is important to discuss it, but also important to first explore patient's fantasies/ projections. However, being too abstinent regarding acknowledging the truth of a situation can be harmful to a patient's reality testing.

Others of those nine clinicians reiterated the theme of modulated disclosure based on the particularity of the diagnosis, but also stated the value of disclosure to the clients:

My husband had lung cancer 25 years ago and his clients were so relieved to know that they weren't crazy to think something was wrong with him. I know of Park Avenue psychoanalysts who never let pts know they were dying, because they feared no one would send them any more referrals! I also have stage 4 kidney disease but have been stable for over six years. When and if that changes, I will of course let all my remaining clients know.

Four clinicians more particularly stated that the appropriateness of disclosure was dependent upon the particular characteristics, history or goals of the client (e.g. "only if doing so advances client goal attainment" and "I would think it important to be honest with some clients especially if they have a history of loss"). Two clinicians worried about disclosure having a negative impact on the course of therapy (e.g. "I have a lot of training in psychodynamic theory. It is deeply ingrained in me to maintain a safe container for the work and not to provoke clients



to worry about my well-being”). Two respondents mentioned the importance of the therapist first processing her own feelings around the diagnosis:

I would say never until you know for sure...especially since if it is uncertain, then likely the therapist will not be at an acceptance level and may still be grieving/in shock, etc. Not appropriate to pull a client into that until therapist knows for sure and has processed with their therapist or a trusting friend/colleague/spouse, etc

- *Please briefly explain the nature of your professional will, or your informal arrangements:*

Eighteen clinicians responded to this prompt. Five clinicians reiterated the fact that they don't have a professional will, and additionally spoke to some elements of resistance or denial (e.g. “Here's where my denial of death appears. I had a colleague die suddenly, and know the mess that is created when a professional will is not left. Yet, I have not written out a formal one”). Two clinicians specifically claimed that a professional will is not necessary (e.g. “Actually I plan to retire before dying, and will make whatever referrals are needed at that time”). Five clinical social workers described the contents of their professional will or their informal preparations as primarily related to contacting and referring clients to new providers:

My plan is to have my bookkeeper call the clinician who I have designated to tell the client of my disability or death. After a release is sign my updated record can be sent to this clinician who may be able to continue with the case. If that is impossible I have prepared a list of clinicians in the area that I refer to for them to arrange continued care.

- *Are your clients made explicitly aware of what would happen in the event of your incapacitation or death? (That is, are they made aware of the contents of your professional will or your informal arrangements?) If so, when do they become aware of this?*

Eight clinical social workers responded to this prompt. Three of those clinicians stated that clients are told when they explicitly ask or if it seems to be a relevant therapeutic issue (e.g. “Only on a need-to-know basis, i.e. when it's a therapeutic issue. I don't put it in my intake documents (i.e. informed consent)”). Two clinicians report that they include the information in

their intake paperwork (e.g. “In my counselor's disclosure statement”). Two clinicians mentioned sharing information about these arrangements when they are away or travelling (e.g. “When I am away from the practice”).

- *If you work in an agency, hospital, school (or other system) or group practice, are you aware of specific policies regarding a therapist's terminal illness, incapacitation, or death? Please explain more, if you wish:*

This prompt only elicited one response, which was, “I work in both private practice and in connection with an organization-- not sure about the organization’s policies about this.”

- *Please share how you felt during the completion of this survey:*

Seventy of the 83 survey respondents recorded responses to this question. As such, there are a wide variety of sentiments represented. Eleven clinicians reported some level of unease, anxiety or discomfort,

I feel anxious. I have never thought about this. There's so much to think about in terms of treatment, referral, confidentiality, etc. that at times you may not consider all possible areas that one needs to! I will likely at least think about what would happen in the event that I died--as far as records.

Other of these eleven clinicians related their anxiety to more existential concerns (e.g. “It induces anxiety and fear thinking about my own mortality or incapacitation”). Seven respondents reported some variation of feeling either fine or at ease (e.g. “Fine- I think it is an important topic. I am in good health but I contemplate getting older and dying”). Seven other clinicians recorded having felt some level of guilt or embarrassment (e.g. “Well, at first it seemed like an unnecessary issue to even consider, which I suppose reveals how off of my radar this issue was for me. Now, I feel a bit irresponsible and guilty”). One of those clinicians reported this guilt as having felt, “chastened. I have not acted in accord with my values.” Four clinicians reported that they will think more about professional wills and other plans (e.g. “It

made me think about writing a professional will”). Four clinicians reported feeling grateful for the present research,

Good. I think you are raising good points on a subject that is often - in my experience- ignored. As a clinician with retirement on the horizon, I definitely need to consider and start writing my professional will! I also worked with a colleague who at 78 was literally falling down on the job and I saw first hand the terrible consequences of not dealing with this subject.

Three clinicians reported feeling thoughtful, contemplative or reflective (e.g. “I will think about my morality and my practice”). Three respondents reported feeling “neutral,” while three clinicians also stated how important, though difficult this topic is (e.g. “This stirred up some sadness for me, because it reminded me of the deaths of friends and relatives of mine who were therapists. I also felt glad to participate, because it is an important topic”). Three respondents felt that the survey was leading or directive (e.g. “like you were leading me to think that I should make a professional will,” or “Feels like a directive about how we should practice”). Related to this, two clinicians felt the survey lacked in necessary nuance (e.g. “concerned that several questions do not allow for nuance or complexity”). Two respondents discussed feelings or themes of denial (e.g. “I felt fine. I am a good denier”). Finally, two respondents reported feeling shocked or stunned by the survey:

I am sort of shocked that I hadn't given this more thought. It has been a passing thought at times based on the experiences of others. I consider myself to be fairly comfortable talking/ thinking about mortality, have even led a "Year to Live" group in the past, but had not considered this so closely until now. Great topic.

A notably unique response mentioned feeling, “Disappointed with law suggesting I should have a professional will in place but no training or general support for discussing mortality with clients.”

- *Do you think the completion of this survey will have an effect on your clinical or professional practice? Please explain:*

Fifty clinicians responded to this prompt. The most consistent response (n=13) was that the clinician was planning to (or was more likely to) formalize or write down a professional will (e.g. “I will make a plan with my clinical colleague that I share an office suite with, in order that patients will not be abandoned if I die or become incapacitated suddenly”). Others of those thirteen additionally considered how issues of mortality might impact practice, beyond the professional will,

You remind me to put formal arrangements in place. I am of retirement age (67) and have begun to feel some of the diminishments associated with aging. I have no intention of retiring any time soon, but it behooves me to stay mindful of my limitations (including my limited time on earth) and to include them in my formal clinical arrangements and in my thinking about my relationships with clients.

Ten respondents stated that the survey would elicit further thinking about the topics addressed, but stopped short of stating that this would result in any other actions or behavior (e.g. “I will probably think about it for a while before I actually do anything about it”). Four respondents felt they were certain of the arrangements they have in place (e.g. “I already do consider the pact of my death/serious illness on my practice, and I think it's great that you are researching this very important topic. Best of luck!”). Four clinicians considered the survey to be a useful “reminder”:

The survey reminds of the importance and places it more in my consciousness--5 years ago it was very much on my mind and as time has passed so has the poignancy. I am 62 and as I age, and my clients age and become more compromised, discussions about health, death, infirmity are more frequent and the topic of the clinicians mortality does have a place in them.

Three clinicians reported plans to discuss the issues raised by the survey with colleagues, either informally or in consultation (e.g. “I'll discuss the issue with colleagues, and perhaps prepare a professional will”). Three clinical social workers discussed operations of denial with regard to the subject (e.g. “Denial of death will take over again”). Two clinicians planned to

review their professional wills, and two others reported that they will consider telling clients about the nature of their professional wills. Two other clinicians wrote of a “hope,” but not a plan to create a professional will (e.g. “Hope to do will; maybe look at my own denial of death, and not wanting to think about its effect on my patients, who I care for and enjoy”). Finally two clinicians weren't sure what they would do (e.g. “Not sure - maybe at some point”).

### **The Interviews**

Eight clinical social workers from across the country took part in recorded phone interviews. These interviews were open-ended and structured around the five interview questions listed in Appendix F; these questions related to and expanded upon the themes explored in the survey. Participants were allowed to discuss or respond to whatever felt most salient to their experience; likewise, the interviewer—with measured subjectivity and intentions toward “evenly hovering attention”—attempted to ask questions that expanded and continued the discussion without unduly influencing the interviewee.

### **Demographic Data**

The survey participants were eight females, all white-identified (one participant also identified as Native American). Four participants were from the West and four were from the Northeast. Four interviewees identified as psychoanalytic or psychodynamic, while the other four identified as integrative or eclectic in their theoretical frame. The average age of interviewees was 62.4 (nearly 6 years higher than the survey average), with the oldest clinician being 76 and the youngest being 54. On average, clinicians had 30.9 years of experience (nearly eight years more than the survey), with a maximum of 40 and a minimum of 20 years. Three interviewees identified as Jewish, two as Christian, one as Buddhist, one as inter-denominational, and one interviewee identified as non-religious. Six of these respondents work in solo private

practice and two respondents work in a group private practice. The present interview sample was biased toward white, older women, from two regions and orientations, all of which is summarized in Table 2.

**Table 2**

*Interview Demographics (n=8)*

<i>Gender</i>	
Female	n = 8 (100%)
<i>Age</i>	
53-62	n = 3 (37.5%)
62+	n = 5 (62.5%)
<i>Race (choose all that apply)</i>	
White	n = 8 (100%)
American Indian/Alaskan Native	n = 1 (12.5%)
<i>Theoretical orientation</i>	
Psychodynamic/Psychoanalytic	n = 4 (50%)
Eclectic/Integrative	n = 4 (50%)
<i>Geographic location</i>	
Northeast	n = 4 (50%)
West	n = 4 (50%)
<i>Religion</i>	
Non-Religious	n = 1 (12.5%)
Christian	n = 2 (25%)
Jewish	n = 3 (37.5%)
Buddhist	n = 1 (12.5%)
Inter/Non-denominational	n = 1 (12.5%)
<i>Practice setting (choose all that apply)</i>	
Solo private practice	n = 6 (75%)
Group private practice	n = 2 (25%)

**Results**

Interviews were transcribed and then analyzed for thematic similarities between respondents: to qualify as a common theme or response, at least three of the eight respondents had to discuss it during their interview. Three general categories of responses might be termed: 1) relational/therapeutic concerns, 2) professional considerations, and 3) personal issues. Within these broader categories, various patterned responses were discovered, articulated in Table 3

below, and discussed further in the following pages. These categories are admittedly broad and overlap and inform each other. Loosely, the relational themes correspond to questions about mortality discussions and terminal illness as they impact the clinical relationship, and the professional themes chiefly relate to professional wills and other mortality preparations.

**Table 3**

*Interview themes and patterned responses*

Relational Concerns:	<ul style="list-style-type: none"> <li>• The benefits of disclosure</li> <li>• The pitfalls of disclosure</li> <li>• Client referral</li> <li>• Client characteristics impacting disclosure decisions</li> <li>• Illness variation impacting disclosure decisions</li> <li>• Client avoidance of mortality talks</li> <li>• Client initiation of mortality talks</li> <li>• Long-term clients</li> <li>• Moving away from the classic analytic frame</li> </ul>
Professional Considerations:	<ul style="list-style-type: none"> <li>• Lack of professional guidance</li> <li>• Not having a professional will, and implicit resistance involved</li> <li>• Consultation and mentorship</li> <li>• Knowing colleagues who have died/encountered terminal illness</li> <li>• Clinical practice as distraction</li> </ul>
Personal Issues:	<ul style="list-style-type: none"> <li>• Clinician age</li> <li>• Clinician's experience of close others dying</li> <li>• Clinician's thoughts about death</li> </ul>

*Relational Concerns*

**The benefits of disclosure.** Every participant (n=8) discussed the potential benefits of clinician self-disclosure around issues of death, dying, and illness, though they differed in the

particularities of when it might be appropriate. When asked about whether she would discuss a terminal illness with her clients, one clinician (P6) stated that, “I need alone time to process it, before I could talk about it in session, but I would definitely have to talk about it in session. You have to. You have to. I mean you have to, yeah.” When asked whether she was speaking from a clinical or ethical standpoint, she clarified that she was speaking from a clinical standpoint.

Another participant (P5) articulated that the need for the self-disclosure was both a clinical and ethical imperative,

Well, I think it’s both [clinical and ethical], because people... therapy offers people an opportunity to relate to the therapist in a way that they can’t with a lot of other people, especially if they haven’t been lucky to be really close to someone they can really reveal themselves and understand. So I think clinically it gives people an opportunity—most people have had some kind of losses in their life—and it gives them a chance to work it out in... a more adult way or a more open way. So I think clinically it’s really helpful, because we all have trouble with transitions, losses, and to have someone help us work through it is a gift. And then I think ethically, yes. When we take on the responsibility to see a client, it’s a huge responsibility, and if we can’t work with them for whatever reason and we have to refer them on, I think we have the responsibility to do it in the very best way.

Echoing the theme of providing a corrective experience with regard to loss and abandonment, another participant (P7) noted that having an open discussion about the therapist’s mortality related to illness might help clients deal with the universal truths of death and impermanence, stating that she would have such conversations “carefully, and really mindfully I hope, and hopefully use it as something that could help them deal more effectively or powerfully with other relationships—i.e. all of them—that are going to end someday.”

The one clinician who had gone through cancer diagnosis and treatment while practicing clinically (P2) offered a unique perspective on the diagnostic benefit of her self-disclosing to her clients, specifically the children with whom she worked,

I think, for me, when the kids would show empathy, concern, not necessarily excessive anxiety, but empathy or concern, for children that I’m working with who have had



interruptions in caregiving and some vulnerabilities in the area of attachment, it was somewhat of a reassurance to me and diagnostic that this child is growing in their capacity to form relationships that are meaningful to them, to feel with and think about how somebody else feels, and to take that into account and be sensitive.

But beyond any specific clinical benefit, one clinician (P3) articulated a general theme amongst respondents that it just wasn't "fair" or "respectful" to not disclose to some degree,

Well, I think that patients have an enormous number of fantasies about you, and some of them are true and some of them aren't, of course, especially long term patients. I think that to be as truthful as possible when you have your own personal crisis is just being respectful of the patient. And, so to you know say "I'm retiring because," or "I'm closing the practice because I want to go live in Hawaii," that doesn't make sense at all.

**The pitfalls of disclosure.** At the same time, nearly every respondent (n=7, P1, P2, P4, P5, P6, P7, P8) noted the potential negative impacts of clinician self-disclosure on clients and on the clinical work. A typical response came from a clinician (P1) who was "betwixt and between" on the issue of whether to openly discuss a potentially terminal diagnosis with clients, "on the one hand I don't want to burden the person who is coming to me for help, [unless] it's interfering again in some way with their treatment." This sentiment was echoed by a clinician (P2) speaking from the personal experience of having dealt with a cancer diagnosis, who worried about needing to "keep your focus" on the client,

I think it does shift a little bit... it can't help but shift the dynamic a little bit, in terms of them feeling some care and concern for you.... what you're wanting to do as a therapist is keep your focus on what the client's experience is, and so it can't help but shift some of the attention to the therapist.

This clinical social worker additionally worried about the potential to "create undue anxiety and stress" for clients—specifically child clients. Echoing concerns of potential worry in the client and a distraction from the clinical work, another participant (P7), worried about what would have happened had a colleague discussed a nearly fatal medical crisis with her clients, hypothesizing, "I think had she shared that with her clients, it would have been so huge it would

have been hard for them to get back to their own work or concerns; it could have been really hard for them to not worry about her.”

Another clinician (P8) considered arguments against aggressively discussing and disclosing her thoughts and feelings about her mortality with clients suffering from cancer,

At that point I don't think that my ideas about it are that important, so yeah, I really, really am careful about that and try to refrain. Because first of all I'm with somebody who is in one of the most profound times of their lives. What I would do, it pales at that point. And secondly, I always want to be careful because—well, there's lots of reasons I would want to be careful—but one of them is: I don't want somebody to worry about me. And if I start talking about what my concerns or fears are or what I think, than all of a sudden, who is the client?

**Client referral.** Every interviewee (n=8) discussed at one point the nature and importance of referring clients to new clinicians in the event of the participant's death or incapacitation. For example, one clinician (P6) who didn't have a formalized professional will in place was certain to “always have a list of patients and a list of who they could go to.” The one respondent (P3) with a formalized professional will described a thoroughly considered system of client referral in the event of her death or incapacitation,

When I say they're picking them up, these colleagues—there are four of them—will have the initial interview after my death, or after I'm ill, in order to size up the appropriateness of a referral and to size up how the person is dealing with whatever has happened to me. And these are colleagues who are close to me, so they know me well and they know my work and all that. Now, these colleagues may be able to continue, but geographically we're here, where my practice is and where some of these colleagues are there is enough of a distance so they may not be able to continue with that patient. But I wanted particular people to be like the first responder, so these people would do the initial interview with my patient and either keep the case themselves or manage the referral to someone who would geographically be more comfortable, or maybe insurance-wise.

Clinicians considering how they would handle a potentially terminal diagnosis while practicing clinically repeated the importance of helping clients get connected with a new clinician, with one participant (P4) noting that they would further explore the meaning of this referral for the client,

If I was getting close to dying then of course I would tell everybody and I would make a plan, I would have a plan in place, and I would talk about what the plan was, and I would ask people what it is that they would want: do they want a referral to someone else, do they not want a referral to someone else, what does that mean to them; someone would call you if I actually died, or someone would be in touch with you and let you know about my progress if I am no longer able to work.

Another clinician (P7) made the connection between hypothetically ending her practice due to illness and a past geographic relocation, when the process of referral and transition had taken a good deal of time,

[I would] help them with a good referral, and help them get started with someone else. In some ways—this happened in a different way—when I moved across the country there were people who I had seen for four years, and we took sometimes three to six months to talk about and to wind down the relationship and make the transition to someone new.

**Client characteristics impacting disclosure decisions.** Six participants (P2, P3, P4, P5, P7, P8) were explicit about ways in which client characteristics—such as age or trauma history or illness—would (or have) impacted the way they handle their mortality with clients, including disclosures of illness and other discussions. As noted above, the participant who battled cancer (P2) was especially mindful in discussing her cancer treatment with child clients, but she also noted feeling grateful that the adults with whom she worked (often the adoptive parents of those children) were especially understanding and flexible,

[I found] myself feeling extremely fortunate, blessed that there was just people that were patient and had the capacity to put things in context and realized that I was doing the best that I could, and that there was something important going on and could accommodate that, and so I just felt very fortunate. Again, you would not necessarily have that experience with every clientele or with every client in every setting.

Recalling specifically two clients from her past, another participant (P7) worried that some individuals with severe trauma histories might not be able handle a therapist's self-disclosure of terminal illness,

There are people for whom you are important, but only in so much as you're able to meet their present needs: you're not important as a person. And that kind of information would

just be too shattering. And the two people I'm thinking of just had huge amounts of many layers of trauma and abandonment anxiety and may have acted out in very harmful ways themselves.

A clinical social worker (P8) who previously worked in palliative care, discussed how she was more open in broaching and sharing issues around her own mortality with terminally-ill cancer patients,

I know that I've been with cancer patients who are facing end of life, and you know, you kind of get to that point and all the facade drops away and some of the persona goes, because you're with someone who may not have very much time left of the planet. So we just get down to it. And in that work, patients have asked me about my views, and I have, I mean, I think I have probably spoken—and this is something I may not do in my private work—but in that setting I have spoken about perhaps what I would want and not want at the end of life if they asked me that. I've had some pretty elevated conversations with people around spirituality, because of this being in this place.

**Illness variation impacting disclosure decisions.** A majority of clinicians (n=6, P1, P2, P4, P6, P7, P8) were careful to note that their clinical decisions about hypothetical self-disclosure would be affected by the nature of their potentially terminal conditions, that is how visible their ailment was, or how close they were to death. As one participant (P4) summarized, also incorporating the theme of client characteristics,

I think it would depend on how sick I was and how close to dying I would be. So, you know if I got breast cancer and I was in a process of treatment, but I wasn't going to lose my hair, and someone couldn't necessarily see, I would not disclose to people who would feel to me like they were doing their own work, in their own process and didn't need to know that about me, didn't need to use me in that way.

These sentiments were similarly expressed by another clinician (P8) who additionally considered the physiological and psychological impact that hypothetical treatment might have on her ability to practice clinically,

Well, you know, hypothetically, I think I'd put my practice on hold. I think that... and I tend to think about cancer, but you know somebody can have a heart-attack and bounce back. There they have a potentially life-threatening illness and they rehabilitate and they go back to work, and they do the same thing with cancer. But you know, the cancer journey is a little bit long, you know, it can really, at the very least it takes six months to

a year out of somebody's life, and that is on a good note. So when that's happening it's hard to work. I think it would be—and I'm going to just think oncology here—it would be really really hard to do psychotherapy with the distraction of chemotherapy running through one's system.

**Lack of mortality talks.** A majority of respondents (n=6, P1, P2, P3, P4, P5, P7) spoke of either a complete absence of discussions about the clinician's mortality in their clinical work, or a general avoidance on clients' parts of such discussions. As one clinician (P2) noted, even with regard to her cancer diagnosis, “My immediate response is [mortality hasn't been in the room], but I'm trying to think of more subtle ways. It's not coming up for me... again I'm relating it back to my cancer treatment, but I don't think at that point in time I was really very concerned that this was going to do me in.” Another clinician (P3) mentioned that very rarely clients might ask about her preparations for the event of her death or incapacitation, but that as soon as they are told of the procedures in place they prefer to switch the subject. Echoing this perceived avoidance on the client's part, another participant (P5) asserted that,

Most people don't really want to talk about me getting sick or not being there. They're always checking in: “You're not retiring, are you?” I go, “no, planning to work a long time.” But I mean I've had people, a couple clients, who've been very attached who get scared like if I go on vacation, you know. But, I personally, I haven't... I talk sometimes... I don't know how to describe it. I have one client I thought she was dying, turns out she hasn't: she's anorexic and has Lyme's disease kind of thing which makes her very ill. So we talk about spiritual things, but it's not... certainly not about me dying. I think it would be too terrifying for my clients to be dealing with, I mean the ones that are really attached to me.

One clinician (P4) proposed—echoing themes of other respondents—that some client's may not discuss the clinician's mortality directly but that it may be an undercurrent in other clinical dialogues,

Nothing direct, but I think it does come up in people's worries about losing you about—to make it more personal: different clients get worried about losing me, but it's not... I mean especially in analysis, I have one particular analysand where that is an issue, but it isn't direct. But I wouldn't bring up for somebody, “What would it be like for you if I

died?” or, “Have you thought...?” I don’t feel like there’s a way that it would come up directly, where I would initiate that conversation.

**Client initiation of mortality talks.** Continuing directly off that last response, five participants (P1, P3, P4, P5, P6) explicitly articulated the importance of allowing the client to broach any discussions of mortality that might arise. As one clinician (P1) mentioned when discussing the aftermath of her husband's death, she would discuss her experience, “Only if anything was picked up directly. My motto is: if something is picked up, then it’s a real issue... If they're picking it up, I won’t run from it; I will make a general remark about it, so then I can get through the next part of the time that I have with that person to help them.” One clinician (P3) relayed a variety of questions that she tends to receive regarding her mortality practices, again noting that she only discusses these preparations upon the initiation of the client,

Yes, I have discussed it, but at the initiation, as I said of the patient, the client. I haven’t said, “I’m getting old and I don’t know how long I’ll be here.” People, because I am old and have white hair and all of that, people will say, “Are you going to retire?” And I say, “It’s not in my plan: as long as I’m well I plan to continue to work,” and they feel somewhat settled. And then some people say, “What happens with the records?” And then I walk them through what I just walked through with you, which is how my records are set up, what my plan is if something were to happen to me, who would pick it up, how it would be processed, and you know, do I say “Am I going to die?” No, I don’t. And I’m sure, I don’t know whether I look my age or not, I’m sure it’s in the minds of some of my patients.

**Long-term clients.** A relatively common theme amongst participants (n=5, P1, P3, P5, P6, P7) was that “long-term clients” tend to be more like to engage in discussions of the clinician's mortality, whether in asking about mortality preparations or issues of aging. One clinician (P1) noted that such a client is more able to pick up distress in the clinician and she stated that she acknowledges the reality of her own experience in such situations,

Yeah, if it’s something that the client is picking up, like for instance I have a client who is with me for eight years, and she knows parts of me, and if something is bothering her about my attitude, the way I'm interacting with her, and she’s accurate in picking it up, I

will make a general statement, “Yeah I’m having a lot on my plate the last few days.” I will say something, I won’t deny her reality.

Another clinician (P5) discussed a similar increase in intimacy with a long-term client, which seems also related to the client's age,

I have one client, she must be about 70, and I’ve seen... she’s kind of one of those who you hold her hand and care about her for years and years. You know. Although she’s a doctor, she’s not the most high-functioning person. And she and I actually do talk very personally: what’s it going to be like as we get older, you know, what are ideas about what happens when you die, what’s it like... That’s the person who I’ve talked to most specifically, and it’s a relief to her to talk about it.

**Moving away from the classic analytic frame.** Perhaps foreshadowed by the above discussions about clinician self-disclosure, half of the interview participants (n=4, P2, P4, P6, P7) specifically discussed their training in (classical) psychoanalytic theories, but their move away from these theories in the way they practice clinically. One clinician (P7) noted that she has appreciated the analytic focus on relationship, but sometimes struggles with the implications this has for her practice,

I have a lot of psychodynamic, even analytic training, and I've moved somewhat away from that, and I think the pieces that I take from that are the importance of the relationship and what's happening in the relationship. But I think also there are times when it just felt... there are times when it has felt almost narcissistic to keep pushing the relationship.

The other three clinicians (P2, P4, P6) more precisely challenged the anonymity of the therapist in classic analytic theory. Voicing gratefulness similar to the above clinician, one participant (P2) relayed,

While I have really appreciated all that I have learned from a psychoanalytic frame, in terms of how I actually work with clients and what I think people—at least my particular clientele—find useful, there are going to be natural opportunities where the humanity of the therapist comes through.

Another clinician (P6) explicitly mentioned—and cautiously endorsed—the theoretical shifts within psychoanalysis itself, away from one-person psychologies,

I've learned old fashioned psychoanalytic ways: there's certain things in the one-person psychology that didn't work, that are much better for all concerned in two person psychology; you know it's the way psychoanalysis has changed... it works much better with patients. You just got to be careful about how much you reveal, disclose.

### *Professional Considerations*

**Lack of professional guidance.** Every interviewee (n=8) discussed the fact that professional guidance regarding issues of mortality practices is minimal, especially with regard to professional wills. Two interviewees specifically (P2, P7) noted that they didn't receive any training in graduate school regarding how to prepare their practice for unexpected incapacitation or death,

You know, it never came up in graduate school, and I don't think I've seen it in continuing education offerings, so clearly this is not one of those topics, or we can speculate, but I'm not nearly seeing as many as I am on HIPAA, or DSM V, or any number of things. (P2)

When asked if there was any professional guidance available on how to prepare a professional will, one clinician (P6) stated, "No, not at all." Another participant (P5) noted that there seems to be a general avoidance of the topic in her professional groups or within professional training.

So some of it's, the reason I haven't: not many people talk about it. I've heard some people talk about it. In my group, I'm in several groups of professionals, it's not a discussion; there's really very little talk about it... I know that there are definitely talks about ethical concerns in social work, but I've never gone to a workshop about this, I don't have any friends who are really talking about this

One participant (P8) specifically related the need for this type of professional guidance to her shift out of agency practice to private, responding to a question about whether other professionals had talked to her about professional wills saying, "Not at all, not at all, not at all. But here's the other thing, when I was in an agency setting, when I was at the cancer center, all of that would have been handled." She clarified this distinction of agency practice,



I think that people would rally to handle it. People would know my password, there's a whole IT team that could handle things, emails, all of that. People could very easily be able to look at my schedule, look at my notes, look at my charts, and be able to debrief with patients that I was seeing.

**Not having a professional will, and implicit resistance involved.** The vast majority of participants (n=7) reported that they did not have a formalized professional will, with only one participant (P3) reporting having a formal document which seemed to meet the criteria of a professional will. Two participants (P7, P8) relayed that this issue had been totally “off my radar” (P7). One of those participants (P8) had not heard of professional wills before taking my survey and was grateful for the opportunity to consider the topic further,

Well, I have preparations around my personal life. And of course, what I haven't really thought through is that I have a new business, so I haven't thought about it in terms of, “What about that?” And I haven't thought about it in terms of the human element. I really haven't thought about it, like, “What would I do?” I want to think about that, because your questions do bring it up. I think it's a great idea for somebody, for a therapist to have an advanced directive specifically for their practice: “In the event of my death...” And you know how you assign power of attorney to somebody, what about assigning clients to somebody?

Other participants (P5, P6) noted that they had arrangements in place, but that they didn't have a more formal document prepared. One clinician (P5) discussed an informal arrangement she had with a good friend and colleague to take over for each other if one were to die or become incapacitated,

I have a friend in the building who is a social worker, and... we decided that [she] and I would take care of each other's practice in the event that we were really sick or died, and giving each other things like how do you get in to get the information on the computer: I have a little note in my file that says “Will,” that says where my key is when I lock my files. So she and I have an informal, you know... and we take care of each other's clients when we are going on vacation, so we know a little bit what's going on.

At the same time, this clinician also noted that it was important for her to formalize these arrangements, as her husband couldn't remember a conversation during which she had explained these arrangements to him, “I mean we purposely did it in front of the husbands. But he didn't

remember. He goes, ‘You better write that done, I’m the executor of your will and what if I just go and throw those files out.’” Two other clinicians (P3, P5, P8) also explicitly noted this importance of written arrangements. One of those clinicians (P3) noted that she also writes yearly updates, “I have this all written out for my bookkeeper, and the other person, as well as, on a yearly basis I write to all of my colleagues who are picking up the cases.”

Half of the clinicians interviewed (n=4, P2, P4, P5, P8) spoke of the occasionally overwhelming nature of running a private practice and how other responsibilities—“the immediate stuff” (P2)—can get in the way of giving attention to something like a professional will. As one participant (P4) phrased it, when asked why she didn’t have a professional will despite intentions to the contrary, preparing a professional will just feels like a “pain in the ass,”

You know what? The first answer that comes to mind is laziness. The second answer that comes to mind is that it’s a difficult topic that would take some work and I haven’t done it. That there are things... and maybe part of what I need to do is create some structure to make that happen for myself. But you know, all kinds of things like this are a pain in the ass: like the HIPAA requirements, and... having the right paperwork that you give out to people when they walk in your door, you know there’s all kind of those sort of details of things; some marketing stuff I ought to be doing that I’m not following through on. You know, it feels like a pain in the ass, and I haven’t done it.

And as another clinician (P5) similarly noted, “you have to have a lot of specifics on the professional will: where everything’s located, what’s locked, what your wishes are to do with your clients, it even says to have updated treatment plans, which forget it, I’m not doing... Too much work.”

**Consultation and mentorship.** Six participants (P1, P2, P4, P5, P6, P7) mentioned the importance of seeking dialogue with and consultation from colleagues with regards to mortality issues, including if there were to be a terminal diagnosis and for advice regarding professional will and other preparations. Only one participant (P2) had actually received a potentially

terminal diagnosis (cancer) while she was practicing clinical social work, and she recognized the value of consulting with colleagues during this time,

I remember working with a family, they were looking to adopt children out of the foster care system, and I some concerns about the family, but I also was recognizing I was in this window of time, where meds were running kind of high, and so there was this anxious edge that I in general which I had to work with, until they got the medications right, so I had to double check, triple check, make sure I was walking through my rationale and my thinking with a colleague to make sure my judgment was not adversely impaired or I was not magnifying my concerns.

Another participant (P7) supposed that her very first step were she to be confronted with her mortality in the form of a potentially terminal diagnosis would be to, “get a lot of consultation and really explore my own feelings and worries about death.” Beyond discrete consultation or advice, another clinician (P6) reported that older colleagues served for her as, “mentors for aging,” showing her how to approach a greater “resolution” about aging and growing older, and nearing death. One participant (P1) hoped that dialogues around issues of clinician mortality might increase generally in her professional community,

It has heightened my own awareness that it’s time at any age to think about if something suddenly, whether it be an accident or a life threatening illness, to come to the forefront of how other people might handle it, just the way we handle countertransference, we should talk about how we handle issues of uncertainty with mortality.

**Knowing colleagues who have died/encountered terminal illness.** A majority of participants (n=5, P1, P3, P5, P6, P7) have known personally or heard of a colleague who has either died or encountered potentially fatal crisis or illness while practicing clinically. All of these stories either involved what the participant saw as healthy disclosure or an unhealthy lack of disclosure or preparation, as with a participant (P1) who “knew a colleague, she wasn’t really very close to me, but I knew of her, and she was dying and she never told her supervisees that she was dying, and that, I think that—that’s not a good way to go.” Another clinician (P6) reported a strong emotional reaction to a colleague who similarly didn't forewarn her patients of

her illness, stating, “I knew somebody who a year and a half ago... had lung cancer, and people knew she had been sick, but she never discussed it with her clients. And I was furious about it; I felt so angry, I felt it wasn’t fair to them.” This participant heard other “horror stories,” but expressed some sympathy for the analysts who had died, reporting “I know of analyst's who died, but didn't prepare their patients, and it was terrible for the patients. But I always thought that maybe they just couldn't do it, they couldn't talk to patients about it, because of their personal psychology, they couldn't do it. It's pretty heavy.”

Finally, one clinician (P3) related the story of a colleague she believes handled an ultimately fatal cancer in an admirable, courageous and clinically sound fashion,

He was my mentor and colleague, and when he became ill with pancreatic cancer, he called me and we talked about his illness, and I thought he did an appropriate kind of closure. He was hoping that he would stay well, but in fact he didn't. And you know, he made contact with me, and other people who he had been importantly involved with, either as a therapist or an important colleague. And so I think he, and his family they did exactly what they needed to do. It was difficult, but he, from the time he realized he could potentially be very ill he made contact with the important people certainly in his world: his therapeutic world, in his personal world.

**Clinical practice as distraction from death.** Three participants (P1, P6, P8) discussed the ways in which their clinical practice actually helps to distract them from issues of their mortality. As one clinician (P1) discussing her “vulnerabilities” noted, “I acknowledge them. I err on the side of too much of emotionality in my own day-to-day living, so I temper as much as possible down... I find my practice a distraction, so I don't get too heighteningly involved in my own vulnerability, while I'm looking at a client.” Similarly when asked whether her mortality was relevant to her clinical work, another participant (P6) stated that, “To be honest, I think the problem is I ignore it. I deny it, ignore it, because—for the reason I was saying—working is just the opposite to me, work is being alive, vital. So when I'm in the act of work I don't—wouldn't think about my mortality, dying.”

## *Personal Issues*

**Clinician age.** Nearly every interviewee (n=6, P1, P2, P3, P4, P5, P6) mentioned the impact that their age has on their current clinical work and on considerations of how their mortality interacts with their work. One clinician (P4) reported that as she has gotten older she has begun considering practically and consulting with colleagues on how she might prepare her practice for her potential death,

Well, I think that this age right now, and I am 63, I'll be 64 in August. I think my mortality feels closer than it did when I was younger. I mean, that's probably no surprise. In terms of how it actually affects my practice: I think that I believe and I know that I should be preparing my practice for that, but I haven't actually moved to do that, other than thinking about who I might, if I were to get sick in a way that I would believe I would die soon, I have some ideas of who I would ask to help me, you know, move my practice to or talk to patients afterwards or that sort of thing. And I have spoken to colleagues, particularly close colleagues.

In a similar vein, another participant (P6) posited that were she to receive a potentially terminal diagnosis at this point in her life, it would have a different impact on her personally and on her clinical practice than it might have in the past,

Even as I get older, I have friends who are in their 80's, and they're like, "well, this is what I have as much as I have. And if I have more than I'm lucky." Meaning more time. You know a kind of nice resolution, not a terror. And you know, I'm hoping to get to that place. But I think... it's different, when you're older, let's say my age or older it might not be so difficult to do it, as the way I used to think it would be difficult when I was younger. Because you know you're at a certain age and you're diminishing, and it's the way it is, it's the way life is and you've got a certain amount of time.

**Clinician's thoughts about death.** Related to the above, a majority of respondents (n=6, P1, P4, P5, P6, P7, P8) discussed the importance and relevance of their personal thoughts and feelings about their mortality to how they work and operate clinically. For example, one clinician (P1) noted the importance to her of looking at the "darker" side of things,

The last few months, I've had a lot of additional stressors, and just kind of looking at them but not rolling with them—a lot of people deny their stress, and then take on an attitude of the power of positive thinking, and that's not who I am... I definitely look at

the darker parts, and looking at the darker parts helps me be better in touch with myself and better in touch with the client.

Similarly, though without a necessarily “dark” implication, two clinicians (P7, P8) discussed the relevance—to their clinical work especially—of mindfulness and their personal acceptance of impermanence. As one of these clinicians (P7) noted,

It is part of my ongoing spiritual practice for the last eighteen years to remind myself frequently of the truth of that: that I'm not going to be here forever. And I think that informs my work in terms of also kind of the quality of my interactions with the people that I serve. How I choose to respond to what's most important to them. And I think that there are times that come up in therapy where there is a chance to comment that this doesn't go on forever.

Another participant (P6) recalled a specific clinical encounter when she became acutely aware of her own death terror, which later discussed needing to work through to continue in the clinical encounter,

The only time I had a flash of my own death was when I was working with an AIDS patient, and... He was thinking about him dying, and I had this flash that I could be dead, I could die, and it was terribly disturbing, of course. It was like... I'm a psychoanalyst, so it was like his death thoughts triggered off my own death thoughts. Being dead, and it was like “Whoa.” It was just so disturbing to think that I wouldn't exist. And you know, it was just very disturbing.

**Clinician's experience of close others dying.** A majority of clinician's interviewed (n=5, P1, P3, P4, P5, P6) discussed experiencing the death of a close other—a mother, a mentor, or analyst—at some point which had an impact on their relationship to their own mortality. The one clinician (P3) who had a formalized professional will suspected that the death of her mentor and friend was a major catalyst for putting together that document. Another participant (P1) discussed that she “lost my loving spouse of a number of years during the process of work and it was a horrific, agonizing, torturous experience, and I’m sure that at different levels that impacted my work as a clinician.” Two participants (P4, P6) specifically shared how the deaths of their analysts were very impactful. One interviewee (P4) noted the complications and pain implicit in

working with an ailing analyst, though she also stated that these “were neither good nor bad, necessarily,” and was grateful for the model her analyst provided,

My analyst died at the very end of our work together, so before the last session, but as we were completing she got pancreatic cancer and that became a part of the ending of our work. Sure, well you know, there was an end. We knew there would be an end in a way more profound way than if you end a therapy process or an analytic process otherwise. In the last piece of the work I came to her home rather than her office. Once she was diagnosed, she was in a clinical trial, and it turned out she had to go on disability, so I had to pay for a certain amount of sessions, but she wasn't getting paid while she was on disability, and she had to let go of her office and I came to her home a bit. And just before the last session we did some phone sessions and I wanted to see her and not do the last session over the phone, and she was never able to make that appointment and then she died. So, I think there was a real sadness and I missed being able to have access to her at work, and I missed her.

The other respondent (P6) discussed how the death of her analyst actually connected clinically and personally with the untimely death of her mother (during the respondent's teen years), reporting that the work she did with her aging analyst as an adult allowed the clinician to have a healing experience around that earlier loss,

My second analysis she was preparing me for her death. She was really preparing me for it, which was something I needed, because it helped me work through my mother's death. What she was doing was very, she was saying “I'm going to die. I may even die in the middle of this before you've completed your treatment. Or I may get so sick and I can't work anymore.” And I went back to her, but she said to me, “You have to realize I may get sick, and maybe I can't work for a couple of weeks, or I may die in the middle of this... But,” she said, “let's see how much work we can do in the meantime, I'm still alive here.” I think I learned a lot from that, it was very helpful for me. I know I learned a lot from that.

### **Conclusion**

The above findings represent the perspectives of 83 clinical social workers who completed an online survey and eight clinical social workers who completed a relatively brief telephone interview. Both the survey and the interviews explored the topic of clinicians' mortality practices—that is how clinicians prepare for, avoid, interact with, or discuss their potential death and incapacitation within their clinical and professional practice. Survey

respondents offered a rich and varied picture of clinician attitudes and practices regarding clinician mortality. Qualitative responses were also collected within the survey, adding further depth to the survey data. Similarly augmenting the research, the phone interviews provided an opportunity for participants to provide greater specificity and depth in discussing these issues. Those responses loosely fit into thematic categories around 1) relational concerns, 2) professional considerations, and 3) personal issues; within these broader categories various patterned responses and practice behaviors were identified and elaborated. The following Discussion chapter will further explore these findings, drawing connections between the survey, the interviews, and the previously discussed literature. I will conclude with the implications of the present study for social work practice and policy, the limitations of the present research, and some areas for future research.



## CHAPTER V

### Discussion

In the broadest sense, the present study has attempted to capture a picture of how clinical social workers interact with their mortality. In what ways does the therapist's inevitable or impending death enter into the clinical encounter? How do clinicians prepare their professional practice for their potentially unexpected death? What happens when clinicians are struck with a potentially life-threatening illness—or how do clinicians imagine they would handle such an occurrence? As summarized in the Findings chapter, the answers to these questions might be loosely categorized relationally, professionally, and personally. Ultimately, the results of the present study offer a great deal of support for the suggestions and suppositions of the previous literature: around the importance and complexity of disclosure, the value of consultation, and the ubiquity of death avoidance in both clinical, professional, and personal contexts. The study adds an important component of quantitative breadth, providing an accounting of 83 clinical social workers' current mortality practices. This Discussion chapter will explore all of the above, and finally address the practice implications, research limitations, and future directions suggested by this study.

### Examination of Findings

#### *Relational concerns*

**Mortality talks.** The present study seems to suggest that discussions of the clinician's mortality are relatively uncommon, while at the same time endorsing the perspective that when

these discussions do take place they are generally helpful. Only thirty clinicians in the survey reported having had direct discussions of their mortality with their clients, and interviewees similarly discussed that these talks were rare, if they ever occurred, and were particularly more likely with older or physically ill clients. At the same time, all those clinicians who provided a response and had reported discussing their mortality also reported that the discussions had been at least somewhat helpful. Clinicians—in the survey and interviews—generally reported feeling very comfortable with the idea of discussing their mortality with clients, despite the fact that a minority of clinicians have engaged in those talks; this echoes the sixty year old responses of the psychoanalysts in Burton’s study, who reported hypothetical comfort with discussing death, but that the issue rarely arose in the treatment (1962). At the same time, from a two-person perspective one might wonder whether clinicians minimize—to a degree—the mutuality of the mortality talk avoidance; might a dearth of mortality talks be considered a dyadic experience, rather than merely client aversion.

From the perspectives of current study participants, allowing clients to broach clinician “mortality talks” seems to be vital: clinicians report they feel comfortable, but wait for clients to raise the issue of clinical mortality themselves, in the spirit of psychodynamic theory and client self-determination. Indeed, the fact that the vast majority of clinicians who had had mortality talks with clients were over the average respondent age (55) suggests that such talks are in response to certain therapist characteristics. Interestingly, though, it seems that clinicians were more likely to consider their own mortality relevant based on their clients' characteristics: respondents in the survey viewed their mortality as more relevant to their clinical work if they had at least one client aged 65 or older; and a few respondents working in palliative care reflected the same increased mortality relevance. Regardless, the results of my study defend the

general assertion in the literature that clinician mortality discussions are part of a complex interaction between client and clinician characteristics (e.g. Sands, 2009; Chessick, 2013).

**Terminal illness.** My study examined terminal illness in the clinical social worker as a potential crisis that might bring to the fore issues around the clinician's mortality. While few participants had actually been diagnosed with a potentially terminal diagnosis in the course of their work, participants generally echoed similar caveats and themes, which were also found in the literature. In particular, many individuals in the present study noted the real or hypothetical value of professional consultation in handling the deeply complex issues raised by such a diagnosis (e.g. Lewis, 1982; Philip, 1999). Interviewees—even more than survey respondents—were able to explore the reality that therapist illness can be rich with different meanings for each individual client, and that different clients will require different work regarding the diagnosis, and different responses from the clinician. More specifically, both survey and interview participants recognized that this complex clinical situation did not have many easy answers, particularly around issues of disclosure.

**Disclosure.** Questions around clinician disclosure—of real or hypothetical terminal illness, especially—elicited perhaps the most divergent set of responses from participants. This rich multiplicity of opinion reflects the similar uncertainty around the issue in the literature on the subject (Bram, 1995). Indeed, exactly as many participants (n=39) felt that disclosure of a terminal illness by a clinician was only “Rarely” or “Sometimes” appropriate as viewed it as “Often,” “Almost always,” or “Always” clinically advisable. Similarly, of the nine clinicians who had received a terminal diagnosis, nearly as many disclosed to some (n=3) or all (n=2) clients as disclosed to none (n=4). The complexity of the issue was also seen in the responses of interviewees, who noted at once the importance of self-disclosure, in providing patients the

opportunity to process (potential) termination and clinician death, in order to help them through earlier personal losses, and to provide fairness and respect, while also noting the need for critical clinical judgment in modulating disclosure for some clients.

The importance of varying the clinician's level of self-disclosure between clients was reminiscent of Feinsilver's dialectic between reality- and intrapsychic-based clinical work depending on the particular work of the client in the face of clinician illness (1998), though he seemed to disagree with some interviewees on which clients (i.e. more traumatized clients) needed more direct disclosure. Participants also and especially noted the relevance of the particular diagnosis and prognosis of the clinician to these touchy clinical decisions. Repeatedly, though, participants alluded to the negative, even traumatic impact on clients of clinicians who had died without disclosing and processing their illness with clients, defending the four-decades-old results of Lord, Ritvo, and Solnit (1978), and the more recent work of Sorenson (2009). By and large the clinicians represented in the present study defend the proposition—gleaned also from the literature—that at least some disclosure, some of the time benefits clinicians, clients and their work more than no disclosure, none of the time.

**Theoretical shifts.** The above discussion of clinician self-disclosure reflects an apparent theoretical shift within the clinical social work profession toward a greater focus on two-person orientations. Backing up the assertions of Aron (1990), according to study participants the clinician's real personhood and subjectivity—real mortality—impacts the clinical encounter. Some clients pick up on infirmity or anxiety in the clinician, despite the clinician's intention to remain non-disclosive. And as all clinician participants who endorsed having had discussions about their mortality or illness noted, discussions about clinician mortality were helpful to some degree or another for clients. At the same time, participants also continued to express the

importance of moderation and clinical judgment when applying a two-person model to the work: the client and the client's work still demands the primary focus of the therapy. It should be noted that this theoretical shift seems more global than just the specific psychodynamic application of the one- versus two-person debate. The vast majority of participants, regardless of reported orientation acknowledged with their responses that their mortality was relevant for either consideration with regard to or discussion within the clinical encounter; clinicians recognize that they are not immortal, blank screens.

**Referral.** A final relational concern, respondents consistently reiterated the importance of helping clients continue their therapeutic work in the event of the clinician's illness and/or death. Even those clinical social workers who hadn't actually prepared professional wills tended to vouch for the value of either referring clients directly or preparing a list of clients and colleagues to whom they could be referred in the event of the clinician's incapacitation or death. Participants noted that referral was important to continue both the work of the therapy and to address the loss of the therapist, similar to Beder's arguments for a comprehensive response to clinician death (2008). This focus on referral will potentially counteract the loss of the analytic dialogue which Traesdal bemoaned (2005), and provides evidence of a dramatic shift amongst psychotherapists since Burton's study when only 33% of respondents noted the value of client referral in the event of analyst death (1962).

#### *Professional considerations*

**Professional wills.** As previously discussed within the Literature Review, professional wills enjoy unanimous endorsement from authors on the subject of clinician mortality (e.g. Becher, Ogasawara & Harris, 2012; Steiner, 2011). The present study offers a picture of a profession that agrees with that endorsement in theory, but struggles to put that endorsement into

practice. Specifically we see that only 18% of survey respondents and only one interviewee (12.5%) have prepared official professional wills; nearly half of all respondents didn't have informal preparations either for the event of their unexpected incapacitation or death. At the same time, a vast majority of respondents believed that professional wills are both clinically and ethically important. Interviewees, as well as some survey respondents, offered a complex portrait of the multiple issues that get in the way of preparing professional wills, including broader existential denial and avoidance (in line with Becker, 1973) and the overwhelming and busy nature of navigating professional practice. Only one study participant, in the survey, acknowledged that some laws exist around professional wills (Steiner, 2011), speaking to the lack of structure and regulation around this mortality practice and a similar lack of dissemination of relevant information.

Interestingly enough, between a few demographic groups clinicians varied in the level at which they viewed professional wills clinically and ethically important. Specifically clinicians with at least one client aged 65 or older and clinicians with at least 23 years of clinical experience viewed professional wills as slightly more important. This difference was not enormous, but was statistically significant. One might wonder why a similar difference did not exist between older and younger clinicians, but perhaps it speaks further to the modulation of practice based on client characteristics and the impact that clients have on their clinicians, echoing the appropriateness of a shift toward two-person psychologies (Aron, 1990).

**Consultation.** As noted above, clinical social workers represented within the present study repeatedly alluded to discussing difficult issues—such as clinician mortality or illness—with colleagues. According to many participants, consultation helps clinicians reach clinically sound decisions in the face of confusing and stressful life events; this echoes Chessick's

discussion of the aging analyst, and his need to continually depend on the help of colleagues to monitor his denial and countertransference around his mortality (2013).

**Professional training and supports.** All interview respondents and many survey respondents complained about the lack of organized training or professional supports with regard to the present issues, with the preparation of professional wills as a particularly salient example. According to participants, the issue of clinician mortality in general doesn't surface often in professional groups, agencies or organizations. For example, a large majority (75%) of survey respondents who worked in group practices or agencies were unaware of policies regarding clinician incapacitation or death. Similarly, participants reported that they did not receive formalized training at any point on how to produce professional wills, and that they saw minimal if any opportunities for such training offered in the community. While my personal research found a select handful of professional organizations had published information regarding professional wills (e.g. Coleman, 2009), in general it seems that again “denial of death” may be operating beyond the individual and within the profession and its organizations en masse (Becker, 1973). Anecdotally, even when such trainings or workshops are offered, they might be drastically under-attended or actively avoided: one such training on professional wills offered at a relatively large, inter-disciplinary, psychodynamically-oriented professional conference in April 2014 was only attended by the speaker, another participant, and me.

#### *Personal issues*

**Personal loss.** Half of the interviewees in the present study presented a seeming connection between personal experiences of loss and an awareness of the need to prepare for their potential death or incapacitation. While other participants could also describe stories of colleagues who had died while in practice, those who reflected stories of personally losing a

close mentor or therapist offered a deeply felt reflection on the importance of actively confronting and processing the realities of death. Those participants were grateful for having had the chance to discuss their loss before it happened; they ultimately grew from their crises, just like the participants in Garcia-Lawson, Lane, & Koetting's study (2000). Loss also led to a deeper consideration of their future death. This theme was, unfortunately, not actively explored within the survey portion of the present study.

### **Implications for Social Work Practice**

I entered this study with a perception, gathered from the literature, that a few key mortality practices were generally advisable: chief among these, the professional will. I also gathered that an approach toward self-disclosure which acknowledged the real personhood and mortality of the therapist was preferable to an approach which wholly attempted to ignore these. Clinical social workers, as represented in the present study, seem to already be enacting this two-person perspective to a wide degree, but these same clinicians rarely follow that first suggestion that they create professional wills. Indeed, some respondents had never heard of professional wills.

Clearly, the profession would benefit from more support and training around professional will preparation. Nearly every interview participant and some survey respondents desired more discussion and support regarding this subject. Perhaps graduate programs of social work and other mental health professions should more intentionally and specifically teach practices such as professional wills. Perhaps licensing boards (all participants were independently licensed) might also provide greater oversight and support around these mortality practices and include them within licensing exams. While some might see professional wills as primarily a concern for private practice, clinicians in other agencies or practice settings should also consider the fact that



they may have particular systems of notes and records, or have desires for what they want to communicate to their clients in the event of the clinician's death, which would be best addressed in a formalized document. Literature on professional wills neglects to explore the relevance to every practice setting, as do the responses of survey respondents in this study, who tended to view professional wills as irrelevant if the clinician worked in a larger setting.

But, beyond professional wills, there seems to be a general lack of dialogue around issues of mortality within the profession. Some respondents discussed the importance of a focus on impermanence generally in their work, but coupled this with a recognition that considerations around their personal impermanence specifically often recede into the background. Avoidance of death is understandable and ubiquitous, but perhaps greater intentionality around breaking mortality taboos within professional circles would serve the profession—and our clients—well. Organizations, such as the NASW, could facilitate open conversation amongst social workers about death and dying, and a greater awareness of the practice dilemmas for example, of the aging or ill clinician. Consultation and collegial dialogue proved vitally important to participants in this research: perhaps more formalized and normalized systems of these avenues of support would prove helpful to professionals and their clients.

While I did note respondents' general openness to some measure of disclosure around issues of clinician mortality and illness in the clinical encounter, it is worth noting that these opinions were by no means uniform. Clinicians in this study reflected the complex theoretical debates and varied practices of psychotherapists around self-disclosure. It doesn't seem like there are necessarily clear or easy answers to the topic. A well-meaning clinician who broaches mortality talks without careful consideration might prove deeply detrimental to her client's work, in the same way a well-meaning clinician who dies without disclosing her cancer diagnosis

might also hurt her clients. From the present findings and the previous literature, issues around discussing clinician mortality require nuance and a complex understanding of particular clients and clinicians: but all these findings and authors seem to agree that collegial dialogue and consultation are important ways to explore and address these practice concerns and dilemmas. Even if we choose to not discuss with our patients, we must at least discuss with each other.

Again, anxiety and avoidance around death pervades almost as certainly as death itself, so the dearth of certain mortality practices amongst practitioners is understandable. Yet the challenge for clinical social work must now become: do we sublimate this anxiety into ethical and effective practice, or do we deny and displace our anxieties for another day? Can the profession and its organizations indeed provide the supports and trainings to move clinicians toward more preparedness, and to ease the stress of a logistically and emotionally complicated process? The enthusiasm and interest in professional growth of present study participants—63.9% of survey participants believed that having taken the survey will impact their practice—suggest that clinical social workers will indeed continue to work toward the best practices and policies for themselves and their clients.

### **The Study's Limitations**

The present study was limited by a few factors, including the sample size, a lack of diversity on a few counts, the nature of the *quasi*-mixed-methods approach, and the difficulty implicit in reducing a tremendously complex subject into quantifiable data. The study, particularly the qualitative portion, had a relatively small sample size, and the means for recruitment created some potential bias and lack of diversity in respondents. Snow-ball recruiting, and relying on the list-serves of two organizations—one geographically-bound and the other theoretically-bound—created a necessarily skewed sample. Indeed, almost half of

respondents were psychodynamically-oriented, and a disproportionate number were from the state of Washington. None of the qualitative respondents were non-white (one identified as white and Native American) and all were women. The survey respondents were also largely female and white, but interestingly enough, at least with regards to gender and race, the lack of diversity in the survey was more representative of the broader profession's lack of diversity. Thus, there might be some measure of generalizability to the present results, except for the above and the fact that there was also an over-sampling of private practitioners and clinicians over 65.

By relying on phone interviews and internet surveys, the depth of face-to-face interaction and data was also lost. Especially in discussing a difficult topic like mortality, much might have been observed in the embodied encounter—a twitch, a tear, a smirk—that was lost over the phone, much more over the online survey. The survey, as noted by a handful of respondents, also reduced a complex and difficult subject into a format that limited opportunities for nuance and depth. While this lack of nuance was hopefully offset in part by the inclusion of many open-response fields, it's unavoidable that some survey questions failed to fully capture the meaning and realities of clinicians' practices and attitudes.

The sole focus on clinicians might be viewed as another limitation of this study. Though it was beyond the particular scope of the research question, the study did not consider the client's report of his or her experiences regarding mortality practices nor include any outcome measures, such as client improvement or decompensation based on particular mortality practices. While it is perhaps a better question for future research, and has previously received more attention than the present topic, the field of clinical social work and psychotherapy more generally would benefit from continued consideration and research around the client's particular experience of clinician death and mortality.

Finally, due to constraints of time and resources, both portions of the present study—the survey and the interviews—were undertaken contemporaneously. In a proper mixed-methods design, and had it been possible, one portion would have been completed prior to the second, helping with more effective question formulation. For example, if I had completed the qualitative interviews before constructing the survey, I would have included a question about clinicians' experience of the deaths of colleagues, family members, or close others.

### **Future Research**

For a variety of reasons—time, resources, keeping a refined scope—the present study was limited to the profession of clinical social work. Future research might explore similar questions around the mortality practices of other mental health professions. Do psychologists, who developed many of the professional will forms available online, prepare professional wills at a more consistent rate than clinical social workers? How might practices around disclosure of terminal illness differ or remain similar with different professions? Also, in the future, if certain organizations implement supports or dialogues around these professional issues, research around the actual implementation of the mortality practices would be useful to validate the effectiveness of organizational interventions.

Clients' experiences should be continually considered and explored with regard to all of the present issues, so future research might continue to explore this, and particularly involve interviews or surveys of clients. Also, as noted above, a particular theme that resonated within the qualitative interviews, but that hadn't been included within the survey, was the clinician's personal experiences of loss and death. Further research might examine how these experiences of loss impact professional and clinical development and practice. Similarly, future research might explore more explicitly the presence—or lack thereof—of training or discussion about

professional wills and other considerations within graduate schools and professional groups. Also, future work might more explicitly explore how spirituality might interact with the present issues, and effect how clinicians work with clients around the clinician's mortality. Finally, a constant area for continued thought and dialogue: how should we as clinicians use our real personhood and humanity within the clinical work; when might it hurt and when does it help?

### **Conclusion**

The present exploratory study endeavored to provide a picture of clinical social workers' practices related to their mortality. In the end we find a landscape of professionals who wrestle with complicated issues in complex ways. Just as surely as we know the "shoulds" or "woulds" of our professional practice, such as preparing a professional will, we confront our inevitable resistance and outright denial about the uncertainties of life—and the certainty of death. Clinical social workers have begun to more readily bring their "real" selves into the clinical work, as with their mortality, but questions still linger about when and how these discussions and disclosures are most beneficial. All these issues and dilemmas demand our continued attention, reflection, and intentional incorporation. Ultimately, all clinical social workers will die, and we can never be sure of the when, where, or how—yet, the work continues: "You have to realize I may get sick, and maybe I can't work for a couple of weeks, or I may die in the middle of this... But, let's see how much work we can do in the meantime, I'm still alive here."

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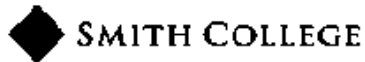
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APPENDIX A

HSR Approval Letter



School for Social Work  
Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950 F (413) 585-7994

January 13, 2014

Joseph Hovey

Dear Joe,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.  
Co-Chair, Human Subjects Review Committee

CC: Cara Segal, Research Advisor

## **APPENDIX B**

### **Informed Consent**

#### **Introduction**

You are being asked to be in a research study of how clinical social workers interact with their mortality in practice. You were selected as a possible participant because you are a clinical social worker, who has been licensed to practice independently and currently perform clinical, therapeutic, or counseling services. We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

#### **Purpose of Study**

The purpose of the study is to understand more clearly how clinical social workers prepare for, avoid, discuss, and/or confront their mortality in their practice and with their clients. The study hopes to gain a picture of how clinical social workers respond to the inevitable possibilities and certainties of death. Do they prepare “professional wills”? Do they talk with clients about the subject? How do therapists approaches to their mortality change when they confront terminal illness or aging? This study is being conducted as a thesis requirement for my master’s in social work degree. Ultimately, this research may be published or presented at professional conferences.

#### **Description of the Study Procedures**

If you agree to be in this study, you will be asked to do the following things:

- Provide demographic data about your identity, your area of practice, and your theoretical background.
- Take part in a recorded 20-30 minute phone interview which will ask questions about how you practice and what attitudes you have related to your mortality, potentially discussing past or present illnesses.
- Optionally you might also take part in a brief online survey.

#### **Risks/Discomforts of Being in this Study**

The study has the following risks. Death and mortality can be troubling topics to ponder and discuss. By participating in this study you will be asked to share your personal practices and attitudes around these topics, which could distress you. Death—especially our own—can be an inherently painful topic. By engaging with this study difficult emotions and thoughts may surface and simmer, even beyond the time of the research interview.

#### **Benefits of Being in the Study**

The benefits of participation are gaining an opportunity to expand your self-understanding and self-awareness regarding your mortality. By looking square at an issue that is often avoided, you may indeed gain access to a greater degree of peace and resolve. A critical look at this vital topic might increase the intentionality, appropriateness, and effectiveness with which you make certain clinical, professional, and personal decisions. You may be compelled to consider new practices or preparations that will benefit your professional competence and self-actualization.

#### **Confidentiality**

The records of this study will be kept strictly confidential. Research records will be kept in a locked file and all electronic information will be coded and secured using a password protected file. Electronic recordings of our interview will be stored and encrypted, and used to create transcripts, which will also be encrypted. After the transcription is complete, the electronic files will be destroyed. We will not include any information in any report we may publish that would make it possible to identify you. The data will be kept for at least three years according to Federal regulations. They may be kept longer if still needed

for research. After the three years, or whenever the data are no longer being used, all data will be destroyed.

**Payments**

You will receive the following payment/reimbursement: The chance to have your name entered in a random drawing to receive a \$25 Visa gift card. Your entry and contact information will be stored separately from your responses to the interview or survey.

**Right to Refuse or Withdraw**

The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely at any point during the study. If you choose to withdraw, the researcher will not use any of your information collected for this study. You must notify the researcher of your decision to withdraw by email or phone by May 1, 2013. After that date, your information will be part of the thesis, dissertation or final report.

**Right to Ask Questions and Report Concerns**

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Joseph Hovey at [email] or by telephone at [telephone]. If you like, a summary of the results of the study will be sent to you. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

**Consent**

Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep, along with any other printed materials deemed necessary by the study researcher.

.....  
Name of Participant (print): \_\_\_\_\_

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Researcher(s): \_\_\_\_\_ Date: \_\_\_\_\_

.....

**1. I agree to be audio taped for this interview:**

Name of Participant (print): \_\_\_\_\_

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Researcher(s): \_\_\_\_\_ Date: \_\_\_\_\_

## **APPENDIX C**

### **Recruitment Email**

Hello and thank you for your attention. I am conducting research as part of my Masters in Social Work degree from Smith College. My research explores the attitudes and practices of clinical social workers related to their mortality. All social workers who work in a clinical capacity (i.e. provide psychotherapy), who have at least 2 years of clinical experience, and who are licensed in their state to practice independently are strongly encouraged to participate.

Participants are invited to complete the following brief (7-15 minute) survey: [Survey URL]. All participants are eligible to enter in a random drawing for a \$25 Visa gift card. Participants are also being sought to take part in a short phone interview (25-35 minutes) about clinician mortality. If you are willing to be interviewed, or for more information, please email [study email].

Please share this information with any colleagues or friends who might be eligible and interested in participating.

Thank you!

Joseph Hovey  
MSW, A'14  
Smith College School for Social Work

## APPENDIX D

### Demographic Questionnaire

1. How many years have you worked as a clinical social worker? (rounded to the nearest whole number)
2. What is your age?
3. Approximately what proportion of your clients are:
  - Children aged 0-12
  - Adolescents aged 13-17
  - Adults aged 18-24
  - Adults aged 25-39
  - Adults Aged 40-64
  - Adults aged 65 and older
4. In months, about how long is your average psychotherapy treatment episode?
5. What is your ethnicity? (Please select all that apply.)
  - American Indian or Alaskan Native
  - Asian or Pacific Islander
  - Black or African American
  - Hispanic or Latino
  - White / Caucasian
  - Prefer not to answer
  - Other (please specify)
6. What is your gender?
7. Do you identify with any of the following religions? (Please select all that apply.)
  - Protestantism
  - Catholicism
  - Christianity
  - Judaism
  - Islam
  - Buddhism
  - Hinduism
  - Native American
  - Inter/Non-denominational
  - No religion
  - Other (please specify)
8. What theoretical orientation do you adhere to most closely within your psychotherapy practice?
  - Cognitive Behavioral
  - Integrative/Eclectic
  - Existential/Experiential
  - Psychodynamic/Psychoanalytic
  - Other (please specify)
9. Where do you practice psychotherapy?
  - Hospital
  - Elementary/Middle School
  - Residential Program

Solo Private Practice  
Mental Health Agency  
College  
Group Private Practice  
High School  
Other (please specify)

10. In which region of the United States do you live?

1. New England (Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut)
2. Middle Atlantic (New York, New Jersey, Pennsylvania)
3. East North Central (Ohio, Indiana, Illinois, Michigan, Wisconsin)
4. West North Central (Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas)
5. South Atlantic (Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida)
6. East South Central (Kentucky, Tennessee, Alabama, Mississippi)
7. West South Central (Arkansas, Louisiana, Oklahoma, Texas)
8. Mountain (Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada)
9. Pacific (Washington, Oregon, California, Alaska, Hawaii)



## APPENDIX E

### Survey Questionnaire

1. My mortality is relevant to consider with regard to my clinical work.
2. I have discussed my mortality with my clients.
3. If you have discussed your mortality with one or more clients, in general, how did such discussions affect the clinical work, for the majority of such cases?
4. I would feel comfortable discussing my mortality with my clients.
5. Have you received a potentially terminal medical diagnosis at some point while practicing clinical work?
6. If you answered "yes" to the previous question, to approximately what percent of your clients did you disclose your diagnosis?
7. Is it clinically advisable to disclose and discuss a clinician's potentially terminal diagnosis with clients?
8. Have you prepared a professional will, a document which details a plan for your clients, practice, and records if you die suddenly or become incapacitated without warning?
9. Are your clients made explicitly aware of what would happen in the event of your incapacitation or death? (That is, are they made aware of the contents of your professional will or your informal arrangements?)
10. If you work in an agency, hospital, school (or other system) or group practice, are you aware of specific policies regarding a therapist's terminal illness, incapacitation, or death?
11. Preparing a professional will is an important part of providing care...  
...from a clinical/therapeutic perspective.  
...from an ethical perspective.
12. Before completing this survey had you thought about what might happen to your clients if you were to die, retire, or become incapacitated suddenly or unexpectedly?
13. Please share how you felt during the completion of this survey:
14. Do you think the completion of this survey will have an effect on your clinical or professional practice?

## APPENDIX F

### Interview Questionnaire

- 1.) How does your mortality—the fact that we all at any point may, and eventually will die—impact the way you perform your clinical and professional work, both in the clinical encounter and in conducting your other professional duties (e.g. running your practice)?
- 2.) a.) Have you ever discussed your mortality overtly with clients? b.) Please describe this discussion(s). c.) How did this discussion impact you? The client? The relationship? The work? Please choose 1-2 clients to discuss.
- 3.) a.) Have you ever been diagnosed with a potentially terminal illness while you were practicing clinical social work? b.) How did this impact your practice? c.) Did you explicitly disclose to your clients? (If so: How did this discussion impact you? The client? The relationship? The work? )
- 4.) a.) How have you prepared for the potential that you will unexpectedly be unable to continue your clinical work, because of death or incapacitation? b.) Why have you chosen these arrangements? c.) (In case it hasn't been stated) Do you have a professional will? (I will define this if requested, as a document that contains some or all of Steiner's [2011] list of provisions\*.) d.) What are the contents of your professional will and why? e. If you have not prepared a professional will, what has informed that decision? Have you considered it directly or not?
- 5.) If you work in an agency, group practice, hospital, or other system, are you aware of specific policies that are in place in the event of the sudden death or incapacitation of a clinician? If so, what are these policies? Are you responsible for any preparations?